



WELCOME

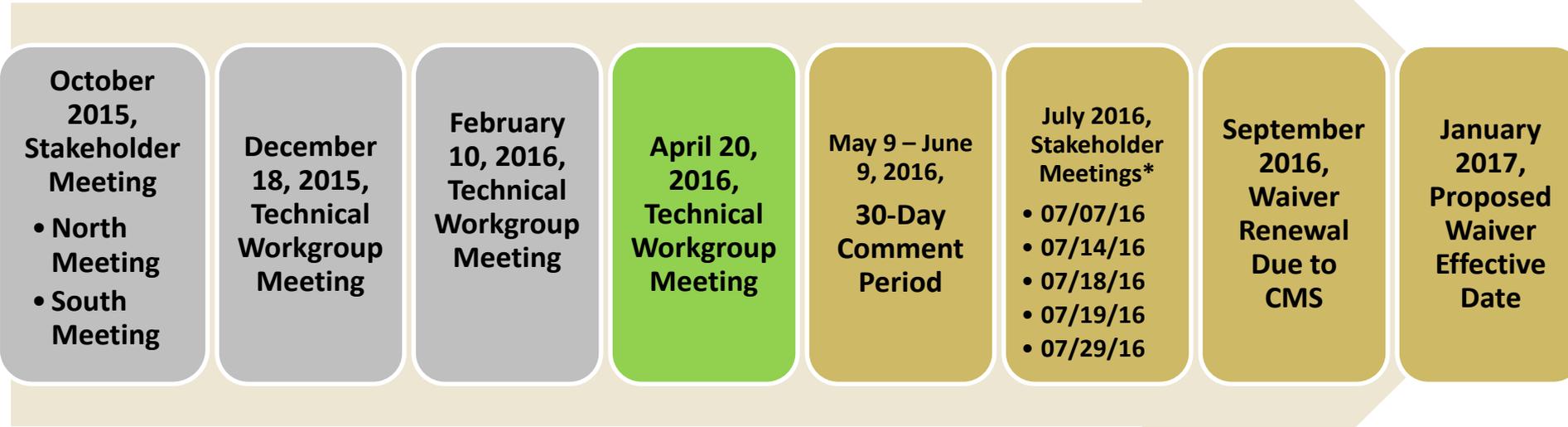
April 20, 2016

**Nursing Facility/Acute Hospital
Waiver Renewal**

Technical Workgroup Meeting # 3



NF/AH Waiver Renewal Timeline



*Sacramento, Fresno, Los Angeles, San Diego, Redding



Topics to Cover

- Care Management Agencies
- Cost Neutrality
- Financial Models
- Charter Review



Options for Care Management Agency Mega Qualifications

1. Entity type capable of serving the target population.
2. Delivers services cost effectively and uses other funding streams.
3. Establishes and contracts with an adequate provider network.
4. Maintains an adequate provider network and identifies health and functional status through care management.



Options for Care Management Agency Mega Qualifications

5. Tracks claims and other necessary data to monitor service delivery and member outcomes.
6. Has a community presence to meet care and service needs and is knowledgeable about the skills and abilities of the target population.
7. Global knowledge regarding Medi-Cal and the disability environment.

Options for Care Management Agency Scoring



What factors could contribute to agency scoring?

- Demonstrated Capacity
- Experience
- Knowledge
- Skills
- Abilities



Options for Care Management Agencies Standards of Participation to Apply

- Which options for mega qualifications would the workgroup want to be highlighted in the Request for Proposal process?



Overview of Individual Cost Limit

What is it?

- Federally required
- Accomplishes the following:
 - Determines entrance into the waiver
 - Provides authorization of waiver services
 - Assists with maintenance of cost neutrality



Overview of Individual Cost Limit

Options For States

- 1) No Cost Limit
- 2) Cost Limit in Excess of Institutional Costs
- 3) Cost Limit Equivalent to Institutional Costs
- 4) Cost Limit Less Than Institutional Costs



Overview of Individual Cost Limit

No Cost Limit

The entrance into the waiver and amount of services that will be provided to an individual is determined based on assessed needs and, as specified, during the development of the service plan of individuals. These individuals may require an amount of home- and community-based services that exceed the average cost of the institutional services for the level of care the person requires.



Overview of Individual Cost Limit

Cost Limit in Excess of Institutional Costs

The entrance into the waiver and amount of services that will be provided to an individual is determined based on assessed needs and, as specified, during the development of the service plan of individuals. These individuals may require an amount of home- and community-based services that exceed the average cost of the institutional services for the level of care the person requires, but sets an upper limit on how much expected costs may exceed institutional costs.



Overview of Individual Cost Limit

Cost Limit Equivalent to Institutional Costs

The entrance into the waiver and amount of services that will be provided to an individual is determined based on assessed needs and, as specified, during the development of the service plan of individuals. These individuals may require an amount of home- and community-based services that is equivalent to the average cost of the institutional services for the level of care that the person requires.



Overview of Individual Cost Limit

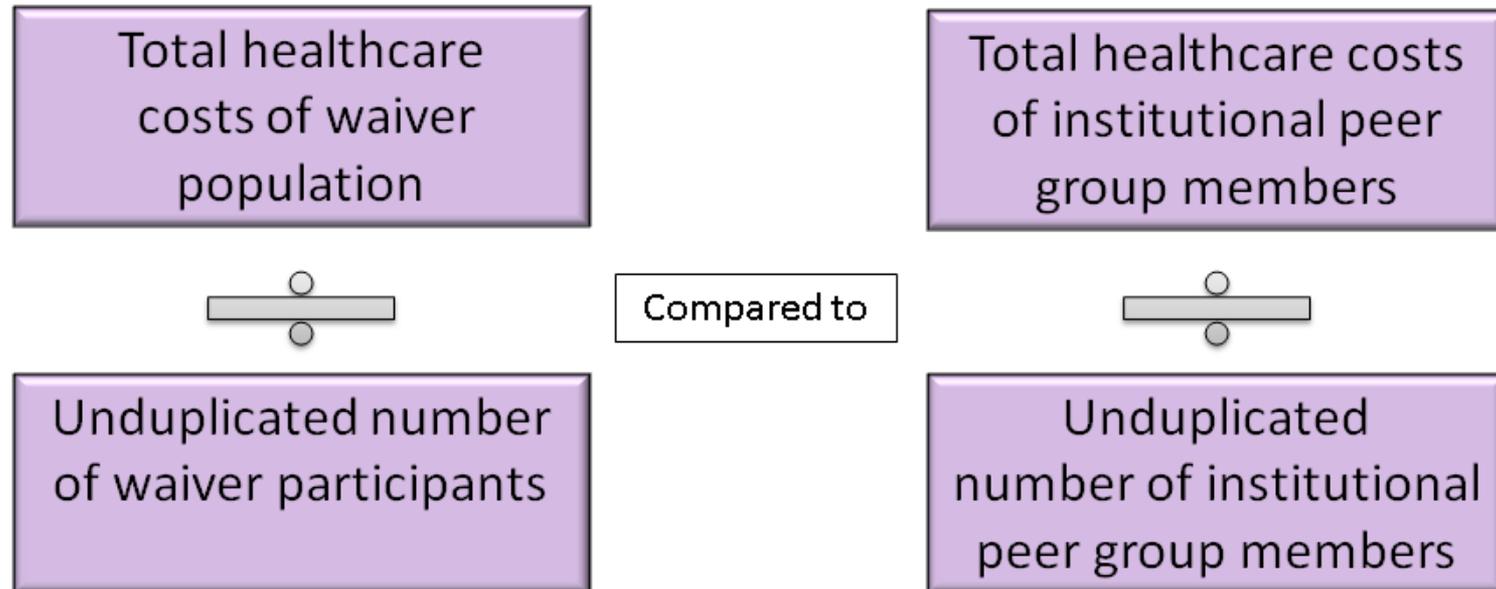
Cost Limit Less than Institutional Costs

The entrance into the waiver and amount of services that will be provided to an individual is determined based on assessed needs and, as specified, during the development of the service plan of individuals. These individuals may require an amount of home- and community-based services that is less than the average cost of the institutional services for the level of care that the person requires.



Overview of Cost Neutrality

What is it?



Overview of Cost Neutrality



What is it?

Total health care costs of waiver population divided by unduplicated number of waiver participants compared to the total health care costs of the institutional peer group divided by the unduplicated number of institutional peer group members



Overview of Cost Neutrality

What are the requirements?

Annual cost neutrality reporting to the Centers for Medicare & Medicaid Services (CMS)

- Examine waiver services and state plan services
- Does not include Medicare or other service funded costs



What We Have Today

NF/AH Individual Cost Limit Methodology

Individuals enrolling into the NF/AH Waiver:

- 1.) Are assigned an “institutional cost limit” based on an assessed level of care (LOC).
 - LOCs: NF-B, Subacute, Acute
- 2.) Participants select and self-direct their care plan as long as the cost of the services are within their “institutional cost limit” and are medically necessary.
 - Example: Will allow choosing between higher cost services at lower frequencies of scope and duration versus lower costs services at higher frequencies of scope and duration.

Possible Options for Discussion and Why



Opportunities for change

- Assessing and delivering services based on medical necessity
- Transitional enrollments
- Serving a variety of acuity levels and spectrums of medical need to ensure cost neutrality

Possible Options for Discussion and Why



How can we achieve change?

- Considerations for the Individual Cost Limit
- Considerations for ensuring cost neutrality



Public Comment Period



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Lunch Break



Current NF/AH Financial Model

Fee-For-Service on an Annual Cost per Level of Care

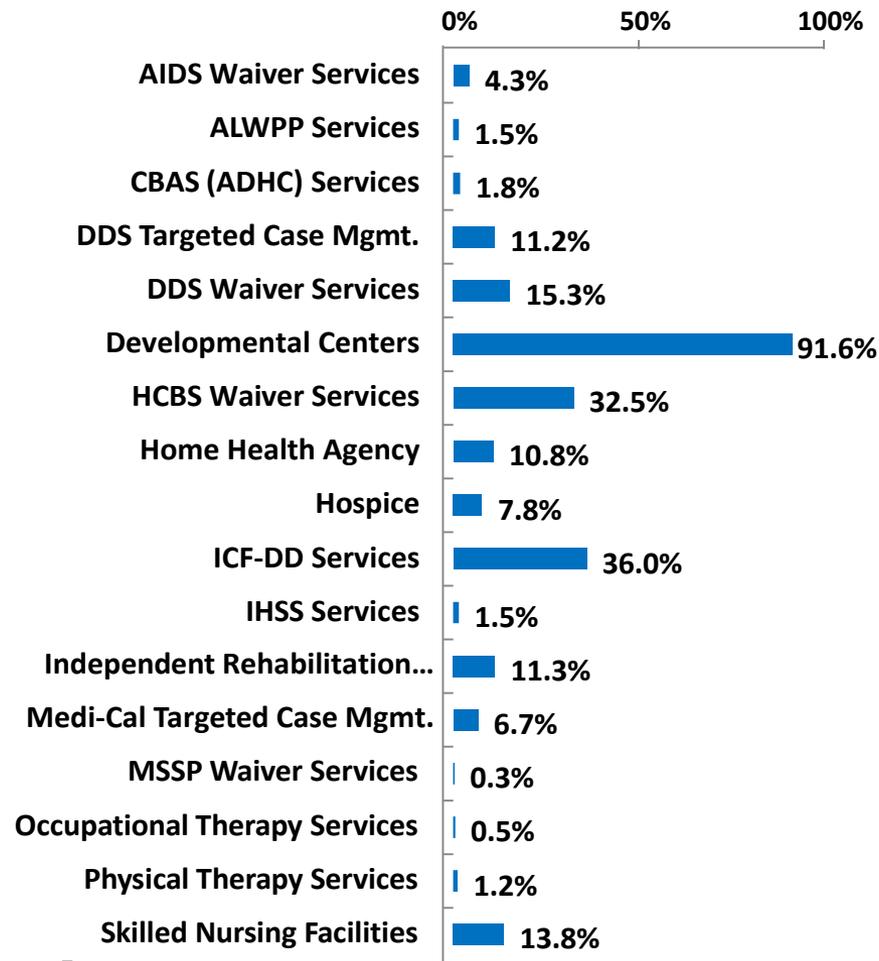
A set rate for every service by provider type

Service	Provider Type	Hourly Rate
Skilled Nursing	Registered Nurse	\$40.57
Personal Care Services	Personal Care Agency	\$14.48

NF Waiver Population Expenditures vs Other Program Population Expenditures - CY 2013



■ Percent of User Subpopulation that are Members of the Top Five Percent of Medi-Cal Expenditures



User and disease groups are not mutually exclusive



NF/AH Waiver Discharges and Length of Stay vs Other Program Discharges and Length of Stay - CY 2013

	Number of Users	Mean Age	Percent Female	Percent Dual Eligible	Eligibility Pathway			Inpatient Discharges Per 1,000 Eligibles / Average Length of Stay	
					AGED	BLIND/ DISABLED	LTC		
In-Home Supportive Services	477,135	67.2	64%	76%	44.2%	55.5%	0.3%	519	5.6
Skilled Nursing Facility	132,432	75.4	60%	87%	26.0%	23.0%	51.0%	1,395	8.6
DDS Waiver Services	68,468	38.0	42%	48%	1.5%	98.3%	0.2%	163	6.4
CBAS - ADHC	26,709	69.1	59%	66%	51.2%	48.0%	0.8%	586	5.9
Multi-Purpose Senior Services Program	11,213	81.4	76%	98%	72.6%	26.2%	1.2%	740	5.3
ICF-DD	8,125	49.8	47%	62%	2.2%	40.8%	57.0%	432	7.2
HCBS Waiver Services	3,386	51.3	46%	50%	11.7%	75.0%	13.3%	1,230	8.72
Assisted Living Waiver	2,505	77.3	69%	92%	61.8%	34.7%	3.6%	850	6.63
AIDS Waiver	1,977	53.6	27.5%	62%	6.8%	93.0%	0.3%	743	5.78
DDS Developmental Centers	1,439	51.6	38.6%	79%	1.0%	25.8%	73.2%	247	8.17



NF/AH Waiver Participants' Concurrent Use of LTSS vs Other Program Population's Concurrent Use of LTSS - CY 2013

Concurrent Use of Special Services (Percent of Row, Read Across)	IHSS	Skilled Nursing Facility	DDS Waiver Services	MSSP	ICF-DD	HCBS Waiver Service	Assisted Living Waiver	AIDS Waiver	DDS Dev. Centers
IHSS	100.0%	4.4%	5.9%	2.2%	0.1%	0.4%	0.0%	0.2%	0.0%
Skilled Nursing Facility	16.0%	100.0%	0.6%	1.0%	0.6%	1.0%	0.6%	0.1%	0.0%
DDS Waiver Services	41.4%	1.2%	100.0%	0.0%	0.5%	0.1%	0.0%	0.0%	0.1%
MSSP	92.4%	11.9%	0.0%	100.0%	0.0%	0.1%	0.1%	0.0%	0.0%
ICF-DD	3.6%	9.6%	4.0%	0.0%	100.0%	0.6%	0.0%	0.0%	3.8%
HCBS Waiver Svcs.	49.7%	37.6%	3.0%	0.4%	1.4%	100.0%	4.3%	0.2%	0.0%
Assisted Living Waiver	8.3%	31.7%	0.0%	0.5%	0.0%	5.8%	100.0%	0.1%	0.0%
AIDS Waiver	47.3%	4.6%	0.6%	0.3%	0.1%	0.3%	0.1%	100.0%	0.0%
DDS Developmental Ctrs.	0.1%	0.8%	7.1%	0.0%	21.3%	0.0%	0.0%	0.0%	100.0%

Identified Challenges from Public Comment



Cost Neutrality and Fiscal Structure

- Individual cost neutrality
- Amounts for individual cost limits
- Reimbursement structure/Rigid provider payments
- Institutional bias

CMS Approved Alternative Financial Models



CMS-Approved Alternative Financial Models

- Fee Schedule
- Negotiated Market Price
- Tiered Rates
- Bundled Rates
- Cost Reconciliation

CMS Approved Alternative Financial Models



Fee Schedule

Individuals are served through a fee-for-service delivery system, in which providers are reimbursed for each service (e.g., personal care service, respite, supported employment) based on a unit established for the delivery of that service (e.g., 15-minutes, hour, per visit, day).

CMS Approved Alternative Financial Models



Negotiated Market Price

- Provider receives the market price of the service.
- There is an expectation that some negotiation will take place between the state and the provider to reach an agreed upon market price.

CMS Approved Alternative Financial Models



Tiered Rates

Provider receives payment for one service in which the rate varies by an identified characteristic of the individual, the provider, or some combination of both

CMS Approved Alternative Financial Models



Bundled Rates

Provider receives a fixed, predetermined rate for a predetermined amount of time that includes the delivery of multiple services

CMS Approved Alternative Financial Models



Cost Reconciliation

- Type of rate setting in which providers periodically file cost reports or cost surveys created by the state.
- Involves interim rates set by the state using the claims history information.
- Provider or state is made whole after reconciliation.

Financial Models in Other HCBS Waivers in California



- Annual cost per person and Traditional FFS
 - HIV/AIDS, MSSP, PPC
- Tier based, Bundled Rate
 - ALW, SFCLSB
- Blend of financial models based on service or provider types
 - DD



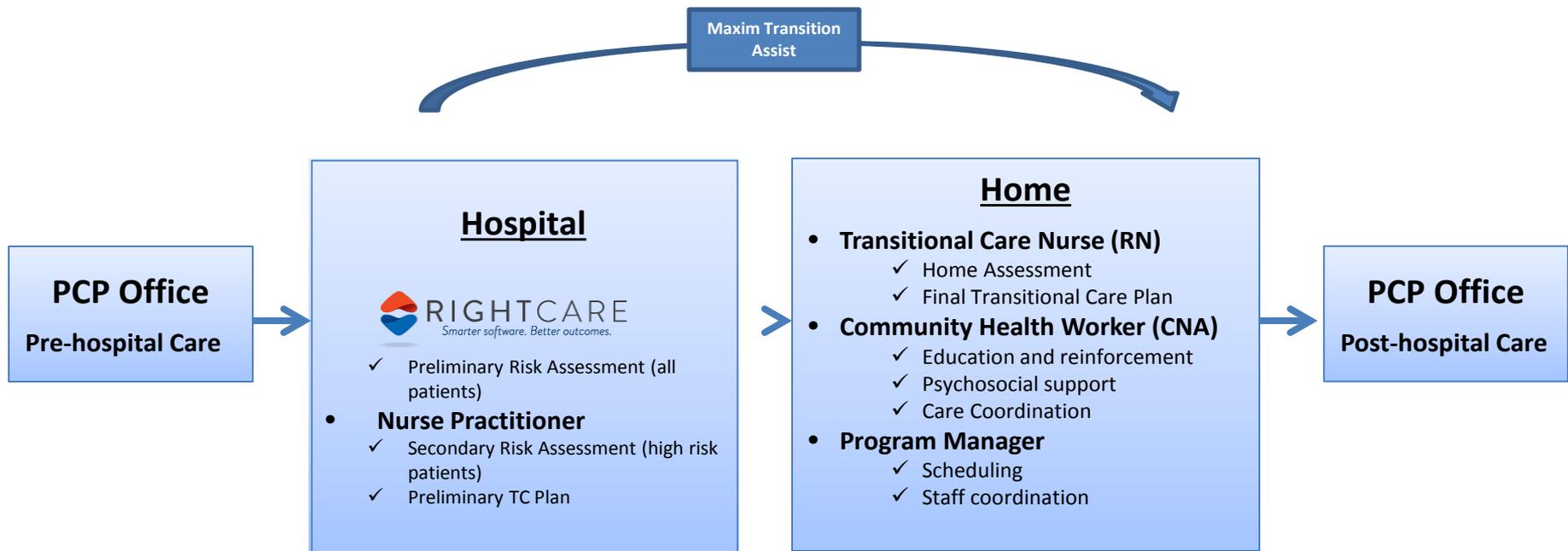
Maxim Transition Assist

November 5, 2015



A division of Maxim Healthcare Services

The Maxim Transition Assist Approach



Traditional Approach

- Post-acute care starts at discharge rather than admission
- Focus is primarily on clinical factors alone; psychosocial barriers are often overlooked
- Fragmentation across providers; little coordination between acute and post-acute providers

As a company that derives 75% of revenue from home care, Maxim understands that traditional home care has not solved the problem of re-hospitalizations

The Maxim Approach

- Patient engagement at admission
- Focus on psycho-social barriers to adherence through patient engagement and social service support
- Continuity from admission through post discharge period
- Transitional care team creates a partnership with the hospital and primary care and specialty care teams

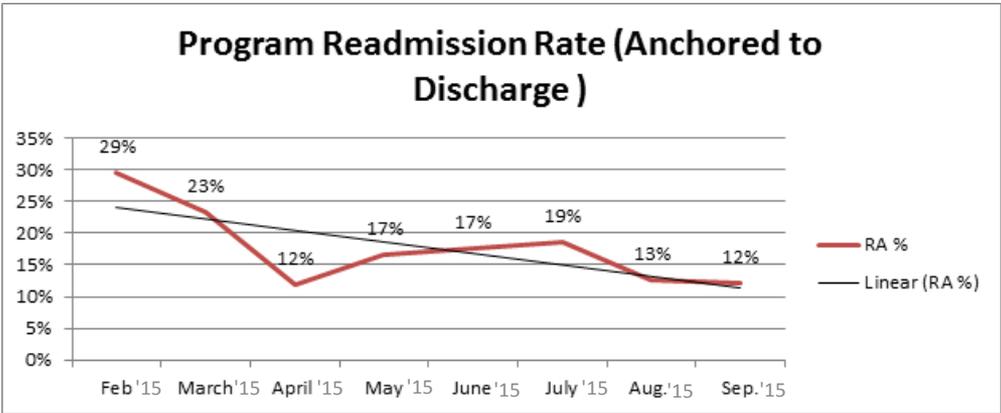
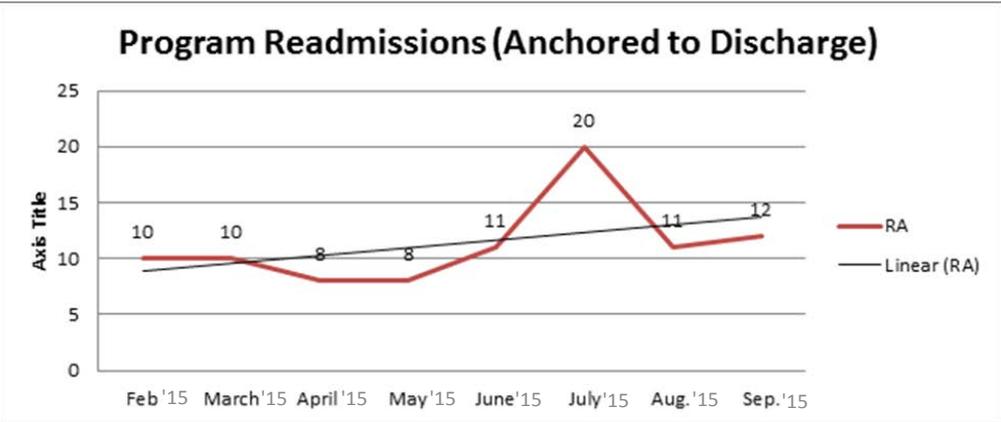
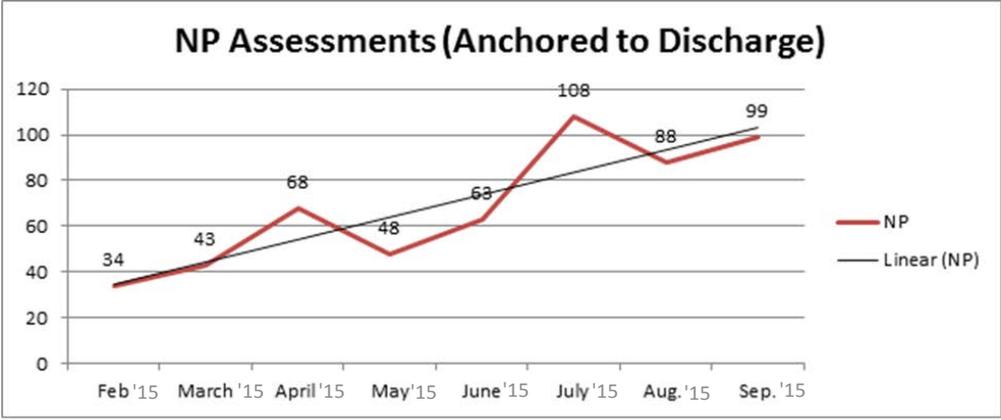
Complements home health and other post acute care services



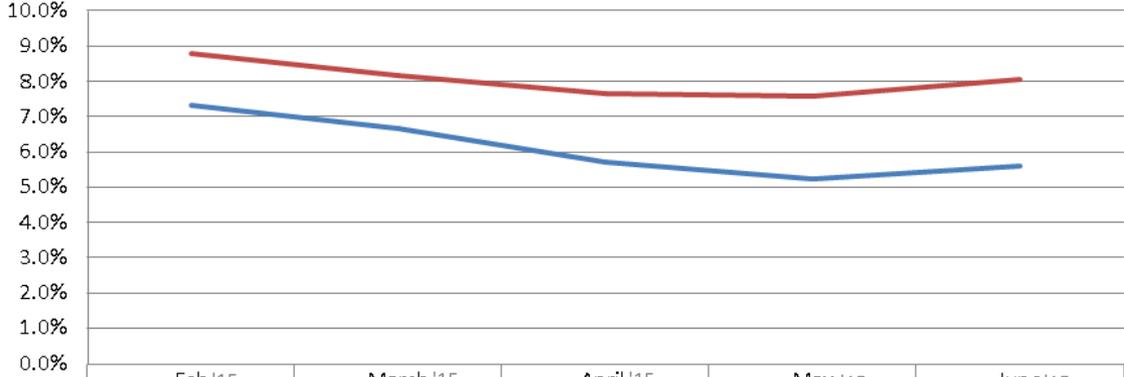
Program Results



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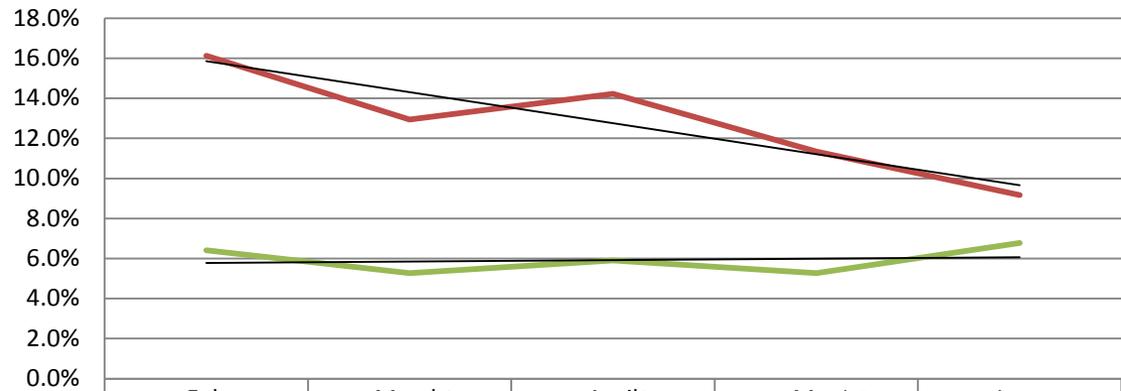


Hospital RA Rate (ADT Data)



	Feb '15	March '15	April '15	May '15	June '15
— Total Hospital Discharges	7.3%	6.7%	5.7%	5.2%	5.6%
— Discharges from Eligible Services	8.8%	8.2%	7.6%	7.6%	8.1%

RightCare RA Rate (ADT Data)

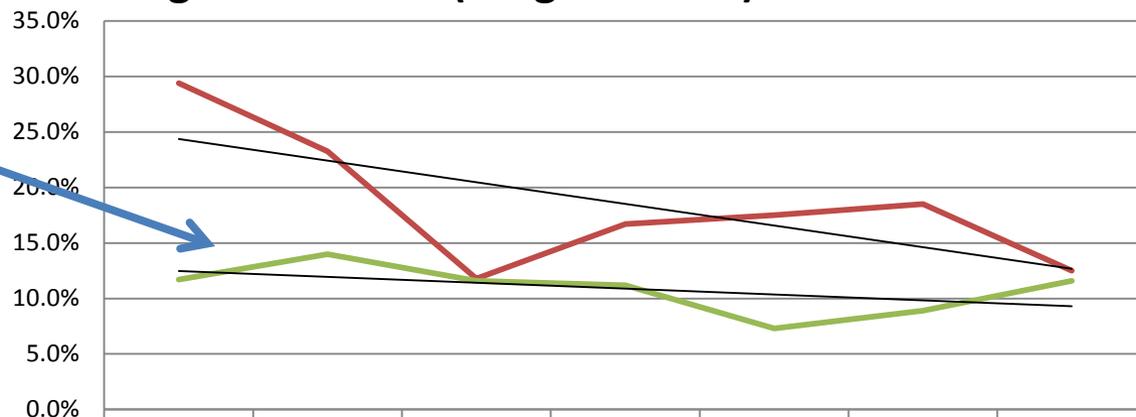


	Feb '15	March '15	April '15	May '15	June '15
RightCare High Risk Patients (RC Risk Score >= 3.0)	16.1%	12.9%	14.2%	11.3%	9.2%
RightCare Low Risk Patients	6.4%	5.3%	5.9%	5.3%	6.8%

Represents:

- DC to LTC/SNF
- DC to SAR
- Left w/o being seen
- Refused consent
- Other

MTA Program RA Rate (Program Data)



	Feb '15	March '15	April '15	May '15	June '15	July '15	Aug '15
Consented/Admitted to MTA program (Completed NP Assessments)	29.4%	23.3%	11.8%	16.7%	17.5%	18.5%	12.5%
Not Admitted to MTA program (LWBS, SNF, SAR, Ref Consent, Other)	11.7%	14.0%	11.6%	11.2%	7.3%	8.9%	11.6%

Transitional Care Provider Basic**Basic Right Care Offering**

- risk assessment of all patients at hospital admission via data feed from EMR

Maxim Outpatient CHW program

- Focus on patients at highest risk (~ top 10%)
- RN home visit and risk assessment immediately after discharge
- Community Health Worker team dedicated to each patient; ~ 11 visits over the 30-day post-discharge period
- Care coordination support to address both clinical and social barriers to adherence

Transitional Care Provider Premium**Complete Right Care Offering**

- risk assessment of all patients at hospital admission via data feed from EMR
- Post-acute care needs recommendation
- Post-acute care provider management tool
- Right Care Touch patient engagement and monitoring tool

Maxim Inpatient program

- NP secondary risk assessment focused on patients at highest risk (~ top 10%)
- Partnership with Hospitalist team to highlight both clinical and psycho-social barriers associated to higher readmission risk

Maxim Outpatient CHW program

- Focus on patients at highest risk (~ top 10%)
- RN home visit and risk assessment immediately after discharge
- Community Health Worker team dedicated to each patient; ~ 11 visits over the 30-day post-discharge period
- Care coordination support to address both clinical and social barriers to adherence

Transitional Care Payor Basic**Maxim Outpatient CHW program****Target: *Readmission avoidance***

- Health plan identifies and refers high risk patients to Maxim following hospital admission
- RN home visit and risk assessment immediately after discharge
- Right Care readmission risk assessment performed on each patient
- Community Health Worker team dedicated to each patient; ~ 15 visits over the 90-day post-discharge period
- Care coordination support to address both clinical and social barriers to adherence
- Data fed back to health plan with broader assessment level detail regarding patient risk factors
- Right Care Touch patient engagement and monitoring tool

Transitional Care Payor Premium**Maxim Outpatient CHW program****Target: *Community-Based Support for Chronic, High Risk******Populations***

- Health plan identifies and refers a group of high risk patients to Maxim
- RN home visit and risk assessment conducted on each patient
- Assessment can incorporate HEDIS benchmarks including
- Right Care readmission risk assessment performed on each patient and population stratified by risk level
- Community Health Worker team dedicated to each patient in the top 40% risk bands. Patients will be scheduled to receive between 16 and 44 visits annually by the team -- based on assessed risk levels
- Care coordination support to address both clinical and social barriers to adherence
- Right Care Touch patient engagement and monitoring tool
- Data fed back to health plan with broader assessment level detail regarding patient risk factors



Thank you!



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- What is distinctive about the FTL/NSHH model program?
- How does the FTL/NSHH model helps members who do not have adequate service hours?
- How does the FTL/NSHH model helps members who are unable to pay for adequate services?
- What is the outcome of FTL recipients?
- How does the FTL/NSHH model ensure the program is cost effective?



Possible Options for Discussion and Why

CMS-Approved Alternative Financial Models

- Fee Schedule
 - Negotiated Market Price
 - Tiered Rates
 - Bundled Rates
 - Cost Reconciliation
- ❖ What is the methodology or appropriateness of selecting one of these options?
- ❖ What data/resources would be used to determine a sound financial structure?



Possible Options for Discussion and Why

Flexibilities For Consideration

- Opportunities to shift inpatient, ER, and SNF costs into waiver services and care management
- Negotiate service provider payments based on many factors – sub capitation, per diem, market rate, etc.
- Geographic rate structure
- Access to essential services
- Establish an adequate provider network
- Services provided based on medical necessity
- Reduces institutional bias
- Ability to manage members based on need

How Possible Options Overcome Identified Challenges



Are there flexibilities we should focus on to overcome public identified challenges?

Cost Neutrality and fiscal structure

- Individual cost neutrality
- Amounts for individual cost limits
- Reimbursement structure/Rigid provider payments
- Institutional bias



Charter Reflections

Workgroup Objectives

- Did we achieve the purpose and mission?
- Did we work toward our objectives?
- Did we accomplish the outcomes?



Public Comment Period



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NF/AH Waiver Renewal Timeline



*Sacramento, Fresno, Los Angeles, San Diego, Redding



NF/AH Waiver Renewal Timeline

May 9 – June 9, 2016 – 30-Day Comment Period

- The state opens the 30-day comment period on draft waiver proposal

July 2016 – Stakeholder Meetings

- Sacramento – 07/07/16
- Fresno – 07/14/16
- Los Angeles – 07/18/16
- San Diego – 07/19/16
- Redding – 07/29/16

September 2016 – Waiver Renewal Due to CMS

January 2017 – Proposed Waiver Effective Date