

NF/AH Waiver Renewal Technical Workgroup Meeting #2

Meeting Minutes

February 10, 2016, 10:00 a.m. - 4:00 p.m.

Department of Health Care Services

1500 Capitol Avenue, 1st Floor, Room 72.170

Sacramento, CA 95814

HCBS Advisory Workgroup Members:

Present: Aaron Starfire, Maggie Dowling, Connie Arnold, Deborah Doctor, Mary Williams, Jonathan Istrin, Karen Keeslar, Denise Likar, Roy Williams, Julie Bates (*proxy for Blanca Castro*), Ellen Rollins

Absent: Charles Griffin, Louis Frick, Francis Gracechild, Beverly Thomas, Irene Tokar,

State Representatives:

Present: Rebecca Schupp, Christine King-Broomfield, Elise Church, Maha Edlbi, Jonathan Alspektor, Lindsay Jones, Nayeema Wani, Peggy Barrow

Proceedings:

Meeting commenced at 10:00 a.m. by Rebecca Schupp

- Member introduction and brief statement about meeting objectives and agenda
- Charter reviewed and finalized

PowerPoint Presentation

PowerPoint presented by Rebecca Schupp, Christine King-Broomfield, and Lindsay Jones to discuss the care management approach, waiver capacity, and care management entities.

Care management Approach

Rebecca Schupp stated: Some of the goals for today is to talk about the care management structure and the model of care; where we want to see the NF/AH Waiver going in the next five years and how we want to enhance the member experience and their health outcomes through a stronger care management structure.

Deborah Doctor commented: In the discussion of care management, I don't see anything about the actual waiver caps and aggregates

Rebecca responded: You are correct in that the two go together. There will be limitations with care management if we don't have a stronger financial structure. But we are considering ways to revamp or transform the financial structure -- which does include the level of care caps -- in the last meeting. So that will be the topic of the discussion for the last meeting.

Mary Williams commented: So what you're saying is that we'll get the program and the model that we want. And then, let's see if the financials can be put on top of that next time?

Rebecca responded: Exactly

Mary Williams commented: So we get to know what we want as a financial picture according to what we're going to discuss today.

Rebecca Schupp responded: Right. So we'll be able to better understand what we want the waiver to be with the model of care and the assessment process and the way we want services to be delivered. That will help us drive what modifications we need to make to the financial structure.

Rebecca Schupp commented: When we wrapped up from the first meeting, it felt like we had a consensus and recommendation to really work with local entities, whether they're a private, non-profit, for profit, proprietary agencies or maybe local county governments. That it would be most beneficial for the population that we're serving to have local comprehensive care management. This PowerPoint is really presented around having a local regional entity that delivers the care management to our waiver participants, and we have the care management approach that the state is looking to set goals for.

Rebecca commented: Currently, the state does care management at an administrative level by assuring the level of care of the waiver participants, working with the participants and their family members -- or circle of support -- to develop a care plan, implementing that care plan, adjudicating all services that are submitted by direct service providers, and then performing reassessments. We believe there is an opportunity to provide a more comprehensive care management to the waiver participants by being able to contract with local regional entities that can do direct care management for the population.

Rebecca Schupp commented: Let's try to clear our minds of level-of-care caps and really ask what do we want a care management approach to look like if we didn't have physical constraints?

Deborah Doctor commented: I want to say that the waiver is not only for people who are in hospitals or nursing homes. There are people who qualify for an institutional level of care, who are living in the community, who qualify for this waiver. They qualify for it because they need more services than they can get under any other program. The goal of care management is to offer a community-based alternative to institutional care. The reasons that people end up and stay in institutions are not necessarily related to having some high degree of medical need that can't be met in the community. The goal of case management is insuring people are able to stay in their own homes if that's what they want to do. With services that are at the level of care that they would qualify for in an institution.

Rebecca Schupp responded: We would say that the waiver program is the alternative to institutionalization. Within the waiver program there should be a care management structure to ensure that our waiver participants have access to essential services. There should be an adequate provider network for participants to select among a number of providers and different layers to care management allowing a participant to self-direct their services. The entire program is the alternative to the institution. But within that program, there needs to be some structure for managing the needs of the population in a whole-person aspect. The goal of care management is not only to assess medical needs. It is to assess the participant's environmental, social and psychosocial needs.

Connie Arnold asked: Can we say disability-related needs?

Rebecca Schupp responded: Yes. We're going to add diagnosis, functional and cognitive abilities, and environmental and social needs, to what we expect the model of care to be, when assessing the whole person. The model of care should also anticipate changes in health, environmental, social, and functional status. The model of care should also anticipate changes in the supports and services system.

Deborah Doctor commented: I think we're talking about some kind of entity such as a supported living provider, Adult Day Health, CBAS Center, an MSSP program, or an independent living center, who would take on the functions that are now done by the nurse case managers in the waiver. Is that what we're trying to talk about here?

Rebecca Schupp commented: That is exactly correct, Deborah.

Rebecca Schupp commented: We are going to look at how other waivers do this kind of organized healthcare delivery system. So when you spoke about the MSSP sites, and the independent living centers, those are already existing infrastructure. The triple A's (area agencies on aging), the HIV AIDS waiver agencies, those are what we're talking about here today. But how can we do it better? Or how can we enhance what's already being done?

Rebecca Schupp asked: How can we transform the NF/AH to be more sustainable in the long term to meet the needs of the growing aging and persons with disability population? We know we have participants on the wait list with unidentified amount of needs today and our existing waiver participants need comprehensive care management.

Rebecca Schupp commented: From the last meeting, it was very clear that the recommendation from the group was not to integrate care management into managed care. So we're not even having conversations around integrating this care management structure into the existing managed care delivery system. Taking into consideration that managed care looks different in whichever county you reside in. NF/AH is statewide. So it's not administratively feasible to have a different care management structure for the NF/AH. So we're talking about, a private, non-profit or for-profit proprietary agency or local government being a care management entity for NF/AH. It was very clear from the recommendations from the workgroup to not integrate the NF/AH care management into managed care. So we are not proposing that.

Rebecca Schupp commented: What we're proposing is more of that local entity that becomes the administrator and the payer of the services that could negotiate rates differently based on their geographic area and the cost of living, to make sure that they have a sufficient provider network to meet their participant's needs. It could be easier managed for the actual direct service providers. Then we're talking about what does that fiscal reimbursement structure look like between the state and a local entity that's doing the care management that already has an established provider network? Or will they establish a provider network?

Aaron Starfire responded: Maybe a direct approach is to unleash the billing code for care management in and of itself. Rewind, 15 years ago, much of the care management was done as a build-in to the existing rate. Twenty-Nine Dollars an hour 15 years ago was equivalent to like \$43 an hour now, according to the California Department of Labor statistics. So just that purchasing power has cleared the board of any case management abilities. You could look at that as profits decreasing into the negative. Or you could just look

at it as case management decreasing into the negative. Because those are the things that start to get pulled away and picked away when there is that pressure.

Rebecca Schupp responded: Yes, there's no one way. There are better ways in which we could do things than we're doing today. One could be through the organized health delivery system. Another pathway could be through allowing flexibility for the service providers we already have today to use care management rates or other services more flexibly for the beneficiaries. We definitely hear what you're saying and we can always have several recommendations that we put forward to the public to comment on. And really look towards this stakeholder engagement process to decide which pathway we end up choosing.

Rebecca Schupp asked: How can we better serve a larger number of the population without being so specific to the types of disabilities or characteristics that a population may have?

Connie Arnold commented: This care team involves the caregivers being given some sort of authority over the person with a disability or this senior citizen. I think this is a problem.

Rebecca Schupp responded: We're not saying that a primary caregiver has authority over your life. And we're not saying that a care management entity would have authority over your life. They're more of your support system to be able to counsel waiver participants on their options and educate them on if you select Option A, this could be a potential outcome. If you select Option B, this is your potential outcome. And we want to help educate you -- on how to select amongst these benefits, the options that are available to you. Options of providers available to you. And then also counsel you on what may be the outcome from what you, as the waiver participant, selects.

Rebecca Schupp commented: We want the care management entity to be aware of what are the barriers and the challenges for the participants that they're serving and they're assisting. For example, they would advocate on your behalf by reducing your share of costs, because you have X dollar amount of medical needs you're paying out-of-pocket. The care management entity would not only help with the development of the care plan, what are the services available within the waiver, and the provider network they have established, but also help with navigating the Medi-Cal, disability, rehab, and Older Americans Act system. Being able to understand, from the whole person perspective, may have a direct or indirect impact on that waiver purchase event.

Connie Arnold responded: It's very hard to find people that have the experience and knowledge to navigate all these issues. Those issues are incredibly time-consuming.

Rebecca Schupp commented: We have a California Community Transitions Program that does just that. They work with Medi-Cal Eligibility Office, they change aid codes, they work with the Social Security Administration, they change their income levels and their personal needs allowance. They work with housing developers to locate accessible and affordable housing. They've worked with the city and county housing authorities to get subsidies. We have programs that do this and we really want to build off of the experience that's already there at the local level and be able to integrate it across other programs within the long-term care tool shed.

Assessment Tools

Rebecca Schupp commented: One thing we really want to promote with NF/AH waiver renewal is streamlining and standardizing the administration across the long-term care waivers that the DHCS directly administers.

Rebecca Schupp commented: Does it make sense to build off of existing assessment tools and assessment processes so that it makes the direction, or the movement, towards integration streamlined, effective, and efficient? So if we're going to propose a new care management process under NF/AH we have to adhere to CMS' person-centered care planning approaches, expectations of CMS' person-centered care, and with the care management process, we would set activities and functions performed by the care management agency.

Rebecca Schupp commented: Looking at the participant's whole person factors. Not just looking at their medical. But looking at their social, environmental, psychosocial needs. And delivery - or tier planning on the person-centered approach does not simply mean giving whatever is wanted. It requires a care management entity to take into account and base decision-making process in which the person plays the central role.

Rebecca commented: It would be a responsibility of the care management entity to proactively know what's reimbursable under Medicare and to leverage Medicare dollars first prior to billing Medicaid for services that Medicare may not cover.

Rebecca Schupp commented: What are your recommendations around using existing assessment tools and if it make sense to adapt one for the NF/AH waiver renewal?

Jonathan Istrin responded: We need to have a single entry to the waiver. We need to put it into the local agencies to do that initial assessment and then have the nurses review it because that will speed up the time that clients get seen and whether it's going to NF/AH or any other waiver. If it's done by the local area agency, whatever that entity is, before it's submitted to the state for approval like it is with a lot of the other waivers. That to me is the way to speed up the entry.

Rebecca Schupp commented: What I'm hearing is that it is worth the time for the state to look towards standardizing assessment tools across the NF/AH and IHO Waiver and CCT program as well as looking at maybe some requirements on standardizing the process that the cost and the personnel doing the assessment. Where the state plays a role in the assessment process is more of an oversight, the direct face to face will be done by a care management entity.

Deborah Doctor responded: The problem with that process and something that we're about to make the same mistake again, I think, is that it doesn't include nursing homes. If we're assessing somebody for their need for long term care, that's what we should be assessing for, not for location of the care.

Rebecca Schupp commented: We are in support of the universal assessment tool and that we do expect the universal assessment tool to become more standardized across all community based programs,

but it's not a tool that will be usable, piloted, tested, reliability tested by January 1, 2017. So we're really talking about existing tools that have been in use since the beginning of waiver programs that are within the administration of the Long Term Care Division. How can we make it better for those four programs and use the NF/AH waiver renewal as mechanism for standardization, and have a more efficient, effective intake process?

Deborah Doctor: We're talking about something that starts in 2017 and goes through 2022. I'm not saying that I endorse the stakeholder process because I don't because I think it's making the same mistake, that it's talking about using a uniform assessment for certain programs. That's the opposite of being person centered. The person's needs are their needs and the needs shouldn't be predetermined by the location where they're going to get the care. We are saying that because if we don't use the same assessment and process, and I know we're talking about the waiver, but this is supposed to be an alternative to nursing home placement.

Rebecca Schupp responded: Are you're saying use the same assessment and process that's done for admissions to skilled nursing facilities?

Deborah Doctor responded: No. I'm saying that their assessment process should be the same. There should be an assessment process that assesses for long term care needs. What I'm saying is we have an opportunity to break down this terrible divide where people are pre-determined to go to a nursing home or to go to home and community based services. That's what we should be doing here. We should be saying we want an assessment that measures the need for long term care.

Rebecca Schupp responded: That makes complete sense. Unfortunately, we can't include institutional benefits into a home and community based waiver application. So we will put your suggestion in the parking lot for broader policy discussion.

Deborah Doctor commented: I want to be clear that I am not recommending that we continue with the assessment tool in process the way it is.

Rebecca Schupp responded: Okay so I hear that recommendation and I also heard your additional recommendation of let's get a smaller group of people together, take a look at the existing assessment tools and see if they really are assessing the whole person. And then maybe we can have a better recommendation of standardizing tools across the four programs we were previously discussing.

Deborah Doctor responded: Well, I'm not discussing - that's not my interest about the other four programs, but I would like to include other people in the discussion, specifically my colleague (Elissa Gershon) who as you know has been working with this assessment process on the waiver as well as the waiver - the assessment stakeholder process for years. So I would really appreciate the ability to have her be part of a discussion in the subgroup of that topic in particular. And I think we may need that for some of the other topics.

Waiver Capacity and Enrollment

Rebecca Schupp commented: One of the goals that we want to be able to achieve with the renewal is timely waiver enrollment and decrease or eliminate the waitlist and then reduce enrollment length of time between referrals to the waiver and provision of waiver services.

Rebecca Schupp commented: The slot allocations that we have today are based on historic data prior to 2007. The methodology was sound at that time; however, it is no longer appropriate for the waiver renewal as we go forward.

Rebecca Schupp commented: The annual increase of 110 NF-B and 50 subacute is not sufficient to meet the need of members who could benefit from the NF/AH. If we continue with the 110 and the 50 we're slowly chipping away at the waitlist. One of the goals for waiver capacity in enrollment is to decrease or eliminate the waitlist.

Rebecca Schupp commented: We can't continue at the allocated annual slots per year based on the number of Medicaid, Medi-Cal beneficiaries who could access this waiver. We may need to take into account the growing aging and disability population. Should we take into account the ACA, the Affordable Care Act, the number of persons being enrolled into Medicaid and having a reasonable allocation of expectations for a population needing NF/AH services over the next five years? Then also take into account there are people residing long term in skilled nursing and other institutions that could be more appropriately served in home and community-based settings. What should the methodology be to determine how many people can we target within a year and transition them out so that we have a sound methodology of annual slot increase every year?

Rebecca Schupp asked: If we do a one-time increase to meet the new January 1, 2017, what does that onetime increase look like versus what does the annual methodology or algorithm for slot increase every year? So is there anything that you would recommend or that you would want to discuss when we talk about developing a sound methodology for slot increases?

Deborah Doctor responded: I've been waiting for this discussion for 15 years. Yes, the slots on the waiver don't have anything to do with the need; they never have. You've heard several people tell you that the information - people don't know about the waiver, hospital discharge planners don't know about the waiver. So there's no way that you could say that even clearing the waiting list would meet the need of people for the waiver. You'll meet the need for people for the waiver when people know about the waiver, when they're able to find their way to it and apply and not have it take six months for an application. And when every person who is being considered for long term care is given an equal choice between home and community based services and an institution, which by the way is the law, and we have so many measurements. We have so much evidence that there are thousands of people in nursing homes at any one time, and you can multiply that because there is some turnover, who could be cared for in the community. There are absolutely credible estimates ranging from 10,000 to 20,000. There are several sources, studies the state has done, and the scorecard.

Rebecca Schupp responded: Another factor that we want to consider is what the provider network can bear as well. If we know for example that between 8,000 to 10,000 beneficiaries residing long term in skilled nursing facilities could be better served in the home and community, that doesn't mean that on January 1, 2017, all 8,000

of those beneficiaries are going to transition out. We want to make sure that we have capacity over time on what we expect transitions to look like.

Deborah Doctor responded: Why did we have extreme growth in the nursing home construction industry back in the 60s and the 70s? It was because the government started paying for it. When the government spends as much money and makes as much of a commitment to home and community based services as it has the nursing homes, people will provide those services. You've heard these providers talk about the struggle. If the state fairly and timely compensated long term care providers and the community, took care of them the way they take care of nursing homes, and they provided an increase every year the way the nursing home industry has, we'd have a lot more providers just dying to provide these services.

Mary Williams commented: My experience is that we have not had that cooperation from a nursing home. It makes you feel like they don't want to help get that person out. They're more involved in keeping that bed filled instead of getting the patients out, and I would like to see more cooperation between a nursing home and the home and community based offers so that they can all cooperate and get more people out because it isn't that easy when I've been working with them.

Ellen Rollins commented: I totally agree with (Mary) because I had acquired the same problem when you go to nursing home or sub-acute facility and you see the client who is completely ready to go out to the community. You meet the full resistance from the management who wants to keep that client and wouldn't give an option to the family or to the client of moving forward to the community.

Rebecca Schupp responded: I hear what you all are saying. You know, the challenge of Medicaid / Medi-Cal is that I think all providers would say Medi-Cal rates are the lowest rates across the board. That even skilled nursing facilities want increases in their rates, that their rates aren't sufficient either; that's a barrier we have to work with but I do hear what you're saying about the disincentive from the provider perspective to be a home and community based provider compared to the alternative that a provider could choose for their business model.

All of the discussions that we are having today do have fiscal considerations attached to them and once we get to that fiscal discussion in our third meeting, there may be ways -- we're already spending dollars, general fund dollars, on higher levels of care -- that if we could free up those dollars and reinvest them into home and community based services, we could increase the capacity of the waiver to serve more people, increase provider rates, and/or start to reimburse for comprehensive care management.

But some of what we talk about today for setting goals for waiver enrollment could really incentivize the waiver to free up a lot of dollars that could be spent on long term institutionalization, long term acute hospital institutionalization. Maybe there are other factors: reducing in patient ER admissions, dollars that we know we're already spending today that we could shift to home and community based services if we set enrollment goals or if we set utilization goals within the NF/AH renewal.

Rebecca Schupp commented: If we were to set a goal that 50% of our total enrollment needs to come from long term SNF and acute

hospital, we could divert spending that we're already having on the institutionalization to home and community based, and then match the 50% enrollment with community or EPSDT age outs. The higher the number of transitions we have, the higher number of community residents we can serve.

Deborah Doctor responded: Well, we would say no to that because that's how we got into this terrible place with people dying at home waiting to get on the waiver because of the state's definition of cost neutrality which was put in the SB643 where basically the Department of Finance doesn't like these transitions, these waiver slots, unless they can see that a body is moving from a location that costs a lot to one where it costs less. But that's not the federal definition of cost neutrality at all and it shouldn't be the way this waiver works either.

Rebecca Schupp responded: I mean our concern is that we do know there are people in skilled nursing facilities. I mean you said it yourself when you referenced the LTSS SCAN scorecard and, you know, numbers of people that could be better served in home and community based settings. That we know that there are people there and if we incentivize having more - a higher number of transitions because we do add enrollment goals on the NF/AH waiver, then we could possibly be freeing up dollars spent on long term institutionalization serve two community residents on the waiver and with every one from a SNF transition.

Deborah Doctor responded: I understand that. That's how we got - that's the thinking that where we are now. And I am - I completely agree. We should have a unified budget so we're not looking. I mean the nursing homes don't have to justify how many people are in there. It's only the waiver that has to justify how many people are on the

waiver. It - everybody assumes that people who are in the nursing home must have to be there. It's only in the waiver where you have to prove that you really need to be on it. So I think we need to remember that the people in the community are people who are at the level of care of the institution. They're not - and they're suffering trying to make do without the services. They're not people with lesser needs. So I would really recommend that we not walk into this again disadvantaging people in the community and not play these groups off against each other. They all are entitled to services at a level of care. And I just want to say that we should not assume or refer to the institutions as being a higher level of care. They're a different location of care.

Rebecca Schupp responded: Institutions have a higher cost.

Deborah Doctor responded: Yes and I agree with that, but this has been such a painful issue for our clients who have waited for years because they are in the community and they know that if they went into a nursing home they could get on this waiver, the very same person. And they do everything they can to not go in a nursing home even though that would be a path to getting on the waiver.

Jonathan Istrin responded: The reality is there's a fiscal constraint on the way the state spends money. So if we have the opportunity to increase this waiver to 10,000 slots and 5,000 have to go to nursing homes and 5,000 go to the community, I consider that a win because fiscally you have to make sense because of those bean counters whether they're right or wrong with the cost neutrality. I've had these arguments with every person in this room on the other side of the table about cost neutrality.

Rebecca Schupp responded: From DHCS' perspective, if we can set benchmarks or enrollment goals that incentivize a higher number of SNF transitions, we can serve more community people. It's not as simple saying we're going to get 10,000 slots, because we're not going to get it. We have to justify where those people are coming from. How can we be flexible with existing dollars? If we have checks and balances within the program that we know we will meet certain goals or benchmarks, then we will have a stronger case of doing what we want with our NF/AH waiver renewal proposals. That's where we really want to build the synergy within this workgroup. We know what our constraints are within the administration and what the administration wants to look for. So how can we make changes to this individual waiver that can help us make a difference in the renewal program? That if we set enrollment goals and we're not spending new dollars and we are shifting dollars from a higher cost provider to a lower cost provider, that lower cost provider can now serve more people. And that was one of the goals we wanted to meet.

Deborah Doctor responded: I am not happy with - it sounds like now there's another thing that really isn't just decided in advance. It's not my job to figure out how to have this governor play this game. You invited us to be advocates and it doesn't mean that I have to buy into this. I've been working on this issue for a long time. This way of calculating cost neutrality wasn't in place before it got snuck into SB643. It's not the way the federal government calculates cost neutrality. Any of these people in the community could go into a nursing home at any time and be admitted. And so I am really - I'm not going to just say well let's figure out how to make this governor like something. That's not what my job is as a stakeholder here.

Rebecca Schupp responded: And I'm not asking for that. What I'm asking is within the control of what the state has over the NF/AH waiver program. How can we put incentives in place for the program

to be able to serve more people and do it more in a person centered fashion? The NF/AH waiver does not have control over the entire Medi-Cal administration, the entire MediCal insurance product. What fixes can we make to this NF/AH waiver that can achieve some of the things that we want to do? We have an opportunity to use enrollment goals to serve more people through existing dollars, but maybe that's not the best route. Maybe there's other ways to do this and that's what you guys are here at the table for, and there are other ways to do it.

Rebecca commented: Let's really get into the conversation around what are recommendations for waiver capacity increases and then ways to be innovative around enrolling beneficiaries into the waiver. Let's also have under that the conversation about priority enrollment. Is priority enrollment necessary? Do we still need it? Is it useful? If we can and make certain changes to the waiver, maybe it's no longer useful. We are in the last year of the NF/AH waiver. 3,792 slots are the slots for this year, and if we don't make any changes to the way we increase waiver capacity, we're talking about adding another 160 slots January 1, 2017. Based on the historical trend that the state has seen and some other factors that we had mentioned are there recommendations either in an approach the state should take weighing several factors of the aging and growing Medi-Cal population. Looking at the LTSS SCAN scorecard, how many people maybe could transition out within the first year of serving the waitlist population? Or is there a random recommended number for a January 1, 2017 increase?

Deborah Doctor responded: Well, 20,000. I'm not joking.

Jonathan Istrin responded: Yes, we have to clean up the waiting list. I think we need a large number. We have CCT data which will tell us out of those transitioned, how many of them use NF waivers, and we can extrapolate that for the rest of the state in terms of population. If there are 10,000 people in nursing homes who don't belong there according to the Kaiser Foundation, of those 10,000 we estimate that really only 5,000 can be transitioned. Of those 5,000, historically based on the data we have from CCT X percentage went to CBAS, X percentage went to MSSP, X percentage went to NF/AH and you can do it by age. Then you'll have a number. I mean that's - otherwise I would have to agree with Deborah, 20,000.

Deborah Doctor responded: 20 to 25% of the people at facilities say they would like to talk to somebody about leaving. The CCT data is useful except that some - they don't always use the waiver because the caps have been so low. There is plenty of data to support a figure of 20,000. And if they're not needed, then they're not paid for. It's not like you lose the money on them.

Rebecca Schupp responded: I'm hearing one recommendation of 20,000 and the state looking into the various factors that build that 20,000 being MDS section Q data, CCT data, and other literature by foundations, looking at transitions. Maybe managed care transitions that have started to begin. I know there are reports on the aging population, so also factoring in that community based need to divert institutionalization.

Deborah Doctor commented: Nursing homes should be incentivized to get people out. It's been done in other states and nobody wants to act on it.

Rebecca Schupp responded: The incentive that the NF/AH waiver has is setting those enrollment goals is on the entity who ends up enrolling the beneficiary into the waiver, and has to meet a benchmark of X number of institutional transitions. The incentive is in the reverse, but that's what we have within our tool shed to put into place.

Deborah Doctor responded: The Department has many more tools than that. The nursing home should be incentivized to not keep people, but get them out in a successful transition.

Connie Arnold responded: First off I agree with (Deborah). I think the incentives that exist right now politically are that the nursing homes contribute to all the political campaigns of the legislators. And therein lies the incentive for the nursing homes. They may want to keep those beds filled for as long as that person could be alive until they die, you know, so they get paid.

Connie Arnold, asked: Do you know how many people on IHSS are at maximum 283 hours of IHSS? Because those people should automatically be able to get on the waiver if they're interested.

Rebecca Schupp responded: The state needs to look at data points. And that's something we can also include in the justification methodology for annual increases.

Technical Workgroup Member commented: We do need to use data. We have all this data we should somehow be able to come up with a

good number that will work. For example, IHSS data, MDS data, CCT data, and all the labor data.

Technical Workgroup Member asked: Would the 20,000 slots be over the next five years?

Mary Williams commented: Just for clarity, we have got a one-time option for five years. Is that correct?

.

Rebecca Schupp responded: The states can do amendments to the waiver at any time.

Technical Workgroup Member commented: 20,000 slots, would that be over the next five years?

Rebecca Schupp responded: It could be a one-time increase and then what would be the annual increases thereafter within the five years?

Rebecca Schupp commented: There has to be other checks and balances when we ask for 20,000. It's more about our justification. This is a need we anticipate having and we want to make sure we can provide access for the need.

Technical Workgroup Member asked: Because they're thinking it is less costly?

Rebecca Schupp responded: Yes, and back to the conversation (Debra) discussed about how the state administration looks at cost neutralities versus how the federal government looks at cost neutrality. The federal government does take into account cost avoidance, which is not actual cost savings; however, because the participants served on the waiver are at the same level of care as people in institutions, there is cost avoidance in the long-term. The state government has a general fund budget that every single state funded program has to operate under and the more innovative we are about freeing up the current dollars being spent, that shows cost neutrality for things we ask within state-run programs. For example, by reducing in patient ER utilization, those dollars can be freed up to be used for home and community based services.

Technical Workgroup Member responded: Yes, I absolutely agree with that. It should be easy to get the data about the ETS AP transitions.

Rebecca Schupp commented: Some of the things that I'm hearing that could be beneficial to such a large increase in capacity would be looking at what our current Medi-Cal funding for a population that is at the same level of care, relying heavily on IHSS information, looking at the waitlist, Medi-Cal spending, looking at a portion of institutional - long-term institutional clients that could be better served in the community, and using all of that Medi-Cal spending to justify an increase in waiver capacity. Then layering on top of that fiscal analysis what we know about the aging population, historical trends, and referrals to the waiver. MDS Section Q, referrals to finding more information on how to get out so that we don't find ourselves in another barrier of limiting our members' access to the waiver.

Rebecca Schupp commented: A number that was discussed was a 20,000 one-time increase for January 1, 2017. The justification methodology would look at people who are on the Community First Choice program with maximum IHSS hours, which is an equivalent level of care, and are not already on waivers. Looking at current Medi-Cal spending of that population and the waitlist population to show justification on increasing capacity to meet those members' needs. Looking at MDS Section Q, those that have wanted to know more about returning back home and anticipating institutional transitions from that data point and tying in with that also is the LTSS SCAN scorecard using literature and academics and studies to speak to a potential institutional transition. After viewing that data analysis, whether that number is less than 20,000; 20,000 or more than 20,000, does it sound like that having the state take this approach is most reasonable.

Technical Workgroup Member commented: I think with the recognition that it must be accompanied with funding reform, otherwise you're looking at almost an unfunded mandate similar to what we saw all over the news with the Medi-Cal expansion of all these new enrollees. But still the same crisis in primary care; same crisis in dental care. So we need to be careful we don't fall into that same trap of, oh great, we've got all the slots, so we really didn't fix the funding.

Rebecca Schupp responded: Right, and that kind of leads us into enrollment goals. If there is a way we can make sure we meet the need without spending too many new dollars, and/or having to try to fight for new dollars, and if we can free up existing dollars, what would those goals look like within enrollment? How can we better incentivize institutional transitions? It could be a part of care management when we look at the historical or the current Medi-Cal funding of the people we aren't serving. How much inpatient / ER

utilization could we reduce by having more comprehensive care management on the waiver and being able to serve those participants on the waiver?

Rebecca Schupp commented: We had some public comment a little earlier about priority enrollment. We have priority enrollment for EPSDT age outs; long-term Skilled Nursing Facility transitions and a few hospital transitions. So is priority enrollment something that the State should continue enforcing? Does this become a moot point if we have enough capacity?

Technical Workgroup Member commented: I think the priority only works - you know you need a priority because you don't have enough nurses to go out and do the assessment. So if you move it to a community based organization to do the assessments then you don't need the priorities any more.

Rebecca Schupp commented: The priority can only become a safeguard if we can't predict the need halfway through the waiver term.

Connie Arnold commented: I personally think you should have a priority enrollment because I'm thinking about my friend that was lying in a, you know, acute care facility after her work injury, you know. And if she didn't have priority and couldn't get on the waiver then she couldn't have gone back to her apartment and to her life.

Technical Workgroup Member commented: Does priority mean faster assessment or does it mean priority for the money?

Technical Workgroup Member Woman commented: Yes, fast assessment.

Technical Workgroup Member Man responded: Right, or not be on the waitlist. But I think part of it speaks to the funding theme. So if I'm hiring a nurse to do ventilator care, you'd think I'd be able to pay that person more because additional training is required for ventilator care for some that live in the community; however, that's not the case at all. It's the same exact rate as if it were a lesser level of care within the same program. So therefore we do need this priority enrollment with the way it's set up now.

Technical Workgroup Member Man responded: Structure and funding based on zip code as well as complexity for example, to show real costs involved, that could solve itself in certain ways.

Rebecca Schupp responded: We want to make sure you are all informed about the process that we took; the methodology that we took with the number we did arrive at whether that was under 20,000, 20,000 exactly, or more and that we did follow and look at the data points that we had discussed. We could put in the parking lot whether or not there is a need for priority enrollment, and that's something we could have put out there for broader engagement and get their feedback on.

Technical Workgroup Member Woman commented: I think that incentivizing goals would be to have an organization that would specialize in something; something say, well our goal would be to take so many and transition them and then at the end of the year

have a tally of the goals. I feel that there should be different goals between the diagnostic groups and what their needs are.

Rebecca Schupp commented: Right. DHCS is really looking at that local entity or organization to not restrict beneficiaries from accessing their organization because of their level of needs; however, we would want to see a good mix of acuity levels within one organization and a good mix of institutional transition versus community enrollment. I do like the proposal where the organization can come forward with goals that they're going to set for themselves and maybe the state can develop a framework. We want to see EPSDT age outs. We want to see hospital discharges. We want to see straight to home discharges. We want to see institutional transitions, and we want to see institutional diversion. And then the organization can say okay, well we think we can enroll X percent along these four types of enrollment settings.

Technical Workgroup Member Woman commented: But that still then plays into my thought. If we know it costs X amount of dollars to house a person in an acute care hospital, skilled nursing unit, or in a skilled nursing facility, we know how much that costs under Medi-Cal.

Technical Workgroup Member Woman commented: Right.

Technical Workgroup Member Woman commented: And we know how much it costs for diagnoses code. And we know that's a known. And we know that it costs significantly cheaper to provide services within the community setting, whether it's with Medicare Certified Home Health; whether it's with In-Home Supportive Services; any of these other things. If we can show that by keeping a patient or a client

or a participant at home, at the end of six months; three months, a year, is X dollars; save the government. Because the Medi-Cal - these are Medicare and Medi-Cal recipients.

Technical Workgroup Member Woman commented: It's not - excuse me. But it's not - this goes to the core of the funding discussion. One of the reasons - it's not cheaper for everybody. And one of the reasons that it's been cheaper is because the waiver funding has been so restricted. So I think, while it was true that in general services at home are less well paid for and cheaper than institutions. But I think we just need to be careful that when we talk about the cost comparison, because one of our major problems with this waiver is, how low the budgets are set for community care.

Rebecca Schupp commented: Right. And if members have a broader spectrum of need. Not everybody is at NF/A, and depending upon even their informal support and how much other access they have to other programs and services, their needs are different even within the same level of care. That if we're in the aggregate serving the total population, there will be cost savings, and that cost savings, by serving all of the people to their Medi-Cal necessity or to their care needs.

Rebecca Schupp commented: So if that were able to be a component of the waiver funding and the intent is to the legislature to say yes, but we'll give - we will say yes to 20,000 plus. And annually the NF/AH waiver is going to have to yes, prove itself by saying, here are the 20,000 people, after a five year enrollment period that are on the waiver. We know it would have costs, you know, hypothetically X dollars. This is the actual cost being provided services to these individuals through the waiver at a cost savings to the state of Y. I

mean we could go even a step further and say we know what we were spending and what we have saved now by enrolling our participants on to the waiver. And then in addition to that we are avoiding costs of X number of dollars.

Deborah Doctor commented: We've been arguing this for decades. But the problem has been with this state that the Department of Finance and Department of Health Care Services historically has not accepted that argument because they don't necessarily believe that the people who are in the community on the waiver would ever have gone to a nursing home. And thus they don't believe that there are savings. That's why the waiver is unfortunately, constructed the way it is. There's many ways to measure cost neutrality. And it's the methodology in this waiver that has produced the problem of an individual cost cap. Not an aggregate.

Rebecca Schupp commented: Right. There's been changes in leadership throughout the administration. And changes in governors have been four years or longer. And we - I think we can do a better job of justifying the cost savings and the cost avoidance by showing what current spending is and showing that we have safeguards; checks and balances in place to drive incentives, to continue demonstrating cost savings and cost neutrality. And I think, you know, from our perspective at DHCS, that's what we want to do is we want to take the time to show that justification and show it very clearly.

Jonathan Istrin commented: Would we be able to, when we talk about the finance component, would we be able to make a suggestion that we'd look at the average cost savings instead of having individual cost savings so this way we could adjust rates, take the savings that

we have on the lower cost cases, and use those rates - use that to adjust the rates and bring them up to the 21st Century? And also use it to provide care for those people who need more than what is currently the cap.

Rebecca Schupp commented: Right. So we're going to talk about all of that. But I think we want to talk about - there's a number of ways you, you know, develop a fiscal structure. And the level of care cap is not the only way. And once we get into that conversation there are ways that we could do - I mean we could do managed fee for service. We could do straight fee for service and just increase rates across the board. We could do value-based purchasing. We could do pay for performance. I mean there's all that we could (unintelligible). I mean there's all these types of payment structures that the state - that could be done within the waiver. And so, you know, the state will put forward some options or things to consider that will hopefully have a final recommendation from the work group.

Backup providers

Rebecca Schupp commented: So what we're talking about is the care management local entity to ensure that that backup plan is in place at the time the participant is enrolled or any time during the intake process.

Rebecca Schupp commented: Well we're not talking about changing WPCS, but it does allow for the coordination of a community based organization, making sure these safeguards are in place for beneficiaries for participants because of what they're required to do for care management.

Technical Workgroup Member Woman commented: So if an IHSS IHO Wavier Personal Care Services recipient - provider is a no-show, it's not left on the shoulders of just the person with the disability to cover those - figure out how they're going to survive?

Rebecca Schupp commented: Correct.

Rebecca Schupp commented: Right. So we're talking about a local care management entity that is, you know, has direct interaction with the participant. The participant has a relationship with their care manager and the care manager is in constant contact with the participant, making sure their needs are met and helping facilitate access to services. And having a backup plan developed with, you know, clearly identifiable members to call, providers to call, that's easily accessible with the participant's home.

Connie Arnold commented: Well I think that could be good. Because I'm getting older and things are harder. And when you go hire the IHSS providers, nobody wants to be a backup if you're not going to hire them on a regular basis. And then a lot of them don't want to be backup. And a morning person might not know what they do in the evening and might not have the capacity to simply, you know, help you get into bed and how to put your feet into bed. Simple things that could be such a nightmare that could result in injury to you. So I think is going to be a positive thing for this.

Connie Arnold commented: I have just one comment. People living in the community do not, you know, want our homes turned into corporations. Do you get what I'm saying? And my point is that we

don't want intrusion any more into our lives and our homes than is necessary. That we're getting services, because it means living in the community and functioning. That's one of the big issues, is not corporatizing our homes if we're not in a nursing home.

Rebecca Schupp commented: The state's oversight is of a care management entity, a care management entity usually functions within an office building. They're not like a primary care clinic or a doctor's office. They are more administrative office type that the state would go on site there.

Parking Lot Items

Technical Workgroup Member Woman commented: Just as you know there has been a continuing and serious problem affecting some waiver clients about the inability to get shift nurses and nursing services, as indicated in the plan. How do you see this structure changing that?

Rebecca Schupp commented: Right. So I think you're talking about the individual nurse provider...

Rebecca Schupp commented: Or a home health agency. And we foresee it being - it's easier with a home health agency in that the home health agency would directly contract with the local entity to provide nursing supervision or hands on nursing care at various levels - RN, LVN, certified home health aide. We would continue to see continuity for the individual nurse providers. How that relationship works with the local entity or the state would definitely be something

we have to consider. Is that a subcontracted, a sub-employer/employee relationship between the care management entity and the independent nurse provider? Or, is that a relationship between the states that the care management entity can leverage.

Technical Workgroup Member Woman commented: I think - you've got providers in the room, some of whom I believe at least have had problems meeting the needs of some clients right now because of the difficulty in getting nurses to meet all the shift needs. And so I'm wondering...

Technical Workgroup Member Man commented: It's the rate. That's all there is to it. It's the rate.

Technical Workgroup Member Man commented: Correct. Yes, so if they fix the finance (unintelligible) care management thing, sure you could find three providers and say, fix the rate.

Technical Workgroup Member Man commented: The rate is a problem. When minimum wage is at \$10 and you're paying, you know, a minimum wage worker who's going to work overtime will get an hour to \$15 an hour. And you're paying your LVN and getting just a couple of dollars more, you know, there's a problem in the system.

Technical Workgroup Member Man commented: Right. For one, everybody else has gotten an increase except for the home health and the waiver providers. So, that's the next time.

Ellen Rollins commented: The recipient feels a loss of control over their independent hire and fire and their responsibility of if they have family members and they have independent providers that just have sort out and achieved independently. They don't want that's compromised by agency driven services and that's not something readily in the reality.

Connie Arnold commented: Well I think that's true Rebecca. I think what she just said is true, that if you raise the rates for the agency and then you leave the independent providers at a lower rate, then we have a hard time. And we're already having a hard time finding care givers and providers that can deliver the kind of high level services that we need and can do the tasks that we already need approved under IHSS. So I think you've got to also look at the jurisdiction or the regions and you know, and you're in a facility and that's where you live. And the rates are just not adjusted to get the quality people. You talk about quality care, and we want to talk about, where's the care in the caregiving. And you know, let's put the care back into the caregiving and let's let people try to find people that don't want to just - it's an easy paycheck. And so they're going to cherry-pick clients that they don't have to do too much for, and yet they get the hours. And maybe in some cases some people have more hours than they really need. And so they're able to, you know, they're able to adequately pay that individual more than those with significant disabilities that have greater physical needs and demands on that individual for a lot of physical care. And the rates just aren't there across the board right, because that (unintelligible) agencies. If you do raise it you have to equalize it so we're not disadvantaged.

Technical Workgroup Member Man commented: Right, I would agree. And just to piggyback on that, I think you're going to have to decide if you go with this care management agency approach, just like how control that group would have. You know if it was up to NFH to

establish - you know, to keep established providers, you know, as their network and set the basic rate per the zip code or however demographically you would choose to do that, you know I personally would think that might be a fairer way than to get control of rate negotiation and network settings by care management agencies. That's where you might get into some weird conflicts where they're going to funnel people a certain way or away from individual providers so that they can clear a better, you know, margin. I think that we just really want to be careful by like building a care management agency pool, but perhaps just making sure that there's not implicit conflict with either rate setting or network.

Technical Workgroup Member Woman commented: Well if we are talking - I agree with that. You know the ones that I'm most familiar with like some of the supported living providers who are doing a fabulous job; the ones that I know. Or MSSP programs or independent living centers or the ADHC programs, I don't see that as a bigger issue. But I think all of them would probably say that the home and community based services have been starved for rates. This issue of not having enough nurses to fill the shifts is a really big and serious problem when we're talking about work that cannot be done by any available IHSS provider.

Rebecca Schupp commented: Okay, so we will table all of these for discussions in the next meeting.

Care Management Entities

Rebecca Schupp commented: Slide 29 demonstrates a similar structure if the Long-Term Care Division awarded a contract with a local non-state entity to do care coordination. However, the local non-state care coordination agency would actually have the direct contract

with provider networks and look more like the relationship our sister departments have with the MSSP sites or the regional centers or the HIV/AIDS waiver agencies. The Long-Term Care Division would then play the role of waiver administration, monitoring and oversight of the local entity and the local entity would have a bigger role than our care coordination agencies have under the assisted living waiver with direct enrollment and participant enrollment into their organization. They would directly reimburse the service providers and DHCS would then reimburse the care management entity.

If we were to adopt a similar model what would your recommendations be? If we are looking to build a new infrastructure or even with existing infrastructures, what could the requirements of those care management entities be and their roles and responsibilities?

Connie Arnold commented: I think people with disabilities would prefer to have it similar to the DD waiver type of system. Now the seniors who've never been part of this disability movement (unintelligible) might feel better off with their, you know, California Department of Aging type of philosophy. But I think most people want to be treated the same way that they have their entire life of living. So whichever entity would serve that community those needs the best. We have a greater understanding. It's very different to be non-ambulatory you know, or a wheelchair user than being a senior that's you know, walking around at 90 or 100-years-old. And it's a different philosophy. I think that people need to move away from seeing people as patients. So - and that's part of that independent living philosophy. So the entities that's closer to an independent living philosophy and social model, I think are the best. So as far as I'm concerned the agency type would be better to be like independent living centers, DD.

Rebecca Schupp commented: Or if a care management entity was required to have a classification that was well-versed in independent living.

Connie Arnold: Well that would probably be okay, but not the geriatric model.

Rebecca Schupp commented: Right, and we would want the waiver to serve the benefit of participants through their continuum of care. So we wouldn't want to have to set up a structure for the waiver renewal. Whereas as soon as you turn 65, MSSP is more appropriate for you. You know we would want that waiver to serve the participant from when they're enrolled into the waiver until their end of life.

Technical Workgroup Member Woman commented: But the heart of person-centered means that it's okay if the person with disabilities say, you know what, I'm sick of having to hire and train attendants. And I would like some help with that. It has to be okay to say that and it has to be okay for somebody not to assume that because somebody is 90 years old that they can't hire and train by themselves. I think our strength is in getting away from assumptions based on age or disability or gender or any other factor. That's what person-centered is.

Rebecca Schupp commented: Making sure that we do cover the whole spectrum of participants that could access the services and look at that as a good approach if we were to contract out, what are some of the personnel classifications? What are the requirements or

the qualifications of an entity wanting to perform care management can cover or conserve that participant through their end of life?

Jonathan Istrin commented: I would say, you know we've seen from the other models, the CCT and the ALW which really are more of a social model than the clinical nursing facility waiver model which really takes on the clinical and the Independent Living Centers participated in it as well. We've developed a really broad spectrum of providers that are the - you know, that we refer out to. But more importantly is that, depending on which kind of pool you're going to use, because that's really - they're going to become the gatekeeper. They're going to be the ones who are going to be making that, you know, doing that assessment, sending it up to whatever entity is going to be reviewing it and then approving it. What I'm more concerned about is the - you know, it's the qualification. We can look at what we require for LOs and look at what you require for CCAs. Obviously, that looks like the model that's going to be coming out a hybrid of those somehow. But what I'm thinking about is heart process. One of the beauties of ALW is its. Once the client gets approved by the state there's no chart. And so the billing process is a lot easier and it's smoother to move a client in and around providers because you don't have to have a chart. So you know, I don't know how it works with MSSP and the AIDS waiver because we do AIDS waiver as well. I mean we're a provider for one of the AIDS service organizations. So you know, we bill them; they pay us. I don't know if they have to do a chart or not.

Technical Workgroup Member Woman commented: They don't.

Jonathan Istrin commented: Yes. So then if that's the way it's going to be that we enroll the person - the gatekeeper; the CMA enrolls the

client, sends the paperwork up to Sacramento, Sacramento approves that client; however, the dollar amount they divide. Then it ends up to the CMA to purchase those services, reimburse the providers for them, and bill the state.

Rebecca Schupp commented: Or we could even, instead of approving dollar amounts, maybe it's reviewing the care plan; approving the care plan that has the identified services within it. Then the CMA is free to bill those services at the scope, duration, frequency identified in the care plan. The state responsibility then becomes back-end monitoring to determine if the claims match what was in the service plan.

Jonathan Istrin commented: Because the AIDS service organization bills for the services that they have. The MSSP bills for the services they have and we reimburse their provider, but so I would lean towards having a broad spectrum of provider types, whether it's the ILC, the LOs that are out there, the CCAs that are out there. They've already been working in the system that you're designing, and let them be the gatekeepers. Because (Deborah) and (Connie) have both been complaining about the lack of awareness of the program. Well that's one thing that the ALW CCAs and the LOs have been doing is they're just out there beating on doors, you know, both for housing. And you know yes, they're going to the nursing homes to find clients, but that's what the design was. So we are getting those words out, and that's probably the biggest thing that the LOs and the CCAs bring to the table is that ability to get the word out.

Rebecca Schupp commented: Yes, you guys would be doing monitoring and outreach and education for us.

Technical Workgroup Member Woman commented: And I'm going to throw a little something else in here. You know my feeling - my philosophy was all along, attaching counseling systems that they had for like IHSS advanced pay was a good option. Where if the individual with a disability wants to incorporate themselves a DD agency and then receive the funding. To be able to pay more to the providers and be able to hire your own providers was another model option that would allow a person to bypass a whole lot of things and be able to make sure that their needs are met. Simultaneously to what has been said, having the option when you don't want to do it any more, you have somebody else take over. But you're not tracking your service hours based on the fact that you might be getting different levels of staffing - LVNs, HHA, TNA. And then they're going to say oh well, you know your budget cap is at, you know, your level of care is at \$48,000 but we're going to lower your service hours because the provider wage went up or because you're using LVNs or RNs to deliver your services.

Technical Workgroup Member Man commented: So the regional center has come up with a system that is the...

Deborah Doctor: Self-directed services.

Technical Workgroup Member Man commented: Yes, the self-direction. And but what they do is I mean, they have a physical manager who then pays all of these services. The consumer at the regional centers is given a pot of money to spend. And then it's monitored through one of the FMAs, physical management entities. So you could have - you could have the same thing in the NF waiver which has currently individual nurse providers. But again, instead of having Sacramento have to monitor those, that would be the

responsibility of the - because, you know, I will tell you our strengths in individual nurse providers -- I hope there's none on the phone -- has not been good.

Aaron Starfire responded: I just want to mention that just from the home health side, like I see, you know, hundreds of our supervisors being connected to the community; to the patient because of different types of providers are already required through the Department of Health Services audits, to do for their plans of treatment. So that means they must, by virtue of what they're doing as a home health provider, you know, be integrated with some of these other provider groups. Somebody like this could be an option for those individuals to feed them that connection and deepen their knowledge of resources across the board for people on the waivers. I think it's a good direction to move towards.

Ellen Rollins commented: Is it a challenge for our systems to figure out how to classify in a clinical kind of way, nursing provider status? It's always been simple for me. If someone doesn't have any training and they need to be trained in whatever, that's a nurse's aide. If they have some training, they're a certified nurse's aide. Or they're an LVN or they're an RN or they are, you know, the classification capacity is there but it doesn't appear the system uses it for - to handle whatever the disconnect is from the home care provider to an agency driven provider.

Rebecca Schupp commented: Yes, but I think that filling that gap would be the local care coordination entity.

Technical Workgroup Member Man commented: Right. I think that adds a layer. Because right now it's two camps.

Rebecca Schupp commented: Right.

Technical Workgroup Member Man commented: There's a cap of individual providers that skirts all medical regulation and operates independently as a direct employee to someone that's not regulated by anybody, which is okay. And then there's the medical model. So this could be a way to maybe - I think there must be a move towards integrating these two because ultimately one human being that needs help. Whatever you call it.

Summary

Rebecca Schupp commented: Just reflecting back on things that we talked about today, when we look at the model of care, there is an opportunity or a request for diving in a little bit deeper with a smaller group or a different subset of stakeholders, looking at the assessment tools that are currently in existence. And if there is any enhancement or modification that may need to be made. It sounds like we did come to a consensus on having comprehensive care management available to the NF/AH waiver participant.

Also with waiver capacity we heard a recommendation for a 20,000 waiver slots within the first year of waiver renewal. But that primarily relying on research and analysis done behind what an adequate amount of waiver slot increases should be.

- We are looking at IHSS users and different factors on IHSS users. We are also looking at current Medi-Cal spending, MDS Section Q, and the LTSS scorecard for annual capacity increases look at other historical data that we have.
- CCT historical trends with the NF/AH waiver also anticipating growth with the AIDS and disabled population. Enrollment goals, you know, we didn't really get to consensus on that, but we'd be tabling some conversations around enrollment goals when we get into the financial structure.
- And then last, for care management entities, it sounds like, you know, there are support for having a local non-state entity doing care management - care coordination. Maybe looking at similarities across waivers, making sure that the care management agency can continue serving that beneficiary, having the classification and the expertise and the knowledge to serve our participants through their continuum of life.

Workgroup Timeline

- Next workgroup meeting is April 20, 2016, same time and location.
- The third meeting on April 20, 2016 will focus on costs.

Public Comment

Joey Riley commented: It seems like it's going away from consumer directed, because you want to have it all under a managed care which to me you're not saving money because the state is not getting rid of personnel.

Rebecca Schupp responded: Thanks (Joey) and we appreciate your comments. I apologize if there was some confusion. We are not just talking about medical needs. We are talking about the whole person, their social needs, their lifestyle needs, and we have noted that and we will include those other factors of people's lives in the care management structure. We're not talking about individual service providers only being agency model or licensed organizations. We are keeping the individual provider more for IHSS and WPCS. So those things will not change. The local entity will help the waiver participant better understand, and access those benefits and services, that are available to them.

Susan Pellegrino commented: My concern is there are many patients and their families that are not being given all the options that are available for them to look into and make conservative decisions as to whether or not they want to place the patient into a long term facility or a rehab. The only way that they're going to find out about [their options] in the long-term care in a lot of ways is through the hospital staff.

Rebecca Schupp responded: Great comment and we talked about that in the outreach and education topic at the first meeting.

Connie Arnold commented: What really has to happen is there has to be an improvement in provider wages to attract better quality individuals with a higher level of skill or interest in jobs of working for individuals with high level of significant disability because they have more need. You [need] to give the higher pay to the individuals with the higher level of needs so we can attract people that are willing and maybe have the skills in order to do that.

Ellen Rollins commented: I am a provider for Congregate Living Health Facility. This is an essential part for the labor program I believe and so many people have no idea about the services we provide. This is a very big issue, because when we go to the local hospitals, when we go to talk to the discharge planners, these people have no idea of the IHO waiver or how to utilize the benefits. And this is why we're getting a lot of difficulties to bring this knowledge to participants at home. People simply have no idea of services that can be provided through the waiver. Education about the waiver program should be part of the licensing, because there are so many providers who somehow would like to get into the Congregate Living home health or home business, but they have no idea of what clientele they're going to work with or what kind of services they're going to provide.

Rebecca Schupp commented: Thank you for your comment. From our first workgroup meeting we decided to survey our existing waiver participants and those on the waitlist to better understand how they found out about the waiver. And then looking towards educating the providers in opportunities to become providers under the waiver is kind of our second phase of outreach and education.

Terry Racciato commented: I'm calling because I have a concern, if the local care entity is going to be the managed care entity that has a vested interest in reducing the amount of care expenditures, that they can keep the difference of the balance between the two, you'll end up negotiating every individual patient along the way which could be very difficult. And my second comment is, that the rates that we're currently using are from 15 years ago. You're looking to carry this for another six years out. To think that you're going to be able to have care providers that are going to be able to provide that service for those rates is really unrealistic, especially if you are considering the fact that you want them to be able to guarantee that there will be

coverage for the patient and become basically responsible for their care.

Rebecca Schupp commented: Thank you for those comments. And just to clarify, we are not looking at Medi-Cal managed care organizations doing the care coordination, care management. We heard that from the first work group meeting and throughout public comments. And so we're talking about either local county entities or public/private, not-for-profit organizations that are community based in nature.

Next Step - Action Items

For the April 20th meeting, the agenda and meeting materials will be mailed out by April 14th.

- Meeting minutes will be drafted and distributed to work group members by April 14th.
- Workgroup Meeting #3 on April 20th will focus on a better proposal for cost neutrality and fiscal reimbursement structure.
- DHCS will send out the following items:
 - A list of workgroup members, their affiliations and email contact information.
 - A link to the NF/AH Waiver Renewal website

Objectives for Workgroup Meeting #3

- *NF/AH waiver cost neutrality and fiscal methodology*
- *Opportunities for change*

- *Solutions to address the challenges we are currently experiencing*