

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

The meeting convened at 10:00 AM.

Attendance

*Technical Workgroup members attending:* Richard Bock, Molina Healthcare of California (by phone); David Ford, California Medical Association; Dean Germano, Shasta Community Health Centers; Bradley Gilbert, Inland Empire Health Plan; Michael Humphrey, Sonoma County In-Home Supportive Services Public Authority; Jerry Jeffe, California Council of Community Mental Health Agencies; Lisa Kodmur, LA Care Health Plan; 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 (by phone); Erica Murray, California Association of Public Hospitals; Chris Perrone, California Healthcare Foundation; Cheryl Phillips, On Lok Lifeways; Brenda Premo, Center for Disability and Health Policy; Jacqueline Ritacco, AltaMed Health Services; Deb Roth, SEIU; Leila Saadat, Alameda Alliance for Health; Rene Santiago, San Diego Health and Human Services; Margaret Tatar, CalOptima; Anthony Wright, Health Access California; Casey Young, AARP.

*Others attending:* David Maxwell-Jolly, Director, DHCS; Gregory Franklin, Director of Medi-Cal Operations and Project Director, 1115 Demonstration Waiver Project, DHCS; Tanya Homman, DHCS; Luis Rico, DHCS; Bobbie Wunsch, Pacific Health Consulting Group.

*Public in Attendance:* 29 individuals attended in person, and 42 people called in on the listen-only telephone line.

Welcome and Introduction

*Bobbie Wunsch, PHCG* welcomed the group. She announced that materials from the webinar on dual eligibles held March 30 were available online, on the DHCS Waiver SPD and Duals web pages. Questions from the webinar and the CHCS paper on options for enrolling dual eligibles are also available at those sites. The SCAN Foundation will be funding two community dialogues on dual eligibles, on April 8 in Sacramento and on April 9 in Orange County. These meetings require reservations, and interested parties should contact the SCAN Foundation directly.

Bobbie introduced the agenda, to include a discussion of home and community based services (HCBS), a presentation on the PACE model, and discussion in large and small groups of how to organize services for SPD in non-managed care (especially rural) counties.

## Home and Community Based Services (HCBS)

*Jackie McGrath, California Council of the Alzheimer's Association, and Casey Young, AARP,* introduced the panel to discuss HCBS.

*Jackie McGrath* thanked DHCS for putting HCBS on the agenda for the SPD Workgroup as well as the duals' workgroup. People in the SPD categories typically have the acuity and complexity of duals, and thus the potential for better and more efficient care. Jackie added a caveat: that the presentation ideas and principles for integration of HCBS into organized systems is not an endorsement of mandatory enrollment. In addition, the presenters endorsed earlier presentations and discussions regarding consumer protections and readiness standards.

The State's goals for the renewal of the 1115 waiver include:

- Promoting long-term, efficient, and effective use of State and local funds
- Improving health care quality and outcomes
- Promoting home and community-based care.

These three goals are inter-related and achievement of the first two – long-term fiscal efficiencies and improved care – is highly dependent on three things:

- A system's having access to a complete array of social and health-related services outside the medical setting *and*
- The system's having maximum financial flexibility *and*
- Consumer choice and a preference for the most integrated setting.

Only then can a system have the ability to minimize use of the most expensive levels of care – hospitalizations, ER visits and institutional care – and enable consumers to remain in the community as long as possible.

Services included in a comprehensive home and community-based system must include the full range of social and health supports that sustain health and independence. The following is a menu that consumers and their care managers need to have available to implement an individualized plan of care. The list may not be exhaustive but conveys the breadth of services included in HCBS:

- In-Home Supportive Services
- Adult Day Health Care
- Respite – Caregiver Resource Centers
- Caregiver support – Caregiver Resource Centers
- Alzheimer's Day Care Resource Centers
- Care coordination/management – Multi-Purpose Senior Services Program/Linkages
- Home health
- Personal care services
- Transportation
- Nutrition
- Housing alternatives
- Targeted Case Management
- Legal services

- Home modifications
- Assistive technology
- Independent Living Centers
- Transition services
- HCBS waivers (MSSP, NF/AH, AIDS, ALWPP)
- PACE (Program for All-Inclusive Care for the Elderly)
- Benefits counseling (e.g., HICAP)
- Employment counseling
- Regional Centers

*Janet Heath, Director, Care Management Services, MSSP, UC Davis*, further described HCBS with case examples. There is tremendous variability in the care plans developed, but one near-constant is the use of IHSS.

*Deborah Doctor, Legislative Advocate, Disability Rights California*, discussed the *Olmstead* decision (1999) and the integration mandate in the Americans with Disabilities Act (ADA). *Olmstead* said that people with disabilities had the right to leave institutions and live in the community. The integration mandate essentially states that people with disabilities are entitled to receive services in the most integrated setting.

Two over-arching principles guide the panel's recommendations for integrating and promoting HCBS in Medi-Cal managed care systems:

- The state must establish the philosophy and the clear, expressed intent that home and community-based services are the preferred method of providing long-term care services in California (Mollica LTC Financing Rept, Rec 1)
- The service delivery system should be consumer-centered.

### **Recommendations:**

#### **A. The organized delivery system must have financial flexibility in using resources across the full spectrum of services and care settings.**

- Flexibility through full integration of funds (global budgeting) will provide financial incentives for the system to use resources in ways that avoid or postpone institutionalization and minimize hospitalizations and ER visits.
- Integration of funds will also enable the system to align spending of funds with the needs and preferences of the consumer and his/her family. It will enable there to be capacity for providing adequate services in a home and community setting.
- The system must have flexibility to reinvest savings in the acute care and institutional settings in those services which sustain health and maintain independence.

#### **B. Comprehensive care coordination – this is predicated on a comprehensive assessment and development of an individual care plan.**

- Care coordination is a core service for people with multiple, complex conditions and ensures appropriate and efficient use of services across the full spectrum of a delivery system – it's what integrates the medical, health and social.
- Prior to transition of a person into a Medi-Cal organized health system, there must be a comprehensive assessment and development of an individual care plan.

- There must be periodic reassessment and modification of the person's care plan to reflect the assessment.
- Care coordination ensures that individuals are linked to, and *actually receive*, needed services. Must include:
  - Qualified, trained staff – this should be a multi-disciplinary care team that is structured to address the full range of beneficiaries needs.
  - Development of a care plan that reflects individual's choice and participation
  - Access to included services *and* those outside the scope of the plan, and
  - Accountability for follow through on implementation of the plan.
- Inherent in care coordination is involvement of the consumer and his/her family as appropriate in making choices for services and care.
- Integration of HCBS and appropriate utilization of all services is not likely to occur routinely without care coordination/management.

*Janet Heath* described in detail what comprehensive care coordination means in MSSP. A nurse and social worker together do a visit with a potential client, and complete a 16-point evaluation addressing such things as environment, financial status, medical history, and ability to make decisions. At a care plan conference, the RN and SW meet with a clinical supervisor and together write the care plan. The plan is sent to the consumer and/or her representative who can agree or disagree. Once accepted, that care plan follows the client for a year. Care managers are in contact with the client at least monthly, with quarterly in-person meetings and an annual update.

She also noted that there has been enormous erosion in the availability of community-based services over the last few years. Locally, IHSS social workers have caseloads of 1:500.

*Margaret Tatar, CalOptima*, talked about how comprehensive care coordination is done at her plan.

- There are really two 2 fronts: 1) formal programs and 2) informal practices that are really de facto programs that have grown to address these needs.
- CalOptima has had the LTC nursing home piece and been an MSSP provider since 1998.
- CalOptima brought up a SNP 5 years ago, and has been able to do things in that program that encourage client independence: added a transportation benefit, added back podiatry.
- Two years ago, a county collaboration in which CalOptima participates applied for and received funding for an integration project, one of six in the state. This has been very valuable.
- Funding flexibility is key, as is knowing what services are out there. CalOptima has the benefit of a defined service area.
- Elimination of core HCBS services such as IHSS would dramatically erode CalOptima's and the county's collective ability to ensure independence for as long as possible. However, there might still be options to consider modest steps toward integration with the development of global cap.

*Casey Young, AARP*, said that there will be difficult tradeoffs in the state budget, but he remains concerned that this vulnerable population will be mandatorily enrolled into system

that is not equipped to serve their needs. Coordination of HCBS doesn't work if the services aren't there. The discussions in the waiver TWGs and in the legislature seem to be moving on parallel and disconnected tracks: here there is talk about promoting HCBS, while in the legislature those same services are threatened with decimation.

*Deb Roth, SEIU*, said that IHSS has an important role to play as part of team that is still consumer-focused. The IHSS caregiver is there every day, and often the first person to notice changes in clients' health status. In the case of a transition to organized care, IHSS caregivers can play an important role there as well.

*Brenda Premo, CDHP*, said that the group should be balanced in understanding individuals. Some people with disabilities don't need care coordination, but they may need help understanding their options in the community. Some people want to manage their own care, while others need more help. IHSS is critical, because it allows people to choose and train their own providers. (Other people might need more help training the provider.) The continuum runs along the line of home and community to institutionalization, but also varies by how much the individual controls/directs care.

*Brad Gilbert, IEHP*, said that there was no inconsistency between the presentation and Brenda's comments: People need to be assessed individually, involved in their assessments, and then resources must be mobilized. IEHP has LCSWs, psychologists, RNs, and LVNs as part of the care management team that does assessments and determines what will work best for each individual.

A lack of flexibility on the financing side can cause problems: transportation is built into the bid on the Medicare side, but IEHP has no source of reimbursement for this service on the Medi-Cal side. That said, even with all the difficulties associated with managed care, IEHP can use its Medi-Cal premiums as it sees fit -- one hospital day pays for a lot of HCBS. IEHP doesn't have LTC in its capitation and thus does not have global budgeting, but capitation offers the flexibility to fill in some of the gaps, although without enough money.

*Lisa Kodmur, LA Care*, echoed Brad's comments, saying that the plan has ongoing relationships with all local Independent Living Centers, Regional Centers and with IHSS. LA Care offers supports and services to those organizations that help them build care programs for their consumers. While managed care is not for everybody, some of the disability organizations refer consumers who they think would do better in managed care than in FFS.

*Michael Humphrey, Sonoma County*, said that the panel's presentation was excellent, but HCBS still got only one hour out of 21 in the SPD TWG process. If enrollment of SPDs in managed care is going to work, this piece is critical. He suggested additional sessions focused exclusively on this issue. *Bobbie Wunsch* agreed, and said that in the duals group there will be a larger focus on HCBS.

*Casey Young, AARP*, noted that there are several provisions regarding HCBS in the HCR statute. They move in the direction of community-based services, including helping states with additional FMAP for integration, and include some fixes that allow interventions after 90 days, instead of 6 months, to address the problem of people losing community connections. The federal government and many states are increasing their investments in HCBS, while

California is unfortunately moving in the other direction. The SCAN Foundation has an article on what's available for seniors in the HCR statute.

### Overview and Current Status of Program of All-Inclusive Care for the Elderly (PACE)

*Cheryl Phillips, On Lok Lifeways*, gave a presentation on the PACE model. Her slides are available at

[http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/PACE\\_Onlok\\_SPD](http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/PACE_Onlok_SPD).

*Lisa Kodmur, LA Care*, asked if PACE programs had ever subcontracted to other managed care entities. Cheryl Phillips said that CMS does not want PACE to sign off risk to others. PACE can be a part of a larger system, but must be the risk-bearing entity.

*Jackie McGrath, Alzheimer's Association*, asked about the PACE project in Pennsylvania and how that was accomplished. Cheryl Phillips said it was structured as a demonstration project, and that some structured requirements of the PACE model – such as staff-model physicians – have been waived, but that clients must still meet the state authorizing agency definition of nursing home certifiable.

*Jackie McGrath* asked how California criteria for participation compared to those in other states. Cheryl Phillips said that most states look at Activities of Daily Living (ADL) functional criteria, but that California uses a more medical model, requiring first medical needs and then ADL needs. This means that, for example, a 92-year-old with dementia but without other medical needs would not meet the criteria for PACE in California.

*Margaret Tatar, CalOptima*, said that recent regulations for SNPs require a team-based approach, with a more robust family presence in the composition of the teams. This is worth thinking about in both the duals and SPD workgroups.

*Michael Humphrey, Sonoma County*, challenged the use of the terms frail and fragile. He said that although he has high needs and requires assistance with many ADL, he is healthy. However, were he hospitalized, upon discharge there probably would not be a skilled nursing facility (SNF) willing to take him because of his needs. Cheryl Phillips agreed, and emphasized that the continuum described in her presentation recognizes the tremendous range of experience under the label "SPD." PACE is not designed for or meant to apply to the entire population. That said, there is a very vulnerable subset of "frail elderly" that sometimes gets lost.

### Options for Non-Managed Care Counties

*Luis Rico, DHCS* presented options for organized care for SPDs that could be considered in non-managed care counties, based on the experience of Medicaid agencies in other states. He focused in particular on Enhanced Medical Home models, describing common features and particular models in Oklahoma (state model), Illinois (single private vendor), North Carolina (local public-private partnership), Washington/Kings County (blended model). Key components of all these models include:

- predictive modeling
- health risk assessments
- physical/behavioral health integration

- medical home (though not necessarily at the at NCQA level)
- engagement strategies for patients and providers
- accountability.

*Brad Gilbert, IEHP*, said he was concerned about the prospect of entities without structures taking on the responsibilities of Enhanced Medical Homes. Rural areas have many solo practitioners whose only staff are medical assistants, and it is unrealistic to have places like that take on real care coordination. He asked whether any of the states mentioned include solo practitioners, not clinics or groups with more infrastructure, as Medical Homes. Luis Rico was not sure, but agreed that the provider network in rural areas is a challenge. Oklahoma and North Carolina do include rural areas in their projects.

*Chris Perrone, CHCF*, asked about outcomes from these models. Luis Rico said that the projects are fairly new, and savings from decreased ED/inpatient use have not yet been seen though it may just be too early.

*Elizabeth Landsberg, WCLP*, shared Brad Gilbert's concerns about rural capacity, and suggested that some of the other states have rural experience that could be useful to California. She also said that Oklahoma began with managed care but moved to the enhanced medical home model. One concern that WCLP would have would be whether a single ASO could implement such a program statewide, or whether local variation would be needed.

***Jim Parker, Deputy Administrator, Medicaid Programs, State of Illinois*** (by phone), presented on programs for IL's ABD (Aged, Blind, Disabled) beneficiaries. His presentation is available at <http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CA%20ABD%20Presentation.pdf>.

*Michael Humphrey, Sonoma County IHSS*, asked whether nursing home residents were enrolled in the programs. Jim Parker said that nursing home residents are enrolled in disease management, where providers are receptive. In some cases, nursing home providers do not want to let other providers in. In the collar counties around Chicago, the state will be launching an HMO-based integrated care program for the ABD population, in which all groups – waivers, nursing homes, etc. – will be included. The state realized that the costs for their nursing home residents was so much higher than for other people in the ABD population that they needed some other entity to manage the care.

*Chris Perrone, CHCF*, clarified that in the Illinois DM program (Your Healthcare Plus), the DM vendor gets some money and so does the provider. He said he was struck by the small amounts of money in that program and in the care management pilot (Illinois Health Connect), which pays \$2 PMPM for children, \$3 PMPM for adults, and \$4 PMPM for ABD populations) and asked Jim to comment on these amounts. Jim replied that in the DM program

Jim Parker replied that Medicaid providers have said that the \$35M that McKesson gets for the DM program could be better used to raise rates. In the PCCM program (IHP), the vendor contract is about \$20M and providers are paid several million dollars per month – still less than what McKesson gets for far fewer clients in the DM program. If the state had

an extra \$10 - \$50M, should it go to enhance the monthly PCP payments, or to enhance rates? Jim said that they don't know, but in any case don't have those additional funds.

*Lisa Kodmur, LA Care*, asked whether the PCCM payment has enticed any providers into Medicaid, and how long it took to implement the program. Jim Parker said that if any providers had been enticed back, it would be very few. Some may have stayed with Medicaid because of the PCCM payment.

Both the PCCM and DM contracts began in July 2006. The PCCM was rolled out geographically over several years, and is still a work in progress. The big weakness of that program is a lack of integration and an inability facilitate communication among providers. The state is looking to see what tools are available at low cost to encourage care integration.

**Dean Germano, Shasta Community Health Center, Shasta County**, discussed the programs his clinics offer.

- California is a hugely rural state, with a tremendous variety of conditions.
- Shasta County has 160,000 residents, SCHC serves 40,000, 80% of those in I-5 corridor
  - 90+% are below FPL
  - 3500 duals
  - 20% uninsured
- Infrastructure incomplete, especially for specialty care. One reason for ED overutilization is that it's the only way into specialty care.
- No organized systems (managed care, IPA) in Shasta County Specialists would say they ran away from managed care and came to Shasta.
- Mental health (MH) and community social services weak and fragile. Of the services described earlier in the HCBS discussion, 1/3 are available, 1/3 are very weak, and 1/3 don't exist at all. SCHC does not have many partners, but on the upside, they know them all.
- CHCs/FQHCs very prevalent in rural California. BPHC has pushed the medical home model, and as a result SCHC has PC clinicians as the center of the medical home. It is a medical model: nursing services, for example, are often not reimbursable, and this creates a barrier to team-based care.
- Some larger FQHCS, in particular, have been on the leading edge of Health Information Technology (HIT).
- SCHC has a lot of tools to permit them to participate in an Enhanced Medical Home (EMH) model, but financial and professional resources are still a challenge. Recruitment is difficult: SCHC has 1 diabetic educator and 2000 diabetic patients; 1 psychiatrist for a medical staff of 35, and a caseload in which 40% have SMI.
- Reimbursement models are key. \$2 PMPM (as in one of the Illinois programs described earlier) will not be sufficient. A clinic like SCHC needs:
  - 1) Adequate direct reimbursement.
  - 2) Monthly PMPM payment for care coordination
  - 3) Opportunity to share in savings.

**Herrmann Spetzler, Open Door Clinics (Humboldt and Del Norte Counties)** discussed the organization of care in his part of California.

- The PACE model is the right model for an integrated health care delivery system, and rural areas should not be left out.
- Economies of scale in rural areas don't make the same types of models possible, but technology offers many options.
- ODC has 10 locations over an area the size of Connecticut, so providers use telemedicine, telehealth, and telecommunications extensively. ODC has a telehealth and visiting specialist center, which they set up in order to bypass specialist reluctance to participate. They sell specialist services back to themselves and all over the state.
- Technology is also valuable in the area of HCBS: dementia groups that began in-person continue through telemed linkages.
- Rural areas do have access to land: their district hospital morphed into a health care district, then took the resources and bought an 11-acre site on which they have co-located a community health center, a senior resource center, a community garden, and other facilities. An early childhood site is planned.
- Recent state budget cutbacks stretch the FQHC's ability. The loss of DV programs, for example, have hit the area hard, and FQHCs cannot provide those services as cheaply or as well as the community-based agencies.
- The four-walls requirement also operates as an impediment to home-based health care.

**Lee Kemper, CMSP**, discussed CMSP's programs:

- CMSP in 34 counties covering 90,000 square miles
- Serve indigent adults not attached to Medi-Cal, income up to 200% FPL. Health care utilization comparable to SPD – very high need, for different reasons.
- Services through third-party administrators – pharmacy through MedImpact and Other services through Anthem Blue Cross.
- Rate-setting by Governing Board. Specialty care at 110% of January 2008 Medi-Cal rate, but can be increased based on the need for a particular specialty.
- Through Blue Cross, have access to a care unit, and 24-hour nurse line (not much utilization).
- Separately funded program offers telephonic care management program.

The focus around HCR is about being ready and about moving to systems that produce outcomes. To that end, interesting elements in federal HCR include:

- Federal government taking on additional increment for primary care providers (PCPs).
- Additional money for FQHC expansion in California and nationally.
- Revenue for care management and medical homes for people with two or more chronic conditions or 1 chronic condition and serious mental illness (SMI). This is important because programs like phone support really only work for people who a) have phones and b) are willing to engage. At the end of day, there's still a lot to be done at people's homes.

CMSP is about to issue grants for projects related to Frequent Users and other high need individuals. They are for integrated programs involving PCPs, hospitals, and 2 – 4 local

agencies, and the goal is to build capacity. CMSP has received 6 proposals for implementation and 7 for planning.

*Elizabeth Landsberg, WCLP*, asked about the overlap between the CMSP provider network and Medi-Cal's. Lee Kemper said that for the most part, CMSP providers are Medi-Cal. Originally that was required, because CMSP used the Medi-Cal enrollment and eligibility systems. Because CMSP contracts for specialty and inpatient care in non-CMSP contiguous counties (i.e., Sacramento), medical groups associated with those are also in. CMSP will contract with individual doctors or groups as needed, and some aren't Medi-Cal providers. Lee Kemper said that the nurse hotline was established in 2005, and is an important piece of the infrastructure for a population that is transient and disenfranchised.

***Jack Burrows and George Koortbojian, Association of California Health Care Districts (ACHD)***, discussed the work of their member hospitals:

- District hospitals are public hospitals, with elected Boards of Directors
- District hospitals are a key element of the infrastructure in non-managed care counties. They may be the only provider, and often provide multiple levels of care – RHCs, acute hospital, LTC, for example.
- District hospitals used to be more involved in the home care arena, but that was mostly eliminated in rural areas. Travel times that allow nurses only 3 or 4 visits per day are cost-ineffective.
- In contrast to urban areas, in rural areas it's important to talk about keeping people *in their communities*, even if they require institutional settings. People sometimes are moved completely out of their communities for LTC. Many districts have relationships with providers in urban areas, but those people need to be returned home on discharge.
- There are no major disagreements with the enhanced medical home models. In the 1980s, some districts participated in a HCFA project to cut costs. The hospitals stratified the patient population to identify people at high risk. Then nurses and social workers found these clients, gave them services, and sent them home, and found that they could reduce hospitalization, shorten lengths of stay, and save money. Rural communities serve as good test tubes for developing demonstrations and pilots, because it's possible to see results very quickly.
- The solution is not in the funding mechanism – FFS or managed care. The real issue is funding itself, and the fact that funding is siloed.
- Because of personnel resource concerns and funding limitations, it may be simpler to identify the appropriate caseload and fund physicians in district hospitals and associated clinics directly for care management rather than contracting with an outside entity for care management.

*Brenda Premo, CDHP*, asked whether CMSP has sufficient provider capacity to handle Medicaid expansion. Lee Kemper replied that, while federal law has some incentives to increase provider participation, it remains a concern. When people get their eligibility card, they need a place to go that's not just for primary care.

*Herrmann Spetzler, ODC*, said that there are definite workforce issues, which are exacerbated by the reimbursement structures that are so medically based. If the

government would allow health care teams, not just medical, teams, to be reimbursed, doctors could be used more efficiently. The only way for a clinic to get reimbursement for diabetic education is for the patient to see a doctor, when in fact all they need is the ½ hour appointment with the diabetic educator. \$1.5B in the federal HCR statute is geared toward re-energizing the primary care layer, but when what also needs to be done is to respect the complexity of the PCP role.

### Small Group Discussions

*Bobbie Wunsch* introduced the afternoon discussion, which focused on two questions:

1. Which components of the options for non-managed care counties would most respond to the needs of seniors and people with disabilities in those counties?
2. How can the standards and consumer protections talked about at previous meetings be incorporated into these options in non-managed care counties?

Each of two small groups discussed both of these questions.

**Group 1:** Dean Germano, Lisa Kodmur, Jackie McGrath, Erica Murray, Cheryl Phillips, Brenda Premo, Margaret Tatar, Anthony Wright

*Margaret Tatar* reported for the group.

### **Models and components**

The group spent the bulk of its discussion on components of options for non-managed care counties would most respond to the needs of seniors and persons with disabilities.

Key components include:

- Care management
  - For non-managed care counties, have to build on what's already in place – whether a district hospital or an FQHC – and expand current infrastructure
  - Care management has to recognize existing HCBS, which varies greatly
  - Telephonic care management, and care management in which the vendor has no contact with the delivery system, are bad ideas. Providers want someone on the ground who can help them. That said, in remote areas, small providers might welcome outside support
  - Integrate disease management into care coordination.
- Medical homes
  - In some cases, the best medical home might not be at the PC office. Senior centers or other HCBS providers might serve as medical homes.
- Family caregiver support
  - In relation to all HCBS
  - Recognition that in rural counties, the family role is often increased
- Telemedicine
  - It works better in some places/types of care than in others. Mental health and internal medicine specialties are particularly good fits.

- Transportation
- Language and cultural access
  
- Workforce development and training in connection with all these issues
- Supporting core agencies
  - Housing modifications and support a key need
  - Fragile community support system could potentially be supported through resources from core agencies.
- Financing
  - Critical to develop long-term incentives and appropriately fund enhanced case management.
  - North Carolina returns some savings to the entities involved – all have some skin in the game.

### **Consumer protections and standards**

- Access for non-hearing people
  - Enhance care for people who are deaf, given long distances
  - Aging rural population may need assisted listening devices or captioning. Most don't sign.
- Regardless of system/payment structure, need basic standards re: access and capacity.
  - Hard for communities to meet the access standards.
  - State dilemma for rural counties: Create standards that may drive providers away, or enforce only minimal standards and risk access and health?
  - Are there ways to incent capacity?
  - Need separate set of standards that are achievable, realistic, and developed locally.
  - Need appeals processes and complaint policies
- Many consumer protections are in response to managed care gatekeeper function, so those are conditional (depending on model)

*Bobbie Wunsch* asked what the group thought about the feasibility of building care management into rural models. *Dean Germano, SCHC*, said he believes that it's very feasible, provided there is money to support it. Other HCBS infrastructure would take more work.

*Jackie McGrath, Alzheimer's Association*, noted that the care coordination goal goes the medical setting. Since the HCBS infrastructure does not exist in many rural settings, it is doubly important to have a resourceful person at the primary care site who can tie it all together.

*Cheryl Phillips, On Lok Lifeways*, said that the initial priority group for care coordination should be on high-intensity, low-volume individuals.

*Lisa Kodmur, LA Care*, said she would be interested to hear more about California's past experience with PCCM models.

**Group 2:** David Ford, Brad Gilbert, Michael Humphrey, Elizabeth Landsberg, Chris Perrone, Jackie Ritacco, Leila Saadat, Rene Santiago, Casey Young.

*Brad Gilbert, IEHP, reported for the group.*

### **Consumer protections and standards**

- Assuming mandatory enrollment into organized systems, *all* standards from managed care should apply: assessment, care plan, quality measurements, access monitoring.
- Other items, such as network requirements, would depend on the model and the degree of risk: the more structure and risk, the more accountable the organization should be.

### **Models and components**

- Create reimbursement for those (non-clinical) things that are most beneficial to the population – care management, care coordination, nutritional services, health education, etc.
- Lack of capacity is an issue but care can be improved through reimbursement for what the current system *can* provide. Meet the providers where they are: a model for Shasta may be different from a model for an area with solo practitioners.
- None of the models solve the issue of service shortages – shelters, ADHC, etc. -- in rural areas. Can risk arrangements create savings that are sufficient incentive to provide services like IHSS and others?
- Decide on medical home requirements and *then* pay for services required. Could be FFS or partial capitation, depending on local conditions.
- Care coordination must be local – remote telephonic versions don't do anything.
- Health IT has to come first.
- The group recommended a multi-tiered EPCCM model. The state should start in areas where there is enough infrastructure to accomplish some level of EPCCM – issuing an RFP to see where willing providers with capacity are.
- Entities able to do this would be FQHCs, district hospitals, other large clinics – organized entities with infrastructure. They might even be able to do the care coordination for patients attached to other area physicians, though this could be dicey.
- Financing: Entity should be paid to provide these services on a PMPM or other non-FFS basis. Any savings should accrue back to the entity.
- Need a process to measure the quality that's delivered, and a quality bonus. This is difficult with care management, but evaluation could look at other outcomes as well.

*Michael Humphrey, Sonoma County, asked what the structure would be for monitoring and enforcement of standards. Brenda Premo, CDHP, said that local involvement in monitoring would be necessary. Chris Perrone, CHCF, said that it is difficult to discuss standards without knowing what the model will be.*

*Dean Germano, SCHC*, said that in rural areas it is important to ensure that penalties for poor performance don't ultimately hurt the patient, as when providers are dropped from the program and there are no alternate options for patients.

### DHCS Next Steps on SPD Mandatory Enrollment in Managed Care and Organized Delivery Systems

*David Maxwell-Jolly, DHCS*, recognized *Bobbie Wunsch's* work in the Stakeholder process, and credited her for the Workgroup's tone and level of engagement. He thanked the DHCS staff for their work on the process and for generating information for the Workgroup.

He said he was extremely impressed by the Workgroup's attendance, commitment, and willingness to engage, and had learned a lot from the meetings. It is now the Department's job to integrate across all these things and figure out what to do.

The effort that went into Medi-Cal Redesign has turned out to be very useful. The state of knowledge and the engagement of Medi-Cal managed care plans has advanced significantly, and voluntary enrollment rates demonstrate that. DHCS also has learned a lot from having beneficiaries at the table, and how to design systems to meet their needs.

Context: California is facing serious fiscal constraints, and DHCS has to consider ideas in light of the available funds. There are great new opportunities in terms of federal funding, but how these are used has to be informed by what the state can put together. *David Maxwell-Jolly* said he felt profoundly the proposed cuts in the budget context, and thanked the Workgroup members for their willingness to compartmentalize the current fiscal situation.

Overall, *David Maxwell-Jolly* said, DHCS has not learned anything to make them think that existing MCOs can't work for SPDs. The potential benefits from organized delivery are clear, and the state is committed to making progress.

Among the ideas that DHCS will be taking from the SPD Workgroup process and integrating into their plans as they move forward with the waiver process are:

- Access
  - SPD population is qualitatively different from the population already enrolled in plans
  - Specialty care needs of the SPD populations are much greater
  - Accessibility of all types – cultural/linguistic, physical, etc. – are critical
- Transition
  - The pace of enrollment has to be matched to the adequacy of provider networks
  - Beneficiaries need to have their options presented in appropriate language and through appropriate media
  - Transition must be as smooth as possible, including giving plans information about clients' current providers
  - Default could be informed by where current providers are

- Phase-in process should be graceful and meet beneficiary needs – enrollment should occur at pace that matches plan readiness
- Transition will include local coordination with providers and other community organizations
- Care management
  - Current contracts are very high-level, but many plans already do a lot of care management
  - New contracts will need to provide enhanced definitions
  - Care management has to be informed by the particular health needs of beneficiaries – plans need this information up front at enrollment so they can call out people who need early intervention, care management, etc.
  - Care management requirements to be informed by particular needs of beneficiaries
  - Care management assessment/planning must be able to adjust as people’s needs change
  - Cultural competency and sensitivity a key part of care management
- Performance measures
  - Will need to adjust performance measurement to new populations
  - May need new measures, may need to report same measures by sub-population
  - Member satisfaction research should be continued, but results stratified by population
  - QI projects should be targeted toward this group
- Consumer protections
  - Provider directories should be more specific regarding access
  - Beneficiary Advisory Groups should include significant representation by SPD individuals
- Carve-outs
  - Even where care is carved out, the MCO should provide assistance to its members in accessing this care at the local level. For example, some plans have strong working relationships with Regional Centers; others don’t. All plans will need to develop relationships with MH, SU – providing an organizational framework within the managed care structure.
  - Development of these connections will be specifically required of plans.

To the extent that these things can be accomplished in the context of the waiver and increased federal financial opportunities, there are some great opportunities.

DHCS will soon announce the formation of a duals workgroup, and some member of the SPD Workgroup will probably be invited. Discussion of HCBS, which needs more development, will be continued in that context.

*Casey Young, AARP*, asked whether the Workgroup will see a proposal that it can react to. David Maxwell-Jolly said that the overall conceptual structure was for the TWGs to support the SAC, and DHCS to work with the SAC to develop the plan. DHCS is working to complete the draft implementation plan by early May so that it can be discussed in depth at next SAC meeting on May 13.

*Elizabeth Landsberg, WCLP*, asked about plans for non-managed care counties. David Maxwell-Jolly said that the conversation had helped provide an understanding of the health care landscape, but that there is still information to be gathered on the impact of HCR. Whether or not to put a proposal on the table regarding rural areas is still an open question.

*Michael Humphrey, Sonoma County*, commended David Maxwell-Jolly and DHCS on the job they have done with the Workgroup process. He echoed his earlier comments that HCBS coordination has been an afterthought in the discussion, and his wish for additional time to focus on that issue. Elimination of IHSS, MSSP, and ADHC would lead to negative health outcomes, and DHCS will have to have comprehensive plans to address those issues. In addition, Michael Humphrey noted that the next step beyond letting people know about their access rights is to enforce those requirements.

David Maxwell-Jolly replied that staff is working on laying out the agenda for the duals workgroup, but that it will include specific times for discussing the question of HCBS roll-out. The implementation plan won't foreclose options around duals and around HCBS, though they may not be included in the May draft.

He said that DHCS will always struggle with enforcement of access rules – there are not enough Medi-Cal providers to require all of them to meet all the access standards. However, DHCS can 1) reveal to the world the state of affairs as far as access is concerned, and 2) look at managed care networks to make sure that within each network accessible providers are available. He agreed that there is a lot that DHCS can do in enforcement.

*Anthony Wright, Health Access*, asked what would come after a draft Implementation Plan. David Maxwell-Jolly said it would be an iterative conversation, with the SAC as the locus of public discourse. DHCS has planned time for specific amendments based on the input received at the May 13 SAC meeting, and there will be additional opportunities for input as well. Federal HCR effects will have a profound effect on the waiver negotiation, and DHCS is sorting through the changes in that context. DHCS is continuing to talk to CMS about individual elements, but CMS is most concerned about the waiver's overall financial structure. There has been no specific feedback from CMS about dual eligibles, but DHCS hopes to have some information by the end of April.

#### Final Words from Workgroup Members

In conclusion, *Bobbie Wunsch* asked each Workgroup member to answer the following questions:

- What work remains to be done?
- Where do you stand on Department's proposals and what would it take for you to support them?

*Casey Young, AARP*, said that what happens on duals will inform what the state does for the Medi-Cal only SPD population. The availability of HCBS is a big concern. AARP would have to see the proposal to know where they stand. While AARP does not oppose managed care *per se*, but has a policy that individuals should have choices, including the choice of FFS.

*Jackie Ritacco, AltaMed*, said that she was concerned about the amount of work entailed in the financing piece – building an integrated system that can share savings back. In response to David Maxwell-Jolly's statements about carve-outs, Jackie Ritacco said that she had heard that plans would have the responsibility of managing carve-outs more closely. She said that the carve-out policies should be re-thought, as it is not possible to pool enough money with carve-outs in place.

*Brenda Premo, CDHP*, said that HCBS can't happen in the health care system alone. For any system to work so people can participate fully, all local and state agencies that are responsible have to be involved. People with disabilities do not want everything medicalized. IHSS was a social service originally, not a medical service. Integration decisions must remain the purview of the individuals involved to the extent they want control of these decisions.

*Cheryl Phillips, On Lok Lifeways*, said she was still concerned that there's a bias toward institutionalization. If there's no safety net and the plans are in charge, it's critical that there be some measure of institutionalization, since right now it is easier to get into a nursing home than into a waiver program. While she believes in organized systems of care, she said she would be concerned if the state pulled people out of functional systems and into systems that don't work as well. Individuals should have choice.

*Deb Roth, SEIU*, said that it seemed premature to offer closing reflections, and said she looked forward to continuing dialogue.

*Margaret Tatar, CalOptima*, said that it felt to her that the Workgroup wasn't quite finished, and that she looked forward to the group's collective next steps. She stated her support for preserving the HCBS structure that currently exists.

*Leila Saadat, Alameda Alliance*, said that the work ahead should incorporate flexibility by location. The Alameda Alliance already serves SPD populations, and increasing the number enrolled would allow the plan opportunities to develop and expand creative solutions.

*Rene Santiago, San Diego*, said that the proposals represent a timely and ambitious Medi-Cal reform, but one that requires significant investment. Capacity analysis is needed. Connection with local stakeholders and county governments critical

*Richard Bock, Molina Healthcare*, said that it is important to take advantage of technology for further integration. The Illinois presentation emphasized that they are still trying to integrate specialists, hospitals, medical homes, etc. Federal HCR offers opportunities around care management, EHRs, outcomes research, and evidence-based medical practice.

*Erica Murray, CAPH*, pointed to two areas of work that remain to be done: 1) Bringing together conversations from the various Workgroups, all of whom are discussing PCMH and organized delivery systems. 2) Understanding the impact of HCR on what's possible and how that takes shape. As has been discussed, California's waiver renewal gives the Obama Administration an opportunity for an early win. Erica Murray said she appreciated DHCS'

understanding of the need for alternative models at local level – public hospital leadership agrees that managed care for SPD not the way to go in every case.

*David Ford, CMA*, noted the tendency to talk about the expense of SPD populations, and said he was concerned that, as the waiver process moves concurrently with the state budget process, cost and not quality will become the driver. CMA has grave concerns about mandatory enrollment of any population into managed care, and David Ford said that he hadn't heard anything that had changed his mind about that. Many issues we haven't talked about – will wait for implementation plan with bated breath. Issues for further development include network adequacy and the definition and role of medical homes.

*Jerry Jeffe, CCAMHA*, had the following ideas:

- 1) It is important to spell out the monetary benefits for providers and counties, as well as the state.
- 2) Duals are a major issue.
- 3) Mental health parity: federal HCR is going to force more integration of BH services, and that work – which Jerry said the BHI TWG had been focused on – should be integrated into SPD planning as well.

*Michael Humphrey, Sonoma County*, said he was hopeful about the process. He recognized Orange County, CalOptima, and HPSM for moving in the direction of integrated HCBS, and said he would like to see more pilots on these issues. He noted that counties need time to design these systems: CalOptima and HPSM have been working on this for 8 years or more. Michael Humphrey noted that he was not impressed by the Illinois system presented, and that if the state is considering that path, he would have significant concerns.

*Lisa Kodmur, LA Care*, said that, as a public entity created to serve the Medi-Cal population, LA Care will be a full partner if the Department proceeds with mandatory enrollment of SPD. DHCS needs to

- Make up its mind about performance standards and outcome measures
- Provide plans the data they need to prepare and transition people.
- Get the rates right.

She also encouraged all plans to hire internal champion for people with disabilities.

*Elizabeth Landsberg, WCLP*, thanked DHCS staff and said she appreciated David Maxwell-Jolly's statements of ideas he was taking away from the process. Care must be improved in non-managed care counties. While the Illinois presentation may not have represented the best model, there are some good models out there, both in California and nationally. She said she was concerned about the process going forward in this environment, with cost as the overriding goal.

Elizabeth said she appreciated the option of an alternative approach in managed care counties. WCLP has laid out the consumer protections they want to see, and are particularly concerned about enrollment and transition processes. She stressed the need to have realistic expectations about how long this will take.

*Dean Germano, SCHC*, said that developing systems will require creativity. While not opposed to managed care *per se*, Dean said he was concerned that the state sometimes

reaches out for a simple solution (like having a contractor do care management for entire parts of the state) when the more successful models are home-grown and locally developed.

*Brad Gilbert, IEHP*, said that his plan cares for 20,000 individuals with disabilities, and works hard to coordinate them with HCBS. He said that he believes that, done right, managed care is better than FFS for people with complex needs (although managed care is not for everyone). Plans can pay more than FFS Medi-Cal, and the probability of members getting what they need is higher in managed care than in any other system. He asked DHCS to raise standards and make the plans accountable for this vulnerable population. He specifically mentioned the CHCF standards, and said that there should be additional standards regarding better coordination with non-medical entities. There are appropriate savings on the inpatient side, and plans can use them to fill holes, but rates must be sufficient to allow that.

*Anthony Wright, Health Access*, said that there is a lot left to be done on this topic. Consumer protections standards were discussed, but not accountability/enforcement/how this becomes real. Where there's a lack of providers, accountability and enforcement are very difficult. Anthony Wright said he appreciated DHCS' willingness to look outside the existing managed care structure at county option, but said that higher standards may be necessary for the existing infrastructure. On both the coverage and service sides, the waiver is an important piece of what California needs to do to prepare for HCR. Anthony said that while he is happy to compartmentalize for the purposes of conversation, Health Access will be looking at the waiver proposals in the context of the budget.

*Chris Perrone, CHCF*, said that this meeting is different from the first 3. Those were about existing models, while this one was about unknowns. He would like to see a stakeholder process going forward for working through non-managed care issues. Although non-managed care counties were raised in the context of SPDs, it is a more general issue and that should be acknowledged.

*Jackie McGrath, Alzheimer's Association*, spoke to the need for comprehensive coordinated care. Work to be done includes:

- 1) Financing: Promoting both long-term fiscal efficiencies and quality. She noted that when providers talk about financing they're talking about rates. Consumers are talking about where to find funds in the system.
- 2) HCBS infrastructure. The Administration is working at cross-purposes between its 1115 waiver efforts and the state budget.

The meeting was adjourned at 4:15 PM.