

**NF/AH Waiver Renewal Technical Workgroup Meeting #3**  
**Meeting Minutes**

April 20, 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

**NF/AH Waiver Renewal Advisory Workgroup Members:**

*Present:* Aaron Starfire, Connie Arnold, Deborah Doctor, Mary Williams, Jonathan Istrin, Denise Likar, Roy Williams, *and* Ellen Rollins, Irene Tokar

*Absent:* Charles Griffin, Louis Frick, Francis Gracechild, Beverly Thomas, Julie Bates (*proxy for Blanca Castro*), *and* Karen Keeslar, Maggie Dowling (Dee), Karen Keeslar,

**State Representatives:**

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

**Proceedings:**

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

- Member introduction and brief statement about meeting objectives
- Overview of discussions in the first and second Technical Expert Workgroup (TEW) meetings. The first TEW meeting focused on how the waiver is structured today and challenges and barriers in the waiver. The second TEW meeting focused on the care management structure. The third and final TEW meeting focused on Cost Neutrality and Financial Structure, and Care Management Models.

**PowerPoint Presentation**

PowerPoint presented by Rebecca Schupp, Lindsay Jones, and Joseph Billingsley to discuss the care management approach, waiver capacity, and care management entities.

**Meeting Agenda**

Rebecca Schupp briefly discussed the items in the agenda and then asked if there were any questions.

Deborah Doctor commented: Yes. I'm going to take the liberty to bring up something that is off the agenda, but is really urgent which is the situation where the current waiver participants and workers are working overtime, and some need exemptions. Those exemptions or exceptions were announced in January. They have had nothing telling them how to apply for one, the violations start in 10 days and they are already starting to get notices of violations, and they are left out in the cold here. I'm speaking on their behalf. This is not something of their making and they should not have the responsibility of having to appeal the violations that they're getting, so that's the first thing that I want to bring up. Then I'm learning for the first time that we're going to have presentations from agencies delivering services and I want to know whether that includes In-Home Supportive Services (IHSS), Community-Based Adult

Services (CBAS), and Multi-Purpose Senior Services Program (MSSP) providers. Those kind of community agencies? Are they going to be presenting?

Rebecca Schupp responded: No, other agencies are not presenting because we are talking about the Nursing Facility/Acute Hospital (NF/AH) Waiver today so it will be providers who are providing services to the NF/AH populations.

Deborah Doctor commented: Does this include IHSS providers?

Rebecca Schupp responded: Yes, there are some IHSS providers, but no, we did not reach out to them for today. So we can do special outreach to that population of providers to make sure that they comment during our public comment period on the proposals so that we know we're getting their input.

Deborah Doctor commented: It would have been good to have those providers who have a long experience doing this included.

Rebecca Schupp responded: Yes, great point, and then to your first comment, the department does apologize about the lack of further clarity on the exemption process and the form. We have been receiving calls from our participants and we've been tracking requested exemptions. Our waiver stakeholders, providers and participants did comment on the draft letter that we will send out to waiver providers and participants on the exemption that closes tomorrow. We will quickly incorporate their comments and turn that around to mail out as soon as we can. We are going to back-out and remove from the system any inappropriate violation. It will not count as a violation and any exemption that is approved will go retroactive back to May 1st.

Deborah Doctor commented: So you're able to go into the IHSS.

Rebecca Schupp responded: Yes.

Deborah Doctor commented: Are they getting these letters from IHSS.

Rebecca Schupp responded: Yes, the counties are being very proactive to try to mitigate violations and so they do not understand the intricacies between IHSS and WPCS, and unfortunately are sending letters to the WPCS providers. We have had conversations with Social Services on how to tell the county to not be so aggressive in notifying our providers of their violations because our policy is a little different with the IHSS program.

Deborah Doctor commented: I am happy to hear that but I'm not comfortable with putting any blame on the counties for something that is not administered by the county but thank you for clarifying that.

Rebecca Schupp responded: Thanks for your questions. We are going to go into action items. I think the action items from our last meeting were to get you all of the care management agency draft mega qualifications, which hopefully, everybody has had a chance

to review. Within that email we had the meeting minutes, and we did not hear back from anyone on amending the meeting minutes. We also have revised the PowerPoint based on discussions we had in the last meeting, and we did not hear any comments on the edits that we made to that power point. Therefore, we will consider the meeting minutes and the PowerPoint from last workgroup final and we will post those to our website.

### **Care Management Agency (CMA) Standards of Participation**

Joseph Billingsley stated: Moving onto Item 4: An agency that maintains an adequate provider network and identifies help and functional status through care management. To expand on that further, providers that must endure provider rates are sufficient to maintain an adequate provider network to meet the needs of the participants. This means that they must ensure provider rates are sufficient to maintain an adequate provider network that is able to meet the needs of its participants, monitor, delivery and quality of services, changes in participants in health and functional status and overall responsibility for the operation of the local care management agency and be able to plan, organize and direct all administrative and program activities across all waiver providers in accordance with the contract with Department of Health Care Services (DHCS).

Denise Likar commented: How can the providers ensure that the provider rates are sufficient if the state doesn't ensure that the rates to the providers are sufficient. I agree that they should do that but you can't pay somebody in essence to do that and then not fund them at that level, right?

Rebecca Schupp responded: It could be a back and forth in that the organized healthcare delivery system or the care management agency should let us know what they believe sufficient providers rates in our areas are; where the state is setting a minimum allowable rate and anything above that is approvable, and that minimum allowable rate across the state is sufficient. A two-way communication in this is needed.

Denise Likar commented: Are you saying that two-way communication is pre-setting the setting or is this after the fact to ensure somebody is in compliance.

Rebecca Schupp responded: It would probably be both. It would be pre-setting the maximum allowable rate, the statewide rate, because it is an administrative burden to the geographic rate structures, so if we did a developmentally disabled structure where there is the minimum allowable statewide rate and then as we progress (unintelligible), there is an open communication and open dialogue to talk about the rate pay by the state being sufficient in those geographic areas. More than a CMA to maintain a provider network.

Denise Likar commented: So you have geographic diversity now. In Los Angeles county to get an RN is higher rate than the rate that is like in the (unintelligible) layer today, but it feels like we need to do something. I understand the administrative burden of trying to do a geographic study, but you have people in those geographies that can give you a baseline. Like for instance, for all of these categories, I'll use MSSP as an example. The MSSP currently has contracts or are required to have contracts and so they already give you late information, and I'm sure other people here have some more situations on what by

geography is asking in order to have the support, the vendor network, so it should be able to support this.

So I understand the burden piece but it might be a little backwards because I'm smart enough to know that even though we can have those dialogues during that period of time of the next labor change is going to be pretty limited to whatever already is set anyway. So I'm just kind of putting out there that you could get a pretty quick landscape from the providers in those counties that you're talking about.

Rebecca Schupp responded: Right and that makes sense. So is there a recommendation on how to rephrase this in that the state is also looking at the geographic rate structure to ensure ...

Denise Likar commented: Well, this document to me says mega qualification requirements. You would need to do your homework in order to substantiate success. I mean, so I'm kind of taking a step back. In order for this sentence to be fair in the publication, there needs to be work done before hand to have it taken into account. I don't know about this restructuring if this can't be implemented. I'm proposing that you really can't implement this until you've done your research. Some level of research. So the waiver could say the rates have to be sufficient for providers to meet those qualifications.

Rebecca Schupp responded: Okay. Great comment.

Deborah Doctor commented: When you're talking about rates, are you talking about Waiver Personal Care Services (WPCS) providers or just agency providers?

Rebecca Schupp responded: It would be anything non-WPCS because of the way WPCS is structured today.

Deborah Doctor commented: I don't understand that.

Rebecca Schupp responded: We could say excluding waiver personal care services?

Deborah Doctor commented: I don't understand - are you saying that this is going to be excluded from the waiver?

Rebecca Schupp responded: Oh, no.

Deborah Doctor commented: Or what?

Rebecca Schupp responded: I thought we heard from the workgroup on the first day that we met and even the second meeting that when there were issues with WPCS or the IHSS delivery system, and I proposed to look at another WPCS structure, that does not leverage the IHSS system, it was very clear that everyone said, "No." So we would not move away from the way that WPCS is structured today. It would remain a benefit under the waiver, but it would not be facilitated through a care management agency, so that the reimbursement and

the managing of the benefit would remain through the Case Management Information Payroll System (CMIPS) with IHSS.

TEW woman commented: What if the rate is not sufficient to - for somebody to find a provider?

TEW woman commented: Yes, that's the problem.

Rebecca Schupp responded: Yes, that's a good point. So we could reopen that conversation about de-linking WPCS from IHSS.

TEW woman commented: Well, I think there are two different questions here. It's linked for some purposes, but it's not linked for other purposes, so ...

Rebecca Schupp responded: So were exploring opportunities to de-link WPCS in the rate setting.

TEW woman commented: Well, I would agree with this, but there might be some people who would appreciate help from a case management agency in recruiting or hiring or...

Rebecca Schupp responded: Oh, yes, and that would be a part of the care management responsibility to assist the beneficiary, but WPCS would still have provider timesheets that they submit through the process, paid out through CMIPS, and the beneficiary would still self-direct (train their caregiver). They may request training with the CMA and that would be a CMA responsibility and then they would self-direct the services on that day and the CMA would also be responsible for ensuring a backup caregiver in the case where the primary may not show or have an emergency.

TEW woman commented: If the case management agency has responsibility for delivering a whole package of services and the consumer on her own is unable to find assistance and one of his/her issues is he/she can't find anybody who is willing to do this work for this pay, that it would be upon the case management agency to fill the beneficiary needs. Is that correct?

Rebecca Schupp responded: That's correct, and I think there are opportunities to look at a personal care agency to find other providers in the IHSS system. We would be open to having dialogue around how the reimbursement amount could be offset through the CMA. I think we're open to that dialogue. We would like recommendations or input on that. I don't expect you to have anything today because it's hard to produce something on the spot, but of course, before we release our public comment on May 9, we would love to receive your feedback or any ideas around being more flexible without WPCS benefit.

Connie Arnold commented: I think there are a number of issues. One issue is the provider rate. That is one of the key issues. I didn't think it was fair to increase the rate for In-Home Operations (IHO) and then have the IHSS be the same, how you're going to elevate that? It's different because waiver people are self-directing.

I have a friend, he has 17 hours of help a day, and if he needs 24 hours, he can get it. I can't get it because of the individual cap. The rate is a key problem across all counties for those of us with significant disabilities because the level of care, who need the assistance. The kinds of assistance we need are different. So it's a situation where the providers can cherry pick the easier people that they don't have to do all these numbers of tasks for or where they have to provide more assistance. So we do need to do something and just saying well, here's a list from the public authority is not fixing the situation.

Rebecca Schupp responded: Right and we want to move away from that. That's not how CMS or the state would want it to be, it would be more from a localized care management structure.

Connie Arnold commented: But of course we want to keep continuous ...

Rebecca Schupp responded: Of course.

Connie commented: I think the pay rates are really one of the key problems whether you're either an individual with a disability doing it all, managing, recruiting, hiring good people and firing versus an agency that has to do the same thing. If the rates haven't changed you both have the same problem. The rates haven't kept up with the times and there's institutional bias.

Ellen Rowland commented: I concur.

Rebecca Schupp responded: Thank you.

Joseph stated: Moving on to Number 5, this is a qualification option requiring an agency to be able to track claims and other necessary data to monitor service delivery and member outcome. Here we're talking about requiring providers to be able to maintain a management information system that has the capability to collect and contract through this data, provide required waiver reports, enable the provider to bill, the nursing facility, run the acute hospital expenditures through the State Medi-Cal claims payment system and the Medicaid Information System (MIS) must also be able to support the care management process, which involves conducting and documenting assessments and reassessments, developing and updating care plans and tracking outcomes. Taking and documenting service arrangement, monitoring service deliveries as published in the CMA and the contract manual. Are there any comments here?

Connie responded: I have a comment. Don't overburden the system with so much paperwork that people aren't interested in doing this, and that's actually what's happening right now. This is happening with the overtime for individuals with disabilities with all the forms that are provided. It's a concern if you're going to overburden the participants and make it an oppressive system with so much paperwork; you're going to have less providers and people interested in doing it.

Rebecca Schupp commented: Yes, however, there are state requirements on a Medicaid management information system, being able to track data, being able to track utilization, all feeding into, our cost neutrality reports, and building out our estimate for future years. We do recognize that we need to have consideration on the administrative burden that may come with this type of a care management structure.

But, I think we definitely need to have a management information system that is paperless. Hopefully something that is system-based, electronic, but we would expect that as an extension of the state Medicaid agency, a care management agency must have an approved management information system. But, I do hear what you are saying about the administrative burden where we need to reduce this burden.

Connie Arnold responded: Change the word member to participant.

Rebecca Schupp commented: Yes, yes. We tried to do that everywhere and you are always catching us. I'm not seeing it but we will make that change.

Joseph Billingsley stated: Okay. Thank you for commenting.

Item six, the agency must have a community presence to meet care and service needs and is knowledgeable about the skills and abilities of the target population. The provider must have a local community knowledge and local experience in establishing and maintaining effective working relationships with local managed care organizations, community based organizations, private and non-profit organizations, service providers just having that local connection to the area that they're serving are the areas that they're serving.

Connie Arnold commented: That's great, I have one comment. The comment is that the stakeholder's - the people that are participants should be surveyed about their ratings just like any healthcare system where they give the rating on Medicare or whatever a rating. A star rating about what they feel and what their personal comments are about that Agency. It's like going on Yelp.

Rebecca Schupp responded: Yes, like consumer satisfaction surveys.

Connie Arnold commented: Yes, but you have to ask the right questions.

Rebecca Schupp responded: Yes, I don't think that's necessarily a qualification of a management agency that they have to do consumer satisfaction surveys about something that the State could look at doing to assess the satisfaction or dissatisfaction with a CMA.

Joseph Billingsley commented: Be more of an ongoing measure.

Rebecca Schupp responded: Right, it could be a part of our monitoring oversight at the State level.

TEW woman commented: Areas for improvement would be good.

Rebecca Schupp responded: Yes, our quality improvement system.

Joseph Billingsley stated: Lastly, item seven, the agency of a global knowledge regarding Medi-Cal in a disability environment.

So we are really looking for experienced providers here. Providers that are able to effectively assist in navigating the disability system under State and Federal funded programs and demonstrate care management and institutional transitions experience related to serving the population that should include either a significant number of frail, physically disabled participants and or a similar population.

This experience should include knowledge and experience of outreach activities, Medi-Cal eligibility, enrollment and disenrollment procedures for managed care and for a waiver assessments and reassessments including level of care - establishing level of care and identifying medical necessity and being aware of those requirements. Having a strong base in person centered care planning, transitional care planning, case conferencing and service delivery including participant monitoring and follow up activity.

Deborah Doctor commented: Could I ask you not to use the word frail, please? If we're talking about people with disabilities, we can just say "people with disabilities". I don't think it needs to say "frail or physically disabled" because people with disabilities have a wide range of disabilities and I hate that frail word.

Joseph Billingsley responded: Okay.

Rebecca Schupp responded: Yes.

Deborah Doctor commented: I would also recommend that the providers be familiar with the disability civil rights laws including the OLMSTEAD decision.

What I'm getting at is; they should know the rights of people to live in the most integrated environment, which you would think they would know because this is the work they're doing. I would also like to see the presence of, in their governance a representation of the people they serve and oversee.

Rebecca Schupp responded: Do you think they should have an advisory committee that is comprised of subject matter experts...Say the number eight.

Deborah Doctor commented: Well, I don't think an advisory committee.

Rebecca Schupp responded: Yes, other areas of governance with a consumer representation.

Deborah Doctor commented: Yes.

Aaron Starfire commented: [Are] there agencies that are going to be able to do this? Has there been some kind of identification from the community at the governmental and the nonprofit level from people that you think might be applying?

Rebecca Schupp responded: Yes, that's a great question. We really built a lot of these proposed qualifications off of established waiver structures today, very similar to what is under the MSSP services program.

There are some county and nonprofit entities, also in the areas. We're doing special outreach to the Aging and Disability Resource Centers that have tried to really integrate the whole broad spectrum of persons who need in home assistance.

The developmentally disabled system is all structured through regional centers. Not that we would look through regional centers to do this work, but maybe mirroring the kind of system that they have.

Aaron Starfire commented: Okay.

Jonathan Istrin commented: Just to follow up on that, yes. Number one: you don't include any for profits; you only included non-profits, just wondering if there is a reason for that?

Rebecca Schupp response: No, I think, we looked at the ways that other waivers were structured with that organized health care delivery system but we are open to that conversation and so, if that's something that the work group would want to see maybe expanded opportunities to, we're open to that discussion.

Jonathan Istrin commented: I think going on what (Maxim) said – Aaron Starfire. In order to have the capacity for the whole state there will be areas that you might need to look to for a profit organization to do this. In limiting to only nonprofits and government agencies it will probably limit good coverage that you could have.

Rebecca Schupp responded: Yes. Good point.

Jonathan Istrin commented: A for profit health plan is able to step up quicker – have readiness availability.

Rebecca Schupp responded: Yes, I don't know if I necessarily agree with that, I mean we do have... organized healthcare delivery system but we're very well prepared. But, we recognize your point in wanting to have that coverage across the state and wanting to provide access to everybody across the state, so that was a great point.

Jonathan Istrin commented: Thank you.

Aaron Starfire commented: Can I also ask, and maybe it's been said but, this may be an administrative cost question. Case management is great. However, that obviously adds a

level of cost to the system, and this is a system that is already short on supply of dollars, so, I guess my question is this is awesome, but at a bigger level, there's still the root cause issue of the reimbursement structure which I know we're going to get into that. But what about the reimbursement structure for these CMA's?

TEW woman commented: Doesn't that come out of the client's budget?

Aaron Starfire responded: Well, even they're not for profit...

Rebecca Schupp responded: Yes, we're really getting into the next conversation and I understand because it's the world we're living in today. We keep talking about the budgets and the cost limits that we have today, but I think, we're really here today to talk about what are our opportunities to change what we're currently experiencing and maybe move away from that cost limit structure that we have.

But definitely we are very aware that we have to reimburse from a cost of care management if we were to do this kind of a structure and we would look at what's already happening in other waivers. What is their care management cost, looking at managed care plans? What is their care management or administrative cost?

If we were to move to this type of a structure of course we would talk with some of our parties around the table or other parties who do deliver these kinds of services to get their recommendation on the most appropriate kind of care management reimbursement.

Aaron Starfire responded: Okay.

Rebecca Schupp responded: Yes. I mean we recognize that this does not come free.

Connie Arnold commented: It's funny in Europe they just give the individual participants "Here's \$50,000 for the year, do what you want with it." Okay.

So, if you need a van or a lift on a van, or you want your tenant care services or whatever you want, you direct where that money goes. You cut out all the middle people, and all the retirement accounts, okay? It's probably a major cost savings. Give it the money to them to let them decide what to do with it. I think the self-directed model where you're managing things is a much better way to do it. I mean, if my friend can get the hours he needs and pay a rate of \$15 or \$17 an hour but the people in IHSS are stuck in Sacramento at \$10.80, you've got issues there.

You're not going to have the same options for hiring people and you've also got the hours that you need so you don't have that struggle. You have IHSS' at advanced pay to give the person the money, let them manage it. In a month, they can turn in a whole time sheet for the full month.

So, that would be a lot easier system than the way you have it for now for personal care services and rate structure. You've got two timesheet periods and then the timesheets now

go to the provider. The recipient has to get all the timesheets and be on multiple providers from all of the people.

If they don't get a timesheet, you have to make five calls and two or three emails just to get the timesheets for March and I didn't get it until the eighth, to do the timesheets for my providers.

If you already know what a person's budget is why do you need to have this system set up? If you're the employer, why do I have to recruit the timesheets from each individual person? Why can't you send it directly to me so I can do the timesheets for my people?

The system set up now is proposing to have these forms with inflexibility in the hours - meaning I sign mine, they sign up because the overtime rules, they have this form to fill out and their hours are locked in - fixed hours. Then I have authorized hours, and that looks like it's a fixed hour thing. So there's going to be a monthly input of the same form over again as hours change every month for your providers.

Well, providers are out sick, they want time off, they want vacation time, they need to go somewhere, they can't come for whatever reasons, doctor's appointments.

Rebecca Schupp responded: We hear what you're saying and we recognize the burden on the participant. I mean, we always end up talking about WPCS or IHSS specifically and we're really trying to have these work groups talk about broader, across the waiver, restructuring or opportunity for change.

Deborah Doctor commented: What Connie is talking about is a real, cash and counseling money problem person program. This should be a real cash and counseling program which gives people the kind of freedom that is exactly what Connie is talking about that has been done in other states. People who want to actually manage their budget - their waiver budget be allowed to do that.

Connie Arnold commented: Yes, that's what I'm saying because the only drawback is what Maxim said in their report about the accounting fiscal part of things that the cost of the fiscal agency came out and addressed participant budget.

Rebecca Schupp responded: That's the DD? Is that the DD?

Connie Arnold commented: No. If you can delink that fiscal agency who's taken the timesheets and doing the accounting of it and issuing...

Rebecca Schupp responded: We can commit to doing some research, see what's happening in other states, how they are doing it, how it's happening in the DD system and then - yes.

Deborah Doctor commented: Twenty years' worth of experience?

Rebecca Schupp responded: Yes, and then see what are the member outcomes, and commit to doing that kind of research, or deeper dive into the cash and counseling. But, I apologize we have a jam packed agenda so we really need to move on.

Joseph Billingsley stated: Next we wanted to review options for care management agency scoring. So we just wanted to get your input on schedule factors that contribute to agency scoring. Some of the factors that we have identified for your consideration are demonstrated capacity so the providers are demonstrating capacity upon application to be a provider.

Experience, this goes back to the qualifications we discussed earlier. So what's their experience in providing these types of services and also experience within the community and also looking at potentially other areas of experience? They should have knowledge with disabilities, OLMSTEAD Act, etc., and Knowledge of the population, regulations, governing the population, etc. Demonstrated skills the provider's ability to provide the skilled care needs for the population, and abilities.

Rebecca Schupp stated: So let me just rephrase. We would of course want to contract with the cream of the crop and so if there were one of these factors that should be weighted heavier than another is to make sure that we were contracting with the best of the best.

From your perspective if you had to give up something more than one of the other qualifications that we listed in a prior chart, what factors rise to the top for you in order for the State to conduct a viable score or ranking of care management.

TEW woman commented: The thing that isn't there, which is customer satisfaction and outcome.

Rebecca Schupp: Okay. How they're going to manage the population?

TEW woman commented: Well how have they. If you're saying that they have experience and demonstrated capacity, don't you think...

Rebecca Schupp commented: So basically experience of managing the population and demonstrating...

TEW woman commented: (Unintelligible)... outcomes and customer satisfaction because, I mean, I've written proposals and you can make yourself sound like the best.

Rebecca Schupp commented: Kaiser?

TEW woman commented: Well yes.

TEW woman commented: I'm a Kaiser member (unintelligible). No, I think that when we talk about (parsons) centered, there is a person here.

Rebecca Schupp responded: Yes.

TEW woman commented: So many of these providers that you referenced as being under the radar are poised for this are already required to be collecting satisfaction data.

Rebecca Schupp responded: Right.

TEW woman commented: So if that is included in your experience description, because some of you are kind (unintelligible). I mean these words are kind of separated out in separate forms and some of them are like one header that includes all of these things that you have.

It really is the experience and the knowledge base that is needed to understand the population served; the history of the delivery of the type of service, and all that kind of rolls together for me.

Rebecca Schupp responded: Yes. Okay, no this is great

Connie Arnold commented: My focus would be, get rid of those systems that refer to people with disabilities as patients. Knowledge I think is important. Knowledge of the disability field and like Deborah had said earlier in the Olmstead decision. Knowledge includes the understanding of the needs of a variety of persons with disabilities and what those needs are particularly since the population that the waivers are investing that those individuals with the more significant disabilities. So the needs are a variety of individualized needs and you have to understand what that is.

I think knowledge includes the understanding of how disability products can make that person's life better in terms of the waiver, when you are aware of product options, like adaptive environmental controls, etc., you can make better decisions. They need to have an understanding of what is out there and go to a few disability expos so at least they will know what is out there for people. If somebody needs a rolling shower or ceiling lift or would benefit by a particular type of electric wheel chair or communication device.

The ability to work with a person who is deaf or hard of hearing or blind or low vision or has a physical disability is important as all of those issues come into play. I think new start up organizations should be included that may offer disability equipment or devices that are not known or offered currently.

Ensure that a proper backup provider is available to the participant if needed. It's not just providing a body for somebody. It is providing somebody that's compatible and capable of doing the task that the individual needs.

Ellen Rollins commented: Having a clear understanding of agency medical model ideology versus holistic independence, being able to somehow demonstrate that you understand those differences, so when you're in a self-directed individual's home you understand those complex nuances.

Rebecca Schupp responded: Great point, great point.

Connie Arnold commented: I concur.

### **Individual Cost Limit & Cost Neutrality**

Lindsay Jones stated: The individual cost limit is federally required. It accomplishes the following: Determines entrance into the waiver, provides authorization of waiver services, and assists with maintenance of cost neutrality.

The individual cost limit is the expected cost of home and community based services when compared to the cost of institutional services. It is required by CMS when we are filling out the waiver application in the portal.

There are four different options that we are allowed as a State. The first being no cost limit; the second being cost limit in excess of institutional cost; the third being cost limit equivalent to institutional cost; and the fourth is the cost limit is less than institutional cost. We'll go into these here as each slide goes on.

For the choice of no cost limit, this is the entrance into the waiver and the amount of services that will be provided to an individual as 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.

A good example for this particular model is both the DD waiver and the pediatric palliative care waivers. Both of those have no cost limits but they do put the State at risk for not maintaining cost neutrality. So, keep that in mind with this particular option.

Rebecca Schupp commented: I would just add if there isn't good local control or assessing of medical necessity it is harder for the State to maintain cost neutrality. Discussion points that you want to raise to the State could rely heavily on the care management structure as well.

Deborah Doctor commented: I just want to say you're right there. The DD Waiver which has 116,000 people on it this year has somehow managed to survive with making this selection. Making this selection means that there's an aggregate cost limit. The government still requires an overall cost limit so I don't want people to somehow think that when you choose this, it means that there's no control on the overall cost – in the slide that shows comparison. This waiver was done this way years' ago.

Rebecca Schupp commented: So further to describe your point, is that because the DD Waiver is serving so many people, they can spread their risk across the large spectrum of acuity levels. They maintain cost neutrality in the aggregate because it is the total - and we talk about cost neutrality -- the total population's cost divided by the total number of

unduplicated participants compared to the institutional peer groups. So, DD is able to achieve cost neutrality with the no cost limit.

Lindsay Jones stated: For the second option that States can choose, this is the cost limit in excess of institutional cost. This is defined by CMS as the entrance into the waiver an 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 cost may exceed institutional costs.

So, the two examples that we used in excess of institutional cost that current waivers utilize would be the IHO waiver and the San Francisco Community Living Support Benefit waiver. Both of those waivers have chosen in excess of institutional cost. This does allow for the State to set a ceiling and to ensure cost neutrality based upon on only medically necessary services being authorized.

So for example, a State can provide for entrance of person whose costs are not expected to exceed 125% of institutional costs. If this choice is selected the cost limit must be specified. In addition, the State still must demonstrate cost neutrality like Deborah said in the aggregate.

Rebecca Schupp commented: This cost limit selection demonstrates cost neutrality across the spread of the population that you're serving and their costs. It's an aggregate cost neutrality.

Those who had medically necessary services may potentially reach the ceiling.

Lindsay Jones commented: The third option is the cost limit being equivalent to institutional costs. This is defined as the entrance into the waiver an 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 are equivalent to the average cost of the institutional services for the level of care the person requires. The example of the current home and community based waiver that uses this would be the Assisted Living Waiver, it has chosen equivalent institutional costs. This ensures cost neutrality and further targets level of care or acuity. It does not allow the state to maintain a broad spectrum of participants to ensure cost neutrality though.

Rebecca Schupp commented: This cost neutrality would be on the individual basis where each individual's annual cost of care would be equivalent to the institutional cost. Here there needs to be a lot more checks and balances in the state system to ensure cost neutrality with the federal government.

Lindsay Jones commented: Last is cost limit less than institutional cost. The entrance into the waiver is the 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 are less than the average cost of the institutional services for the level of care that that person requires. Both the MSSP and HIV/AIDS Waivers are the two waivers that utilize this option.

We just wanted to look at other waivers that also utilized this option. This ensures cost neutrality and is further targeted based upon level of care and acuity, and it once again does not allow the state to maintain a broad spectrum of participants to ensure the cost neutrality.

TEW woman commented: I would like a correction on this slide. Each individual may require an amount. The only way somebody can get on the waiver currently under the circumstance is that they require an amount that's less than their cost cap. But the individuals may need more than that. They are not allowed onto the waiver. This is a little squishy, I think. It doesn't make it clear. They may require care that is more and the consequences are to not admit into the waiver.

Ellen Rowland commented: I think what it is saying is that their level of care is at a minimum net pay. The entry level is still net pay and has to be medically eligible.

TEW woman responded: But people are not admitted onto your waiver right now if they have needs that exceed the cost cap. So, I don't think that's clear here. This is about their cost limit, not their eligibility.

Rebecca Schupp commented: Yes, I mean entrance in the amount of services for the waiver requires the individual to have an amount of home and community services that is less than the cost cap.

TEW woman commented: There's a further slide that - ye, slide 17. This issue comes up again. Right there where it says what happens if you meet the institutional cost limit, it doesn't say what happens if you don't. What happens if you don't this, then you don't get on the waiver.

Rebecca Schupp response: Yes, so we can take a look at this slide and make some edits and then - the normal process and have your guy's feedback on it.

Lindsay Jones stated: Okay and this is just an overview of what cost neutrality is. So, as Rebecca had stated earlier, it's the total health care cost of the waiver population divided by the unduplicated number of wavier participants as compared to the total health costs of the institutional peer group members divided by the unduplicated number of institutional peer group members. So this slide is just a visual and then the next slide is the same thing, it's just written out.

Aaron Starfire commented: Can I ask about that? I know there's discussion later, but I guess when I think about cost neutrality I think about how is facility cost is the bar to set that precedent, how is that cost really established?

Rebecca Schupp responded: Yes, so it's actually not facility in the waiver application, it's the level of care. So there's hospital level of care, nursing facility level of care, and then ICF DD level of care, and then depending upon your mix of members in the waiver by that level of care, we would call the same applicable mix the institutional peer group.

Does that make sense? So if we have 50 hospital waiver clients - waiver participants - and 100 (NF-B) waiver participants, and 30 ICF DD waiver participants then we would pull the same cost data, 50 hospital - but actually without even the hospital. A hundred...

Aaron Starfire commented: Right, I get that but when you're saying cost, is that the price that's been fixed by the State or is that, what it costs?

Rebecca Schupp responded: Payment.

Aaron Starfire commented: I think that's worth being clear on because a big root cause, I think has to do with a failure of price inflations to court sponsor and market value. So I think when you look at the underlined economics I think it may be really important if you're going to, whatever bar you choose to match up with the cost limit and the cost neutrality and the aggregate cost. It would be important to think "what do we mean by cost and who is setting that?" and I know we'll talk about that later.

Rebecca Schupp commented: Really quickly, I just want to clarify that our cost neutrality peeks into account D, the entire spending on the waiver population and the applicable peer group. So, we separately look at what the waiver payment amount is but then we add in that waiver population's ancillary services so there's State plans, hospitalization, primary care specialist cost, and then compare that to the applicable institutional payments and then that population's ancillary services as well. So, we're not just comparing waiver reimbursements to institutional reimbursements we also look at the entire population's health care expenditures.

Aaron Starfire responded: Yes, but only public health care expenditures, you wouldn't be comparing commercial or private so when we get the real pricing providers must often work with all the players involved so it is worth probably a cross comparison between public sector costs versus private and then you begin to approach the real pricing.

Rebecca Schupp commented: Yes but you're getting into like, how the federal government should direct states to determine cost neutrality.

Deborah Doctor commented: I've just got one question about that. Is this historically going back a year, two years?

Rebecca Schupp responded: We look at one full calendar year of data to determine cost neutrality at an 18 month lag.

Deborah Doctor commented: So when we look at the current waiver, the figures for how much the waiver budget is versus the institutional level of care and we know that the institutional costs are way behind what they are. Putting aside what you're talking about, they're less than the payments to those facilities, and the rates aren't even up to date. So what should be included in that comparison is not only for instance the minimum rates but any cost the state bears if somebody goes to a hospital and it's a Medicaid payment.

Rebecca Schupp responded: Yes, we include that, that's all in there.

Deborah Doctor commented: You're talking about overall cost neutrality which figures into that, but it has no bearing on what the individual cost limits are on the waiver.

Rebecca Schupp responded: That's correct. The way we determine, the way the State determines cost neutrality is not directly correlated to the identification of the waiver's individual cost amount.

Deborah Doctor commented: Then there's State cost neutrality which was incorporated in SB643. So should we assume that that's going to go away?

Rebecca Schupp responded: Is that its cost neutral to the general fund?

Deborah Doctor commented: Yes. The State came up with a new definition of cost neutrality which is - so that is the position we're in now. It needs to go away.

Aaron Starfire commented: I just have a question, I don't want to belabor the point, but when it says total healthcare costs I know that the nursing home rates have not changed - no one's rates have changed. But they have a labor component that's an add-on so their actual cost per day is closer to \$200 than \$150 which is published rates. So when you're comparing the cost neutrality, are you guys using the total cost or are you just using what the rate is?

Rebecca Schupp responded: We use - we mine our claims data. So we use our Medi-Cal reimbursement amount.

Jonathan Istrin commented: The Medi-Cal reimbursement amount is probably only the \$150 a day because the other amount comes as an adjustment. I don't know if it's once a year or a couple of times a year, but they do a cost report to get that quota passed to us. So we might be looking at an artificially low number of what the nursing home costs. I know that some nursing homes have different rates. Some get 180, some get 210 on the Medi-Cal rate and it's really based on their individual cost reports and it has something to do with SB 629. The nursing home cost for a client is well over \$50,000 - \$60,000 a day. But yet the NF/AH waiver cap is closer to 48 which is based on the rack rate as I call it of 150 a day. So I just want to make sure if we're going to include total costs (total payments) that we really do.

Rebecca Schupp responded: Yes, these are all additional justification points for us to demonstrate cost neutrality to the federal government.

Jonathan Istrin commented: It's also a way to increase rates because that's not what we're discussing right now.

Lindsay Jones stated: Just continuing on the overview of cost neutrality what are the requirements that CMS states. So the annual cost neutrality reporting to CMS is, examines labor services and state plan services and does not include Medicare or other service funded costs. So, private pay stuff. We compare the waiver population based on level of care to the institutional peer group population, also based on level of care. The state compares both groups using the same number of participants for each level of care.

So, for example we have 50 acute waiver participants total cost compared to 50 institutional care group total costs. It's apples to apples when reviewing the cost neutrality demonstration for CMS. That's the cohort.

Rebecca Schupp commented: Okay, so what do we have today under the NF/AH? Individuals enrolling into the NF/AH are assigned, and we use air quotes and institutional cost limit because we have selected the individual cost limit that is less than the institutional cost of care. The assigned institutional cost limit is based on the waiver participants assessed level of care. So, for example, different levels of care cost amounts are in the fees accrued, as Deborah so graciously said around all seven. We didn't want to get bogged down into the intricacies and all of the different levels of care, but the primary ones are here and the net fees have accrued an acute.

Participants select and self-address their care plan as long as the cost of the services are within their institutional cost limit and are medically necessary. So an example of some things that we do typically see is that waiver participants who stay within that institutional cost limit will have to choose between higher cost of services at lower frequencies of scope or duration versus lower cost of services at higher frequencies of scope or duration.

One of the best examples is choosing waiver personal care services at a higher hour per day or hour per month versus skilled nursing by a registered nurse which is typically lower hours per day, lower hours per month. We have heard loud and clear from stakeholder engagement that the way the FAH cost limit - individual cost limit is structured today is a primary challenge.

Ellen Rowland commented: I've been trying to hold off and when the participant in this strain is that the person using the services or is that an agency? Let's use spinal cord discharge from acute as an example. I'm trying to make sure I understand correctly. Spinal cord discharge to independent living -- okay, can you use that to help me understand how you provide services for that individual in this area?

Rebecca Schupp responded: So, it would depend upon the individual's assessed level of care. If that participant is at an acute level of care. If the participant has been assessed to

meet those criteria, then he/she has an individual cost limit set at the acute level of care. Today in the waiver, acute level of care is not allowed to use the wavier personal care services that we require that the beneficiary have RN, LVN services, habilitation, but the waiver participant can self-choose amongst the benefits available to them and then self-direct their services within their acute individual cost limit.

Ellen Rowland commented: I understood what you are saying but I'm not computing it very well for myself. But, I'll get better. Let's move on.

Deborah Doctor commented: Hey Ellen, call me or send me an e-mail on this. If we can help we will.

Mary Williams commented: I've specialized in final cause injuries, discharges from acute, sub-acute nursing home and there's a big different between all three of them. The acute is, how you say, is no longer available because most clients go into the sub-acute. The sub-acute then only provides a certain level, so it doesn't cover 24 hours even if they're on a ventilator, on a feed tube. So there has to be other services and in the nursing home, the level of care that is evaluated about eight to ten hours of care in the community where there's a bit missing.

So what I would be looking at is a specific time schedule, like a three-month time schedule to have better funding and then reevaluate because jumping from 24 hour care to eight to ten hours of care is not possible. They're back in the hospital all the time. For the Sub-acute level, they are on a ventilated feed tube (unintelligible) and we have to fill in the eight hours with (IHSS) work. So we think about the families being trained, the families are down all the time, and they're not trained -- that's another cause of them going back into the nursing home. So there's a huge population out there that can be independent but the way we're doing it right now is not working.

Rebecca Schupp stated: Yes, so let me cut to this slide really fast - slide 18. The state really wants to address and attempt to achieve these opportunities for change where there's assessing and delivering of services based on medical necessity that the delivery of services can really incentivize transitional enrollments because we understand that once someone goes from a controlled environment to independent living their needs vary drastically from once they're sustained and residing in the community for a length of time. I would also add that we would consider the same thing for our early periodic screening diagnosis in treatment aging out members where they would also be receiving services medically necessary and we wouldn't want to see a change just because they have turned 21 because their needs don't necessarily change.

Deborah Doctor commented: Thank You

Rebecca Schupp continued: The third one, serving a variety of acuity levels and spectrums of medical needs to pick for the State to continue to ensure cost neutrality. The next slide is where we open up for discussion. How can we achieve this change and what

considerations should the State look into for selecting the individual cost limit, and then considerations for ensuring that cost neutrality with the federal government?

Connie Arnold commented: I personally feel like you need to follow the DD Waiver model. The NF waiver level of care amounts doesn't fit everybody. They don't fit the needs of the individuals who need more hours. You're going by just the specific rule requirements for the institutional. The institutionalization of that person and their category doesn't always meet that person's needs.

You have a problem of the age 21. You got a problem with every time the provider waives rights and stuff goes up. You cut the service hours of the recipient. You have a problem where you have a menu of services that is virtually useless for the person with a disability if they need adaptive environmental control except for the person that that's all they need. If all they need is some adaptive environmental controls in very limited health, then that might be a onetime expense.

But a person that has ongoing needs, they have ongoing needs. They have ongoing service assistance, personal care needs but they also may need the environmental controls and the adaptation but those things are virtually unavailable to them because of their personal care needs.

You also have a budget cap of 5,000 or a limited amount which should be uncapped because some of the equipment needs of persons with disabilities are higher than what your cap is. So virtually by your cap and what that environmental adaptation or control is it could be a recyclable shower where a ceiling less cap can be costlier than your cost cap. So, therefore they are precluded from accessing those services.

I'd definitely like to hear what Deborah has to say but the cost neutrality needs to change so it's an aggregate cap and not an individual cap. It needs to be more of an aggregate so that you can allow the savings of one person to allow more assistance to the next person that needs it. You need to free up the diagnosis for the business so that, gee I don't have CP, but because of what my disability is, I have the same level of needs that my friends that has CP has. But he's on a DD waiver.

Rebecca Schupp commented: What do you mean by "free up the diagnoses related..."

Connie Arnold responded: Because you have the level of care. The level of care has such stringent requirements that the person that doesn't meet those requirements but still has a physical disability and assistance needs, and really, the person with the disability knows what their needs are. So, if the person doesn't need the help they are definitely not interested in accessing it.

So, that's why you get a savings that you do. Then, even if an aged out person, age 21 is using - let's say they have a higher assessed need and they continue at that higher assessed needs based on pertinent litigation that's allowing that to happen, that person may still be using less services than what the pediatric waiver they were on allowed them to use. In

reality, they may even use fewer services in general than what you think for a variety of reasons.

Some of the reasons are in the letter that I just sent this morning because of this overtime business and the 66 hours providers cap because of maybe their ability to go do a work exam shift is squashed right now. They can't do it. They couldn't go off from college to another county and do an internship at a Silicon Valley Company because they couldn't have a single provider work for them and its 84 hours. 12 hours times seven days, is 84 hours.

Rebecca Schupp commented: I think what I took away from what you said was research and look at the DD waiver model, consider the aggregate cost neutrality, and then consider shifting from this level of care assessment to medically necessary, where someone's needs may be greater at the same level of care where someone else's need may be less at the same level of care.

Deborah Doctor commented: So in 1990, and I promise I won't go year by year from there, but it's a big year because it's when the American Disabilities Act was signed and it says that the State provide services in the (unintelligible) environment. Institutions are not the most integrated environment for most people most of the time. The reason that there have been losses around the country, challenging the kind of caps that we have or restrictions is because of that law and because of the onset decision in 1999 that says unnecessary segregation of people with disabilities is illegal.

So, we have an opportunity here. We have a program which is supposed to be an alternative to institutional care and its time for us to actually make it that. It is way passed time where we should be having, like, secret exceptions to the caps known only to people who become plaintiffs or find legal assistance.

Deborah Doctor commented: It's time for us to do what people want, what the voters want, the seniors want which is to stay out of institutional services at home. There is virtually no service in a regular institution that can't be delivered at home, and we have always had a very low bar for people to get into nursing homes. We've had a much higher bar for people to get into alternative care nursing homes. That is one of the definitions of institutional bias.

What should really be happening is that when somebody needs long term care, it should be evaluated whether or not their needs should be evaluated without them being - one line - TSA line check for nursing homes, or the circling the parking lot, or looking for a parking place at home and community based services.

Now I know that somebody will say that is outside the scope of this waiver, but that is what we should be doing. The budgets should be connected. They should not be separate budgets. Somebody needs long term services; they need long term services. Their location of care does not determine their level of care.

Rebecca Schupp commented: Can you go on a little bit deeper about connect budget?

Debora Doctor responded: Yes. Unified budgeting was recommended. Global budgeting was recommended in the study that they spent \$100,000 on in 2011. If you need a copy I can show you where you can get them. It's in numerous reports and studies, the person should not be divided. Their stance should not be depending on whether they're going to an institution. It should be based on their needs.

I wrote this in a report in 1981. That's why I get so frustrated about this. It's no secret, this has been something that's been known for decades and decades and this state has been sitting on its IHSS morals for 30 years while some of the rest of the world moves forward and some parts of California move forward. We have examples of people with the most extraordinary needs being supported in a community including by support of living providers.

So, it's time for us to have a waiver that meets people's needs, to not have an individual cost cap, to have an aggregate cost cap. It can be managed as Connie was saying, the needs of people who are less or are willing to manage with lower cost services balance out the ones with higher costs. We've demonstrated this through individual examples.

We have clients now who have been languishing in institutions for years because the limitations of these waivers, and there are people who have gotten out despite the limitations of these waiver because they got exceptions or they are on the DD waiver which doesn't have these types of limits.

I urge you to recommend that we have an aggregate cost cap, and it's not enough to leave it at that. An aggregate cost cap based on the actual institutional payments, it's not costs. It is not enough to make people divide up not enough money. It is not enough to say "aggregate cost cap". It's the pool of money to be divided up if it's big enough. Just switching the current capping amounts to aggregate wouldn't do the trick. It's got to be both.

Rebecca Schupp commented: Since your small payments would be the per diem plus the add-on cost reconciliation, etc...

Deborah Doctor responded: Yes the actual - if we're going to hold people on one side of it, we have to have two sides of the equation be comparable. I would be much happier if we could do away with the strict level of care striations because there are people who may not meet some particular level of care but their needs are high.

We should be talking about meeting people's needs. If somebody can't qualify, what's the two rule, that we've run into, where somebody can't qualify for a higher level of care but their needs are at that level; and by the way - or the department classifies somebody as at the nurse into pro level of care and there's no nursing home in the state that would ever take a person with that high a level of needs, and if they did they wouldn't be able to serve them properly. So, tying this to rigid levels of care is a problem and the financial aspects are standing in the way of people getting their needs met. Thank you.

Mary Williams commented: I agree with everything - that serves to speak to the young quadriplegics that you can't get into a nursing home because they don't have the skills

needed but they have so many other needs that nobody wants to take them. So getting them out of an acute care hospital direct is almost impossible. So they languish first of all in the acute hospital until someone eventually takes them in a nursing home where they are not capable of taking care of them that well, and they get other situations. They are in and out of the hospital with skin problems most of those get within the first year or two years a skin graft. I'm seeing more and more graft surgeries which are a huge expense. So, we've got an initial problem of needs rather than the care - the lack of care because a lot of these quadriplegics they're considered maintenance care, and they're put right down to the floor. They've got huge needs to start off with until you can teach them to actually manage their own care, which they have been - I've done that with a lot of them.

Jonathan Istrin commented: If this isn't appropriate for this time, I just wanted to understand what a global budget looks like and what that is.

Deborah Doctor responded: I can tell you a study that Laurel Mildred did on it. It's where you - in the state of - I think Oregon, Washington and other states do this, where long-term care is in one budget. It's not bifurcated between institutional long-term care and home and community based services. You can actually see where you're spending your money.

Jonathan Istrin commented: So how does it work with the cost cap? Like now we're comparing the cost of nursing homes to the cost of home and community based services, and on the redistribution or what's it called ...

Rebecca Schupp responded: Let us do some more research and see how Oregon and Washington are doing it, and if they're utilizing the 1915C Waiver.

Deborah Doctor commented: They've been doing this for years. They incentivize nursing homes to place people in the community. They took nursing home beds offline. They incentivized nursing homes to shut down beds that were no longer needed. They set goals for themselves and said by this year we're going to have a population of this many in nursing homes, and that money then gets used for home and community based services.

Jonathan Istrin commented: Can I ask sort of a comment and maybe a question for some of the more experts like Deborah and others. What are we doing about the wait list?

Deborah Doctor responded: The reason for the wait is because of two things. The number of slots and this cost neutrality formula, which is why I asked if we could let it go away because if they continue to operate where you can only get somebody off the community wait list when two people have left the nursing home, that's nobody else's definition of cost neutrality.

Rebecca Schupp commented: We talked this out in last workgroup. This is for the ongoing - but looking at the wait list, looking at our CCT data, looking at historical trends of growth, and that would be the one-time increase and then ongoing increase with looking at the LTFS scorecard, the NBF sections Q, return to community ...

Jonathan Istrin commented: We're going to be talking about, I guess, financial structures, reimbursement structures or methodologies. Couldn't theoretically the whole budget almost double if you had added this who group that's not in the waiver? I mean you're adding a lot of costs despite how we chop it up. Is there money for that? Is it available?

Rebecca Schupp responded: I see what you're saying. Medi-Cal is spending dollars on the wait list population, that's not waiver dollars. So what is the wait list population for Medi-Cal utilization, Medi-Cal costs. Is there opportunity to offset costs that we're currently spending that could be shifted to waiver wait list population, which I thought we talked a little bit about last work group.

Deborah Doctor commented: So we're looking for a May revise, which would reflect addition because we're talking about next year's budget revise.

Rebecca Schupp responded: So everybody look out for the May revise.

Rebecca Schupp stated: To summarize what I heard from those that did speak up, the state needs to consider an aggregate cost neutrality. Maybe even drilling down further based on actual institutional payments, which includes a number of things, as past participants based on medical necessity. Then the state researches opportunities for global budgeting.

TEW woman commented: I want to ask a few questions on medical necessity. Now there's a tool that's being developed apparently by about a universal assessment tool. Do you know about that Deborah?

Deborah Doctor responded: Yes.

TEW woman commented: I haven't seen it, and I have misgivings about whatever they creating as a universal assessment tool that would work across broad spectrums of the IHSS and waiver populations.

Rebecca Schupp responded: The intent of the universal assessment tool is to assess core items across IHSS, MSSP, and the CBAS, services benefits. At this time, we're not looking to broaden the universal assessment utilization. We did talk about, which we committed to doing a sub-work group, what are the opportunities for the state to combine or streamline assessment tools between the waivers that DHCS directly administers, and it was recommended by the work group that it's not a topic for the renewal but something that we should commit to with a deeper work group around streamlining assessment tools across ..... We have not started the UPA, but it would be looking at what are the opportunities to consolidate CCP, assessment tool, ALW.

TEW woman commented. The assessment tool should be combined. It should be about needing long-term care. It should be the same assessment tool that somebody would need to go into a nursing home. Otherwise you're compartmentalizing it again.

Rebecca Schupp responded: Yes, we did hear that, and I don't know if I did explain, but the assisted living tool is actually modeled off of the minimum data set - the nursing facility assessment tool. You recommended a key person to participate in that work group, and it's something that we also committed to at our ACDS advisory work group. So we're consolidating efforts.

### **First Public Comments**

Rebecca Schupp commented: I really need to open it up for public comments, so you all have a chance to get a decent amount of time for lunch. So, Operator, can we open it up for public comments.

Operator responded: Thank you. At this time, if you have any comments, please press Star then 1 and record your first and last name clearly when prompted. Please press Star then 1 if you would like to make a comment at this time. One moment for your first comment. Our first comment comes from Ms. Riley, Ma'am, your line is open.

Joey Riley commented: Hi. Thank you. I just want to reiterate that I hope participants who are on the long waiting list for years, are not cut. Well, I as a provider was cut when I got a raise for IHSS. You cut the hours for the recipients. Anyway, the other two things that I'd like you to do is - look at raising the cost caps more frequently. I think that the last time that the cost cap was raised was 2006. So maybe every three years or something you could look at it and really consider it, so that there aren't more that fall between the cracks.

Also if there could be an aggregate cost cap and agree with everything that they're saying, but the other thing is the levels of care, like the 48,000 caps and then it jumps up to like 108,000 cost cap if you have a ventilator. You're not capturing the people who are medically fragile that might be on a CPAP machine, might need help with (unintelligible). They may have all these other care needs, but you're losing everybody at the 48,000 cap that may not be able to survive on that. So if you could look into more categories of levels.

Rebecca Schupp responded: Thanks.

Operator commented: Thank you. Our next comment comes from Mr. Tom Hines. Sir, your line is open.

Tom Hines commented: Hi, thank you. My HNC is a CCT transition case management provider, and my question or comment refers to the care management agency role. It looks like an agency like mine that does case management and has good connections with housing providers, known as IHSS as well, would be a candidate for a care management agency, but it also looks like some of the scope of the work that would be required fits more into like what a health plan would do. I'm just kind of wondering, it's a brand new concept for me, and what do you guys envision the population of possible agencies providing this care management. Would it be case management agencies like us or would it be health plans or both?

Rebecca Schupp responded: Great comment. So we had first had this conversation in our first work group, and it was resounding consensus. I think one thing we did get consensus on was that the care management agency should not be a managed care plan. So we are looking for community based organizations, such as yourself, existing care management agencies that are in the home and community based delivery system today or the California Community Transitions Delivery system today. So, yes, it would be exclusive to community based organizations.

Tom Hines responded: Okay, thank you.

Jonathan Istrin commented: To piggy back on that, when we're asking community based organizations to do provider contracting, would that be on a pass through billing basis to the waiver or would they be managing risks?

Rebecca Schupp responded: So, yes, the care management agencies would not be managing financial risks. The care management agencies would have negotiated contract or memorandum of understanding, something legally binding between the service provider and the care management agencies passing through the cost of the service, the provision of the service, but the care management agency would not bear financial risks because we are not looking at managed care plans of that entity.

Jonathan Istrin commented: Right, but theoretically they might have local rates with local providers theoretically and it would still be funded by the state.

Rebecca Schupp responded: Theoretically and yes. Any other public comments, Operator?

Operator stated: There are no further comments at this time.

Rebecca Schupp commented: There is one public comment in the room.

Brenda Klutz commented: The department should score the applying agency, especially for those applicants which the department is not familiar that they provide some information or proof of financial solvency in order to be a care management agency with the department.

Rebecca Schupp responded: Great point.

Connie Arnold commented: I just want to make a comment. My comment is about the (unintelligible) seven days a week, it's 84 hours, and we need to change it so that we don't (unintelligible), inventions that are listed in the draft letter to (unintelligible), so limited and then burdensome. It puts a burden on proving how many times you tried to recruit and find caregivers that can meet your needs, and we're dealing with a low provider pay rate, so trying to find the quality of people that are capability of doing this after (unintelligible), it's a very small pool or people, and a lot of those people are not interested in doing the services for people with (unintelligible) disability.

Rebecca Schupp responded: We appreciate your comment, and we did receive your feedback on the exemptions, so we will be taking - looking through it with a fine tooth comb, so thanks (unintelligible). Okay. Well, operator, we're going to log off here for an hour and break for lunch and we - if everyone could be back around 12:55, we would appreciate that. Thank you.

***End of first Public Comment – break for lunch***

### **Morning Meeting Re-Cap:**

Rebecca Schupp Stated: Okay. So just reflecting back on the first half of the day, we talked about are there care management agencies standard s of participation. We had recommendation to add an eight qualification around governance of the care management agency with consumer representation and then what we heard from the work group on factors to contribute agency scoring or determining award of a contract - care management agency contracted weighted heavily on the experience, understanding of population member outcomes, consumer satisfaction, person centered model, history within the system and then second the knowledge, disability rights laws and system knowledge, vast array of participants needs and clear understanding of different delivery models and provider types. We then talked about the individual cost limits and the recommendation from the group was for the seat to consider aggregate cost neutrality, assess participants based on their medical necessity and then for the state to do some research on options for global budgeting.

### **Financial Models**

Rebecca Schupp stated: Now we're going to get into some financial models and CMS does have different types of options that home and community based waivers can design financial models for payments of services. I do want to be clear at this point in the conversation today. We are not going to get into rate setting. We are not going to talk about what is the adequate rate for each service the providers have. I mean this is not an actuarial or rate setting work group, it's more about the principal and philosophy in which we want to achieve transforming the NF/AH wavier or enhancing the NF/AH waiver and using a financial model and opportunities for change and financial to overcome the challenges that we heard from stakeholders.

So we're on slide 22, and we're going to talk a little bit about what the current and NF/AH financial model is. It is a fee-for-services reimbursement. The rate is based on the type of service and then also based on the provider type, so even though the service could be skilled nursing, the hourly rate would be different depending upon the provider delivery and the service. Even could be different based on whether the provider is coming from a home health agency or an individual provider, so we do have an example up there of how the state would represent fee for service. It would be upon a statewide basis. What the rate is in Alameda or Pomona is the rate that you would receive in LA or San Francisco, so it is a statewide rate by fee for service.

TEW woman commented: It's not LA, right. It has no relationship to actual (unintelligible) hire that person is what I'm (unintelligible).

TEW woman responded: Well, yes, so absolutely, we'll take the second one, but first (unintelligible) service for (unintelligible). My contract now with agencies for that, for my MMSE contracts are started \$17 per hour and go up to about \$21. It's between \$17 and \$21 per hour. A lot of agencies will say it depends on certain levels of care, but then I go back to earlier, the one discussion about insuring that your rates ...

TEW woman commented: Yes, we will.

Denise Likar commented: What's that for and (unintelligible). The nurse that is able to provide this care.

Rebecca Schupp responded: Yes, I'm sure Aaron Starfire and Jody and Mary will all speak to this, but for the NF/AH model is that these rates are statewide reimbursement and they've been rate established since 2007 about.

TEW woman commented: Reimbursements have actually went down.

TEW man commented: 2001. It's like 99 percent, at least for nursing.

Rebecca Schupp responded: Yes, so they've been stagnant and have had impacts with the dynamic of the state budget so reimbursement currently under the (unintelligible) model, reimbursement does not exceed the rate for the identified service. So this was another pretty apparent challenge that we heard, that we wanted to have discussions around. How can we be more flexible at the local level, how can we insure an adequate provider network and access to services, so we're actually going to get into a little bit of data about the NF/AH Waiver population, so we're going to move to the next slide. So this shows expenditures for the top 5 percent of long-term services and supports to users, but we have on a lot of the comparative, home and community based waver programs, other home and community based benefits. We also have the institutional peer group on here as well, and developmental centers are leading in the charges. We're racing to a (unintelligible) with 91.6 percent of their total population is in the top 5 percent program expenditures and the NF/AH is actually identified as HCBS waivers, so that line beneath the developmental centers is the NF/AH waiver and about 32.5 percent of our population is the top 5% expenditures, users of expenditures.

Deborah Doctor commented: So people who are on the waiver have been using like (unintelligible), so ...

Rebecca Schupp responded: Yes, and they're using hospital, they're using ER, they're using ...

Deborah Doctor commented: So what is this?

Rebecca Schupp responded: So this is total Medi-Cal expenditure, but it's drilled into the (LTSS) population and of that (LTSS) population, what percent of the population is a part of the top 5 percent Medi-Cal expenditures? I'm sorry what you're seeing actually percentages people. So only .3% of the MSSP population is in the top 5 percent high cost users. It's all Medi-Cal expenditures, so now Medicare, no third party payer. It's Medi-Cal expense. So it would be if they're a Medi-Cal only it would be their hospital, it would be their primary care, it would be the emergency room. This is for calendar year 2013 data.

Deborah Doctor commented: So according to this chart, developmental center, the HCBS Waiver services and ICFDD are the top three?

Rebecca Schupp responded: So developmental centers, the IHO and NF/AH waivers and ICFDD's have the largest proportion of their population and the top 5 percent Medi-cal expenditures.

TEW woman commented: Yes, but if you remove and you don't prompt developmental centers and right now you just count the ICFDD services and the (unintelligible) waiver, you're at 40, let's see ...

Rebecca Schupp responded: No, no, no. These are mutually exclusive.

TEW woman commented: It says it's not.

TEW man commented: Yes, it's not aggregated.

TEW woman commented: (Unintelligible) very few, several hundred people who are remaining in the remaining centers in the state so that's why it's an anomaly in that there are very few people and they are living in incredibly ...

Rebecca Schupp commented: It says very high (unintelligible).

TEW woman commented: Yes, very high cost. So if you look at say ...

TEW woman commented: It's 51.3 percent for just the DD, right? Including developmental centers.

Rebecca Schupp responded: No, so the DD waiver, only 15 percent of the 116,000 people have - are in the top 5 percent Medi-Cal expenditures.

TEW woman commented: Yes, but if you combine those two, that DD waiver and ICF (unintelligible).

Rebecca Schupp responded: Yes, but we're not going to combine the two.

TEW woman commented: Okay.

Rebecca Schupp commented: So we're looking at the population that's in these programs.

TEW woman commented: What is the point here?

Rebecca Schupp responded: So what this is demonstrating, it's showing that the home and community based waiver services do have high ancillary costs. That's an opportunity to reduce in-patient ER admission and shift costs to home and community based type services because we know that there is an annual individual cost limit on waiver services that include IHHS, that that alone is not driving the proportion of the NFAH waiver population to be in the top 5 percent of Medi-Cal expenditures. We know that it's their ER reutilization and their inpatient utilization, so we are going to get it into a little bit more in the next slide.

TEW woman commented: Wouldn't (unintelligible). I never heard that term before.

Rebecca Schupp responded: Oh, that's in the - this is IRC's, independent rehabilitation centers.

TEW woman commented: Is that a nursing home or rehab? Is it more like drug and alcohol rehab or?

Rebecca Schupp responded: No, it's a short term discharge, active discharge planning. It's PT, physical therapy, occupational therapy, speech therapy,

TEW woman commented: Percentage of cost for the skilled nursing facilities.

Rebecca Schupp responded: No, so what the percentage is showing is the percent of the user population that are members of the top 5 percent Medi-Cal expenditures. So of the total nursing facility population, only 14 percent of those users are in the top 5 percent of Medi-Cal expenditures.

TEW woman commented: That includes all of their expenses?

Rebecca Schupp responded: Yes, Medi-Cal expenses.

TEW man commented: Total Medi-Cal expenses.

Rebecca Schupp stated: So the next slide gets into the actual utilization, discharges, numbers of users, so we've highlighted the HTBS waiver services, that is specific to the NF/AH again and our number of users for calendar year 2013 was a little under 3400, the mean age of 51, percent female is 46 percent, percent dual is 50 and then eligibility is basically their aid codes, how they become Medi-Cal eligible so we primarily, and we did this through the pie charts in the first technical workgroup.

Thirty five percent of our population is primarily coming onto Medi-Cal through the blind and disabled aid codes, and then on the last two columns is the in-patient discharge per 1,000 eligibles and the average length of stay, and this - this really speaks back to the first chart

around how we do have high in-patient discharges and a higher average length of stay if you were to compare to another waiver that says the DD waiver or the HIV/AIDS waiver, where their length of stay is several days long, and there in-patient discharge is per 1,000 eligibles is a good proportion less than ...

TEW woman commented: In-patient where.

Rebecca Schupp responded: Hospital.

TEW woman commented: The people who are in skilled nursing facilities are going to hospitals at a higher ...

TEW woman responded: Less, lower. They had a lower rate then.

Rebecca Schupp commented: Skilled nursing facility is higher, is the highest.

TEW woman commented: So, these are actual numbers of users and some and not percentages...

Rebecca Schupp responded: Nope. Those are not numbers of users. The second to the last column is discharges. So there - for 1,000 eligibles in a year, there are almost 1,400 discharges so that's saying at least every single person in a skilled nursing facility has been admitted to the hospital and discharged. There the percentage that have done multiple discharges.

TEW woman commented: Okay. Can you go across this again? You've got number of users 36 - 3686. This is a (TBS) labor services.

Rebecca Schupp responded: Yes.

TEW woman commented: Why are you saying it's only 3386? Is this the number of people that entered the nursing - entered a hospital or ...

Rebecca Schupp responded: No, that was the number of people who received waiver services.

TEW woman commented: Oh, on the waiver.

TEW woman commented: That's it.

Rebecca Schupp commented: During calendar year 2013.

TEW woman commented: That's it, okay. The average is 51.

Rebecca Schupp responded: Yes.

TEW woman commented: Then female 46 percent, dual, percent dual eligible is that Medicare-Medi-Cal or is that (IHHS/IHO)?

Rebecca Schupp responded: That is Medicare & Medi-Cal.

TEW woman commented: Okay, so 50 percent and then age it is 11.7 percent. How were they enrolled in the waiver?

Rebecca Schupp responded: How they got enrolled in Medi-Cal and how they were enrolled in some Medi-Cal.

TEW woman commented: Okay. So, then blind and disabled 75%, for people that need long term care?

Rebecca Schupp responded: No, this would be institutional transitions.

TEW woman commented: So 13.3% that's what that says?

Rebecca Schupp responded: Yes.

TEW woman commented: Then in-patient discharges for 1000 eligible average length of stay, so if there's 3386 number of users then ...

Rebecca Schupp responded: No, it's, no. You can't tie the users back the 1000 eligibles. So it's taking a look at for every 1000 eligibles ...

TEW woman commented: Okay.

Rebecca Schupp commented: ... how many inpatient discharges were there?

TEW woman commented: But 1000 eligibles of what?

Rebecca Schupp commented: In the program.

TEW woman commented: You mean of the eligibility (unintelligible)?

Rebecca Schupp responded: So, if you were to look, so maybe a better way to describe this is look at (CBAS) 88C, where there are about 500. So 500 discharges per 1000 eligibles mean every person in (CBAS) only half of the population in (CBAS) is admitted to an in-patient facility and then subsequently discharged.

TEW woman commented: Mm-hm. But waiver services, you've got 1230.

Rebecca Schupp responded: It's not the number of people. It's the number of discharges.

TEW woman commented: ... 236 are in room 1.

TEW man commented: Well, yes. Basically it's saying that there's more - per one thousand people, there's 1200 discharges. So if you look at just 3000 individuals accessing the waivers services on average for that population there's more than 3600 discharges, so individual members are discharging ...

Rebecca Schupp commented: They're being admitted multiple times in a year.

TEW woman commented: Well, that's because they can't get the level of care and services that they need.

TEW woman commented: ... in a whole year there's 3,386 people unduplicated people.

Rebecca Schupp commented: Unduplicated people and it's at least one day on the waiver.

TEW woman commented: So that means a lot of waiver slots went unused.

Rebecca Schupp commented: This is for calendar year 2013.

TEW woman commented: My point still stands ...How many waivers there were. So unless everybody was stable ...

Rebecca Schupp responded: No. The only waiver slots we have today are 3297.

TEW woman commented: So we have a little bit less than that, but I'm saying is that - is there less turnover.

Rebecca Schupp commented: Average length of time on the waiver?

TEW woman responded: Yes.

Rebecca Schupp commented: Yes, that's something we're looking at. We don't have that ...

TEW woman commented: We don't have like 132 (unintelligible) Medi-Cal from nursing (unintelligible).

Rebecca Schupp responded: Right.

TEW woman commented: That reflects the turnover (unintelligible) in a year.

Rebecca Schupp responded: Yes. So it's throughout the calendar year of 2013, people who have access to services are counted as one.

TEW woman commented: So it's unduplicated people and they're not all in whatever at the same time.

Rebecca Schupp commented: We have a chart showing concurrent use. So concurrent use of multiple services.

TEW woman commented: So what is it that you're trying to illustrate here (unintelligible).

Rebecca Schupp responded: So we're trying to show that we have an opportunity to reduce inpatient admissions and discharges if you look at other waiver programs that have a regional care management structure, that have different cost neutralities, methodology that have different financial reimbursement structures, that the rigidity of the (NF/AH) today have caused us to have increased in-patient admissions.

TEW woman commented: What's the excuse for the nursing home? But we don't know as much because most are on Medicare.

Connie Arnold commented: Well, I had a friend that was (unintelligible) went to the nursing home, discharged to the nursing home, who ended up (unintelligible) so many times and nobody would come for hours and hours and they wouldn't come. So he finally reached a phone and he called 911 to transfer him to a hospital. Sure enough he was getting a bed sore and he was a paraplegic. Smart guy, so and he - even so, being a paraplegic, they should know, that he ended up with a pressure sore, even though he's quite agile and able to lift himself out of the seat, ended up having to have block surgery and everything else, and almost - and went into a coma and almost died.

So the point being is that they now have all these quadriplegics, and he is not even a quadriplegic, he's a paraplegic and ended up in that situation where he was in a comma, near death from a pressure sore. So even though there's an average length of stay or discharges 8.6% for the skilled nursing facilities ...

Rebecca Schupp responded: No, They are days in the in-patient hospital.

TEW woman commented: Okay, 8.6 days and then so the waiver services is 8.72 number of days in the institution, and you want to decrease that.

Rebecca Schupp responded: Yes.

TEW woman commented: Okay. But I think there's a lot of factors besides the ages for administration of the services that helps keep people out.

Rebecca Schupp responded: Right, and I said, the rigidity of the financial structure we have today, the costs, the cost, the individual cost limit that we have today of all of the things we have discussed working in coordination with each other gives us a greater opportunity and chance to see changes in the high cost care utilization.

TEW woman commented: Let me add one more thing. That is the problem that the subsidized housing, low income housing, federal rules have a problem with people to go into institutions. Like a hospital or whatever, getting back out so people are afraid to even go because they're afraid of losing their low-income housing that they just - before (unintelligible), so the person I know that's a quad is afraid even though she doesn't have (unintelligible) doesn't have enough caregivers, plays the (unintelligible) because her (unintelligible) and then she's going to go into this (unintelligible) or whatever. I said, "Well, hell with that, just go to the hospital. If you don't have a caregiver, go to the hospital because this is what the problems really are. It's not worth risking your life, call the ambulance and tell them to take you to the hospital."

But they're afraid of their low income housing. Like I had said before about the problem of the shared cost issue, which is still a critical problem for people, when the government says you get \$600 to live on, you can't do it. So it's similarly a problem with the federal silo for low income housing that creates some of these problems with people afraid of losing their housing.

Rebecca Schupp commented: Having the localized care management, having that close interaction with a care manager and the waiver participant, we would help interventions to happen before the waiver participants life got to that point.

TEW woman commented: Well, Rebecca, there are a couple of things that I don't understand here. One is that in a vacuum, we don't know whether these hospitalizations should have happened ...

Rebecca Schupp responded: Avoidable or yes.

TEW woman commented: Definitely. There seems to be an underlying assumption that it's bad for the folks on the waiver to be high cost.

Rebecca Schupp responded: No, it's not that. I think for us it's an opportunity to change the way that we're delivering care management and delivering the waiver services that we feel potential to have a positive impact on reduction in high cost care.

TEW woman commented: Again, what I'm going to go back to is we're not having this discussion about people in nursing homes where we're paying more money, and we're seeing this same or greater percentage of, I guess, we're doing this because we're in here talking about the waiver, but this discussion doesn't ever happen around institutional long term care and it just seems like there's a missed opportunity here. If what we want to do is make sure people are getting the best care in the most efficient way ...

Rebecca Schupp responded: Yes.

TEW woman commented: ... and we're singling out ....

Rebecca Schupp responded: Yes. We actually have this PowerPoint at Olmstead, which was probably the more appropriate forum for this discussion, so ...

TEW woman commented: At the last meeting?

Rebecca Schupp responded: Yes.

TEW woman commented: Rebecca, would we know why, they went to the hospital?

Rebecca Schupp responded: So that was exactly the point that Deborah had is that we are looking at it for comparative purposes in comparing other waivers and how their utilization and average length of stay are for descriptive purposes, but the other thing is we don't really know were these admissions avoidable, unavoidable, which is the reason, do we know why they went to the hospital. I mean we didn't drill down into that detail of level. We used this more as comparative purposes to see the Homan community based delivery system is general is having - has better utilization than what we're experiencing with an NF/AH today.

TEW woman commented: Well, like for instance, I just feel like in some ways we're comparing apples to oranges. For instance, the people on the AIDS waiver may be entirely different population that may not have nothing against AIDS, but there's so much improvement in AIDS and people are living longer and they don't have (unintelligible).

Rebecca Schupp commented: I think that' a good point. We could do further research in making sure that we have apples to apples, cohort comparisons where we look at what the average age is for the (NF-AIDS) and the average gender and dual eligibility and acuity levels and then look at maybe the DD waiver. What looking at the same types of characteristics in the DD waiver to do an apples to apples comparison and then also doing the same with the institutional populations comparing the same demographics as what we have in an FAH to get more of an apples to apples comparison.

TEW woman commented: I think that, if you were going to do that, I think that you would take a split of this so each (DDS) waiver of services, and if you're going to talk about AIDS, that's one population where you have end of life issues maybe there.

Rebecca Schupp commented: They wouldn't be mutually exclusive demographics they would be the average demographics across the HCBS and then pulling out those same characteristics from the DD waiver from the skilled nursing facility and then looking at what is the inpatient discharge per thousand eligibles. What is the average length of stay? Really drilling that down deeper to have a pure co - representation of appropriate cohorts.

TEW woman commented: So right now the lowest average number of days is the multi-purpose senior services? Scroll down, I can't see the bottom.

Rebecca Schupp responded: Yes.

TEW man commented: One quick thing to mention too is you might drive down - the ratio's 1,230 per 1000 but if you increase the user base to a broader set of eligible waiver participants that ratio starts to come down. It may come down to 900 per 1000 once you add all the levels (unintelligible) lower level of care within the waiver that's being underserved right now. So that could be part of the equation.

Rebecca Schupp commented: Yes good point. So the next slide is the concurrent use of LTSS programs so this is concurrent use of the NF age waiver participants. With other LTSS programs - you'll see in the column and the row for HCB (unintelligible) of the HCBS users are concurrently using HCBS labor services. Then when we look at skilled nursing facility - and then almost 50 percent of the home and community based population is concurrently using IHS staff services. Then when you look at the skilled nursing this is just calendar year 2013 we had almost 40 percent of the population had concurrent use of skilled nursing facility care. So I mean this isn't long term skilled nursing, this would be short term rehabilitation, it could be beyond 30 days, it could be subsequent enrollment for long term placement into skilled nursing this (unintelligible) but we think there's opportunity there with the ways that we want to provide more flexibilities in para-participants based on their medical necessity having access to service, having access to adequate home and community based providers that we have the opportunity to reduce the concurrent use of skilled nursing facility services. So it's just this description purpose. It doesn't have the meaning we're trying to use it to move forward into being able to justify changes for the NF age waiver.

TEW woman commented: A person can be on only one waiver at a time?

Rebecca Schupp responded: Yes we did see that but it's during the year. So they could be moving between waivers yes.

TEW woman commented: Concurrent in the full sense of the word.

Rebecca Schupp commented: Like on the same day. Not concurrent in that aspect.

TEW woman responded: Right.

TEW woman commented: Well when you say the skilled nursing facilities are you talking about transitioning out of a...

Rebecca Schupp responded: It could be a number of factors.

TEW woman commented: (Unintelligible) I mean the figure that in skilled nursing facility participants 50 percent of them are using IHSS, that would be not when they're in the skilled nursing facility.

Rebecca Schupp responded: Correct it's during the calendar year 2013. So we identified challenges from public comment on the fiscal structure of the waiver, individual cost neutrality the amount for individual costs were met, reimbursement structure, rigidity of provider payments and then the institutional by it. So we talked about the cost neutrality and our

opportunities for change and enhancing while maintaining cost neutrality of the waiver and now we're going to talk about some of the recognized CMS, and financial structures available under home and community based waivers.

Lindsay Jones stated: So these are five of the CMS approved financial models. So we've got the fee schedule, negotiating market price, tiered rates, bundled rates and cost reconciliation. So those are the five models that are approved by CMS to be used in the waiver renewal application. Oh this is Lindsay Jones for the phone. The fee schedule is individuals that are served through a fee for service delivery system in which providers are reimbursed for each service such as personal care service, respite, supported employment. It's based on a unit established for the delivery of that service so such as 15 minutes - it can be done in fifteen minute increments per hour, per visit or per day.

The negotiated market price is when the provider receives the market price of the service there's an expectation that some negotiation will take place between the state and the provider to reach an agreed upon rate. So the example that's used here is home modifications for a bathroom. So each sub-category of service has its own resource and labor cost. But there is a unique price for each individual and service. If an individual needed a bathroom modified the provider would build one unit for the modifications at the negotiated market price. Keep in mind that participants with this model should come back with a number of different bids from multiple providers so we don't want - with this one we don't want to see one bid. We want to see a multitude of bids so that we can get to a proper comparison and see that their research has been done.

TEW woman commented: Yes and measure the value of the service too.

Lindsay Jones stated: For tiered rates, this is the 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. The example tiered rates for supported living programs offered in an HCBS waiver for persons with brain injury may be tiered by individual acuity for each particular provider.

Bundled rates are when a provider receives a fixed predetermined rate for a predetermined amount of time that includes the delivery of multiple services. So the example for this would be the support of living program offered in an HCBS waiver program for persons with traumatic brain injury again. But when it's reimbursed using a bundled rate for independent living skills training, personal care, home maker and other services.

Then last we've got cost reconciliation which is the type of rate setting in which providers periodically file cost reports or cost surveys created by the state. It involves interim rates set by the state using the claims history information and the provider or the state is made whole after reconciliation. So with this one it can go either way. The state could owe the provider money or the provider could owe the state money at the end. So for the example here is the state compares costs incurred by the provider per cost report and reconciled against the interim rate.

Rebecca Schupp commented: Before Lindsay jumps into the next slide - what models our current California waivers will be using. These models are not silo'd in where the waiver has to only use cost reconciliation or the waiver only has to use tier three. There could be a blend between the financial model depending upon the service, the provider type, the population the waiver is serving so keep that in mind when we open up for discussion.

Lindsay Jones stated: As we go into the financial models of the other current HCBS waivers we've got the annual cost per person and traditional fee for service is utilized by the HIV AIDS and MSSP as well as the PPC which is the pediatric palliative care waivers. As Rebecca was just saying we can use - or we can utilize multiple financial models. The tiered based and bundled rates is a really good example. That model is used in the ALW as well as the San Francisco Community Living Support Benefit. So that is just one where we do have a tiered based on acuity but it is a bundled rate as well for the services that you're provided on a daily basis. Then last but not least is the blend of financial models based service or provider types and then the DD Waiver is a good example of that one.

Rebecca Schupp commented: Okay so this is where we're actually going to turn over to some of our provider partners around the table and they're going to talk a little about some of the innovative models that they have.

Aaron Starfire presented: Sure this is Aaron Starfire from Maxim Healthcare. I've got a few slides here today but this is not like a marketing pitch or anything like that. So let me take that off the table. What some of this data is a pilot project that we did this last year with a hospital, St Joseph's Hospital in Maryland around a care management approach to reduce re-hospitalization within a 30-day period by engaging the hospital and possibly the payer whether that's an insurance or the state group. We have some data that I thought was good for this group to maybe look at. The slides -I'm going to take you through a few slides that have to do with preventing re-hospitalizations. Why I thought it might be valuable to look at for this group is because the data that we're going to look at seems to indicate -- and you can be the judge -- but the data seems to indicate that when we focus a group of care managers around high needs people in particular that their readmission rates drop significantly compared to non-high needs people. So there's an aspect of tiering the approach and doing more of a wraparound approach with people that really need it. Identifying people are in an efficient way.

So if we can do the next slide please. So what we did we're - now Maxim as a background - we're a large home healthcare provider. We work with most of the Medicaid plans in the country. Predominantly we do long hour long term nursing for complex patients and what we saw was there was a gap when people would be referred home either from a hospital or a skilled nursing facility. There would be rather a gap around on getting things coordinated. We could do the home health part pretty well -- our complex care part, but when it came to other providers, or other treatments, or getting involved in the right programs say a state or (unintelligible) program there was a gap there. It was causing people to sort of be frequent fliers so to speak, they'd be in and out, out of the house facility then they'd have to go back in because of the failure to provide adequate support. So one of the ways we tried to address this through a pilot was to bring in at the hospital a - somebody called Ride Care which is a

company we partner with that does software. They basically created a risk assessment for all patients in this pilot and an evaluation through a nurse practitioner. So we in essence hired a team of nurse practitioners who then each had individual care teams who had worked with patients, helped transition them home. So on that team would be a transitional care nurse, an R.N., to do a home assessment, a transition plan. The community health worker usually a nurse aide level to do educational reinforcement, (unintelligible) social support care coordination, and then a program manager to help with the scheduling of staff and different services.

So let's go to the next slide. So the traditional approach that you're familiar with is post-acute care starts with a discharge rather than an admission. Primarily the focus traditionally has been on clinical factors without engaging psycho social barriers as often as possibly they should be. Then often you'll see a fragmentation across providers whether that's something like a fragmentation between IHSS and (WPCS) and waiver services or perhaps other waiver services that might be appropriate. So there's fragmentation there.

Next slide. So with this new approach what we tried to do in a pilot was get engagement during admission, focus on additional support by addressing some of the psycho-social barriers, providing continuity and a team that would basically help enlist the appropriate types of care. That seems to speak towards what I think the department's been mentioning in this committee which is what would a care management approach sort of look like. We are by no means experts on it. This is just a pilot program for us but the data in the next few slides I think will be helpful.

Next slide please. Okay so the top line here on the left bar is the amount of assessments that we do with our nurse practitioner. You can see we rolled the program out over time so the assessments went up over time. We started in February through September and we had an increase in our assessments. The second box there is readmission total number. You can see it's a slightly upward trend-line increasing corresponding to the amount people we're actually servicing in the program. The bottom side is the most indicative of what we think is important. It shows the readmission rate actually going down over time. So you can see the initial month 29 percent of those individuals targeted were being readmitted. By the end of the program it was down to 12 percent.

TEW woman commented: When you say readmission you're talking about hospitals.

Aaron Starfire responded: To hospitals correct. Yes just for this pilot. Next slide please. So this is the overall hospital readmission rate just for comparison. This is their overall readmission rates for the period February through June. You can see it is the top line is - discharges from all services and then the blue line is total hospital discharges. So just the general rate.

Aaron Starfire stated: Next slide please. This is just with the software. You can see the software helped. This RideCare software it stratifies patients into a high risk category and a low risk category. The top line or the red line is the high risk so you can - so this is what I thought was maybe the most important slide. Where we have identified the high risk people

and we've added the appropriate support we see the readmission rate drop substantially from roughly 15 percent at the start down to nine percent at the end. You can see the low risk patients stayed flat relatively low. So it indicates that there are kind of two worlds going on: those people that really need (unintelligible) support and those people that may not need it so much. Next slide.

Then the overall program data for the transition assist program so the bottom couple lines are people that were discharged - the rate of discharge without Maxim transition assist. These are people that might've gone other facilities or left without being seen or didn't want the service. You can see the readmission rate is relatively low. That speaks to possibly the highway from the hospital to the facility that was mentioned earlier. I think one of the members on the phone had mentioned going through a knee replacement and people were being funneled really right to the facility. But we can see possibly why that is. The hospitals don't want to have readmissions. Okay so if the home supports aren't there they do not feel comfortable discharging them to home care. They want to keep that number low. You can see with the increased support the number begins to, the trend line begins to approach all those other discharging facilities. So if we could match the readmission rate of facilities homecare would be better serviced because there'd be more of a case for the hospital if that makes sense. They're trying to avoid penalties as well.

Next slide. I'm not going to even go through all this information but if you want to review it in your free time this is just some examples of ways we thought you could have a care management approach. You could either take it from a hospital perspective or hey they're helping to kick in some money because they're going to save on penalties for readmissions or the payer side. In this instance today we're talking about what is the payer approach, what is the state approach to trying to get care to the right people at the right time. Go ahead and go to the last slide.

That's basically it so just to summarize in like 30 seconds. I wanted to share this data because what we see across the home healthcare spectrum is whether someone has a ventilator and is highly skilled needs at home, or someone that has skilled nursing needs but not as complex, we're seeing one reimbursement rate and we're not seeing really any reimbursement for a care management approach. We at home healthcare (unintelligible) basically clinical supervisors but we have to kind of do more with less to spread out all the care among the people that need it for a low rate. The case management capability has really gone down at home health care companies meaning that there's going to be more costs on hospital side and the payer ends up footing that bill. So if there can be increased wages to providers, rates, across the care management approach, I think that could really drive down some of these other costs that might exist outside of our narrow view. That's why I wanted to share that.

Rebecca Schupp commented: Thank you.

Deborah Doctor commented: On the psycho-social barriers I think they're called -- so one of those that I picture is somebody doesn't have enough money to live on. They can't afford their prescriptions because of the co-pay or they can't afford the food that they need. Or they

can't afford their rent. All of which have reasons that somebody can destabilize and end up in the hospital. So my first question is what's the role of a program like this and (unintelligible) that very real barrier. Then the second is really more of a comment. California already decided to hand over long term care to managed care. It's a done deal. So we're talking about a small waiver population but the issues that you're identifying don't have to do with our waiver population. It's over all and the train has left.

Aaron Starfire responded: Well I think those are fair points. I think we do need to consider what is the - what approach could a care management approach do as far as psycho-social support and other supports. I would leave that to some of the people who are probably more expert in that to take a look. But as far as the train having left with this population I think there's a fair point to be made that perhaps like the trend-line we looked at is really indicative of a greater population of people where you can have cost savings at the top and then at the lower level people you don't apply as much cost as you overall save. I think in our population here what I would respond to what you're saying Deborah is that I think there is potential that this is that high needs group that could be drawn down...

Deborah Doctor commented: I'm not disagreeing at all about that. One of the things that is the most upsetting to me about the coordinated care initiative is not the (unintelligible) but where we've handed over long term care to hundreds of thousands of people to manage care and as far as I know nobody's collecting any information on the outcomes. I mean this is really interesting to me but my first question a serious question. Were the care managers, or whatever the staffing there, did they deal with like economic issues and housing issues and those kinds of things that are real like when you say psycho-social -- were they assisting with those kinds of (unintelligible)?

Aaron Starfire responded: Yes I mean think of it as this is a pilot (unintelligible) broad purview. I don't have the exact ability to really give you an answer. I can do some digging and maybe follow up with you one to one.

Deborah Doctor commented: Then to your point on who has the responsibility for the long term care and the hospital delivery systems. It gets back to that point about if we contract with care management agency that care management agency has to have the knowledge and the ability to know is my member in managed care? Is my participant in managed care? Which managed care product business line are they in? Who do I need to have conversations with? What are the conversations about? So really having those care management agencies that understand the Medicaid delivery system and know who to go to at what point that is in the best benefit of the waiver participant. It's just, it would be Curtis's department in state start recognizing care management as the reimbursable and valuable service and not as a sort of like a fortune cookie at the end of the meal or something. I mean...

Ellen Rowland commented: We've experienced care management and we're working on that here in Santa Clara County that case management experience was well their case management in that independent living site. We want to replace it not partner with it. That's the conflict. The understanding in the reform was the case manager was going to work with

the independent living home health system that the consumer had put in place to make the over all, the wrap around actually work. Not replace it.

Rebecca Schupp responded: Great point. So we have Mary Williams book Freedom to Live. So she has been doing this - she's been doing transitional care management for years, years and years. I have a different business model than some of our typical waiver agency providers and have moved on - have been playing in many venues under (unintelligible) provided types available under the waiver. So she is going to talk a little bit about Freedom to Live, her program.

Mary Williams presented: Well it's Freedom to Live and I have a home health agency and they work in partnerships with each other. What's distinctive about the model is that the program is really a hundred day program. It's a finite program. It's an education program. It really services a particular type of diagnostic loop. That diagnostic loop is the final cause or mentally alert, severely disabled but they have to be cognitively intact. The type of person that I have worked with for over 40 years -- gosh that's terrible. I feel I've been a pilot project for pretty much all my life.

I start in 1982 with the congregate living health facility. I developed this program inside that congregate living health facility. I was able to get a contract with Kaiser for a hundred day program. I promised that -- okay they put the person into this program in a hundred days we would be able to one if they weren't with Kaiser, they weren't on Medi-Cal yet. But we knew they were going off Medi-Cal. So we knew the services long term they were going to have. So we provided the whole solution to a Kaiser to say look this is going to service you with cost effectiveness if we train that person 100 days to be independent and not be in and out the hospital for that first year is critical. Usually, they have big expenses. So I had that contract and for years I have really worked on that hundred days.

Now because I'm getting old and I just congregate living health is needed to expand and I'm retiring. So I have a home health agency which was - I only developed it because of the continuity of care from congregate to the home. Now I was hoping to work with the congregate where they could do that type of thing (unintelligible) and we would be ahead of that game. But that hasn't worked out so what we've done is I've had a non-profit organization. My daughter runs that. She -- I've just sent some fliers around. I've raised funds for the social issues that we were talking about earlier. It's fine to be able to have resources that you do have at a house only haven't got a place to go to, you're stuck in a nursing home anyway. So Freedom to Live partners with (unintelligible) home health. What Freedom to Live does it really looks at the whole person. It's a solution for the whole person and what we do is when we go out to evaluate a person we do it together. If that person needs this services or that services or get onto IHS or we need to get Social Security (unintelligible) we really help them to facilitate all those issues.

That's how we help the members who do not have adequate services because Freedom to Live in order to them to qualify to go into the - we have two Freedom campuses in Los Angeles. One has eight rooms. The other one has five rooms. A person has to qualify. They have to one, show us they have the need. Two, that they have the desire. There are three

that that they have the adequate care needs in service. So what does that mean? We have done - we have had people come into our program because we're not doing it through Medi-Cal right now it's private. We had several private patients that have gone out of it (unintelligible) hospital. They've been floundering around out there and then they've been referred to us. We've done a hundred days program. We've started to finally provide 24-hour care. We do to the number of hours that we know they're going to service. So if they don't have a - a lot of them have IHS at the side. Now you can't go anywhere to live for that. So under Freedom to Live we help them with the low income housing part.

They are eligible to come in for 100 days and to stay there up to 18 months, but the 100 days is the fulcrum. The rest of it is to see, make sure that they are going to be successful and our success rate is really almost 100%. I don't think people have gone back into the nursing home long term, and so on this little thing that you sent round - I sent round - it really shows that some injury to independence. You can go with the red roof, which is a long way round, which is the expensive roof. If you have a family that has a lot of money, you can get the blue roof.

This person, the family had was very wealthy and so she had 24 hour care, and she went there, but if like the green roof, that person really was (unintelligible) on Medi-Cal, and he happened to come to us many years ago, and now he has got his own place. He travels all around the world, but he came from rehab into the individual and taking responsibility service, and he as I would say over the 30 years now, he has been up there, he has been in the hospital maybe twice, once for suprapubic and one for something else, but he is really taught independence so long term it is showing that you can save for lack of money.

Now, they do, what's the next one - the outcome, this chose the outcome and I should have brought a little video, which is three minutes long, and we have people currently that are being serviced as hundred, some through the 100 day program and now able to live independently, meaning they can live on the services that they have supplied, and these are quadriplegics with ventilator-dependent, possibly (unintelligible). One of our recipients is just - he's got a full time job. He is a financial manager. He has helped Newstart Freedom to Live to raise money through his company, and we are seeing that now he has become also a counselor in Freedom to Live.

So, how we - what I see is what I can see as a new waiver that we are wanting to get, is that we need the flexibility of maybe a 100 day program because taken somebody out of a nursing home or hospital, you can see that given that is from the previous presentation, it is proof that if you put the money up front, the problems go down, and so I know that I can give you case after case after case that putting that money up front will then bring the cost - long term cost down because education is the name of the game. It is like college. If you can go to college, you go there. You pay to go to college because you want a good long term job.

In healthcare, if you are disabled and you have the cognitive ability to learn, you go to college and then you start your life, but without that transition, we have seen - we cannot take a Medi-Cal person out of a nursing home to train them, without that 100 day program. Once they've been educated and before we would take them out - I have a guy who is just a

regular quadriplegic, no G-tube, nothing - he was in the hospital for over a year and ended up with a few contractures, you name it. To get him out of the hospital, we were to - because he had some money fire, that he was able to - it was through his work, he was able to additionally pay for the hours in that first 100 days, and during that time, we helped him get down to IHSF.

He is on IHO Waiver and between the two of them, he has 195 hours IHO. He has 264 hours of IHHS, which amounts to about 14 hours of care a day. The other hours, he has to be on his own. So, he has Life Alert, he has a telephone, he knows how to call. He is totally cognitively aware of everything. He is now up to his 18 month in Freedom to Live. He is in his own apartment with his attendant, and he, has an R.N. from the agency because he is under Medi-Cal. Freedom to Live has been partnering with other agencies. Freedom to Live doesn't have to just work with Newstart. They can work with any agency in the area, which is what we find is the agencies really don't know how soon (intelligible) so that case management I see bundling it into a problem, which is finite and the individual actually agrees that in that time he is going to work and commit to the program, because we don't take them unless they sign that contract, that they understand they will have to work hard as well.

I have a whole book, which is a book where all the resources, who they have to do. They can write it, now they've got their computers, we put in the computers. They have to learn their medications. They have to learn, how to get their supplies, how to work their wheelchairs, how to direct, how to hire, how to fire, all these things they have to learn to be able to, and so the evaluation up front is the most important because there is a lot of people that want to be taken care of and those people that have to have 24 - and that's why I don't do head injuries - they need 24 hour supervision.

You cannot leave a head injury for four hours and think they will be in the same place when you come back. So, spinal cord and neurologically damaged people with severe disabilities, cognitively intact, they can do this. It is being proven and if they want to live in that community, they can. Now, it is getting harder with the cost with how to hire those IHHS so what I'm suggesting is the IHSF money, the care management money, the (IOTIL) money, the 100 days, put it together, make it easy to have a program for - and then at the end of the year see how many people have been into the hospital. I would say you're at the hospital, it is going to be after the minimum, and I proved that over the years. Any questions ?

Rebecca Schupp commented: Thanks Mary. Any questions on the phone

Connie Arnold commented: It kind of reminds me of what Mary was doing, sort of similar to the disabled residents program that I went to at UC Berkley when the father of the disability movement, Ed Roberts, who used an iron lung when he went to UC Berkeley, which is probably pre-60s, pre-70s or whatever. That program has changed a lot today too. It is not as good as it used to be in my opinion. That's where the students learn from other students. Now, Ed Roberts originally was living at Cal Hospital because he had an iron lung, and he said, "I don't want to live in the hospital", so he got moved out into the dorms and started the dorm program, and started the Center for Independent Living, and has since then the independent living movement got started.

It is all based on a civil rights movement model, so back in my younger days when I was 18, I thought, oh, I'm going right to the nursing home, graduating high school and going to the nursing home, that's where I'm headed. Well, I went to college and I went to UC Berkeley, and graduated from there. I learned how to handle IHSS and deal with all that, and that's really essentially, I don't know if 100 days is enough, but it's a start because I think people do need that and when people where Mary said she is sending people to that college from her program, on the other hand, there may be people that may not make it to that college program, but I'm thinking back about the number of people I rescued in my life from all kinds of issues.

One was left a quadriplegic at the side of the road, ended up in a nursing home in Warren County and my friend knew someone, and they asked me if I could help them, they had been in the nursing home for 14 months, could I get this quadriplegic out? I had him out in three months in low income housing in Warren County. The unfortunate thing is that when people have - they don't get all of their social issues addressed and they don't have the support that Mary has, the person ended up being later evicted based on lack of funds and food tabs at the grocery store and not being able to pay things and they also had been across the street from a bar.

So if you don't address addiction issues or somebody wants love or whatever in their life, etc., you don't address the whole person, then the person ends up back into the nursing home like during the Gingrich cuts... and dies in the nursing home. Of course, she tells me at the last minute, I can't save the world, but the people that want help have a lot of issues to address -- domestic violence issues, alcohol and drug addiction issues, painkiller addiction issues -- yet you see that right now with the heroine addition, so I think it's critical that there be programs like Mary has where you do give people this, they needs this peer to peer kind of thing, and they need the support.

Mary Williams commented: They need somebody that shows them the way so that they can make it one day. We have peer counselors that are now the intake by Freedom to Live, to help the new ones coming up and you touched on addiction the longer these people, they come to the start program, the more they are addicted to medications because they ...

I had a patient that was referred to me and he was on IV Dilaudid every four hours and would refer to me to watch for him at hospital, and the first thing I said to the patient and to the doctor is he is not eligible to be in the community. He cannot go. So, until he is bound to a program, and the doctor said - well, because he was in ICU, and he had gone through so many nursing homes that he had caught, I'm sure, Medi-Cal. Thousands and thousands of extra dollars because he never got - he just got from bad to worse, and he ended up in the hospital ICU on this medication and I said to the doctor, here has to get off this and I won't even think about him until he is, and he has a young child, and that was the carrot. He wanted to be out to see his young child.

I said, well if you can't live without this stuff then you have to live in an institution and that's all there is to it, and so he said, "I'll do this, I'll do this". The doctor put him on a program. Three

months later we admitted him. He is living in his own apartment, way away from where we are now, and he sees his child. He has taught (unintelligible), even talked with mom who could never have looked after him, and he is doing well. He was in the dregs and those are the types of people I think having referred to us that we cannot do - we can't take somebody out unless we have that sort of a bundle to help them.

Someone's got to send them to school, and that is school, and that is what I feel is the key to success because you have to look at the whole person. You've got to psychological staff. You have to look at the housing. I just had a quadriplegic who is already in his own house, and I went over Medi-Cal with him because they had cut his Social Security from 1800 down to 6, and he was going to have to return to a nursing home. He has, it was a shared account. He was working as a counselor for Freedom to Live, and I found out he was 250% working. He just last week said, "Oh, you saved me on the program" and so - because they stopped his IHSS. He is on a ventilator 24/7 and he has eight hours of skills, eight hours of home health aide, and eight hours of IHSS. He has taught me, he can hire, drain, everything, and what was going to put him back into the hospital was the fact that his Social Security had been taken off and down to the point of \$600. Now if he wasn't working, I don't think we would have gone over that.

### **Re-Cap of Aaron Starfire and Mary Williams Presentations**

Rebecca Schupp stated: I want to highlight some commonalities that we heard from Aaron's presentation and program, as well as Mary's presentation and program, and kind of the core things that we keep coming back to in our discussions is that comprehensive whole person care management where it is not only looking at coordinating Weaver Services, but at the psychosocial, the economic needs of the member having the flexibility and the opportunities to provide that, that comprehensive whole person care management and then the access to medically necessary services and then delivering those medically necessary services that in Aaron's model where they did a comprehensive assessment with the registered nurse and then had that certified nurse assistant to assist with accessing the services so that there was reduction or not being able to defer avoidable ER admission subsequently after going through the program, and then to Mary's program, having the opportunity to have flexible delivery of services through transitional care needs from very controlled setting to independent living.

The same would be for EPSDT age out really having that flexibility of delivery of services as people are transitioning from one program to the next, or one setting to the next, and then serving a variety - making sure that our financial model serves the variety of acuity levels that we have within the waiver and the population types that we have within the waiver, and that it is a across the spectrum of medical needs that we serve today in the waiver.

Rebecca Schupp commented: So, that turns us to impossible options for an alternative financial model within the FAH waiver and this is the first bullet there, the diamond shape, should not be selecting one of these options, it should be selecting any of these options. We said, there are some waivers that do a blend between the financial models, and how do we – know what is the best - what approach could this vacate to really help us achieve kind of the core principles that we keep coming back to, and really opening this up for discussion, and

keeping it in mind if we look at ways to establish rates to a care management agency that reflects the medical necessity of the population type that also allows for flexibility to negotiate reimbursement prices at the local level. We have key providers around the table. We have consumers who experience this on a daily basis and then the advocates around the table who have the knowledge of how this works in other waivers.

So, this is our discussion point. To discuss if you any approaches or methodologies for appropriateness in selecting any of these options.

Deborah Doctor commented: I think talk about the list of services and the waiver and whether we wanted to add any. Well, it just comes to mind that services - there may be services that were identified and talked about today that aren't even covered in our waiver. I don't know that for a fact but it seems like that's something - when the waiver is designed it has to specify what services are covered and I don't know whether the list that - of course it doesn't matter how many services are on the list if there isn't money to pay for them but it would help me if we had a list of permissible services and compared it to the list of services that are designated under the waiver.

I mean, the program that Mary's talking about is similar to the (unintelligible) beloved program that's gone on for years. It's helped many, many people with new disabilities be able to function and I don't know whether there are services that could be included that aren't. So, I know that's not what's on your agenda now but I'm going to say because we got this yesterday it might - it will be released to everybody, I don't know anything about this and I have nothing to say because I got it yesterday afternoon, so.

Rebecca Schupp commented: We apologize about getting this out the day before the workgroup. If you all think that there's a better forum or format to get your feedback to us we are open (unintelligible). I think what we want to get away from that we're experiencing today and opportunities that we want to start to look at is ways to shift inpatient, ER, skilled nursing facility costs to the waiver services. Being able to allow our care management agencies to negotiate provider payments based on many factors, ways that there could be maybe sub-capitation down to a service provider or daily rates or market prices. Just having that - having a financial model that could allow for that kind of flexibility.

Especially if we are going to require that the care management agency have rates that are reflective of keeping an adequate provider network, there needs be flexibility in the financial structure from the care management agency down to the service providers. That would also allow opportunity for care management agencies to have a geographic rate structure depending upon the cost of living in the area by funneling the dollars through a care management agency. Then having access to essential services where the financial model keeps all of these things in mind.

Aaron Starfire commented: I had a couple thoughts on that, if that's okay. Number one, I don't think there's like a silver bullet here. I work with the state programs and I work with 21 manage Medi-Cal organizations and I also work with all the private insurances in the state. So, I'm familiar with all their different fee schedules. Most of the manage Medicaid

organizations take their fees directly from the state schedule. We'll do 100% of the Medi-Cal or 120% or 90% or whatever the case.

Private insurances have their own actuarial analysis and in essence say, here's what we're willing to pay. Some of our networkers don't. There's a lot of work that goes in to that rate and that network creation. What I would say is, I think we want to be careful of a burden on a care management agency. If their primary competence is care management, it might be hard to ask each particular one to negotiate networks and prices. Plus, on the back end, your monitoring of that might be complicated. So, you might have to have new apparatus to address that. So, I mean I love the aspect of the care management approach and I think it's worth considering, though, that the state can have a closer reins who are available providers and what are some of the rates? I think you could take some - in my experience the successful insurances that pay for care and get it for their members the most easily, they basically take a negotiative market price approach. A lot of times they'll tier the rates, like it's not unusual for an insurance or another state program - I manage to work with most of the Medicaid programs in the country. It's not unusual for there to be like an RN ventilator rate or a high tech LVN or RN ventilator rate.

That way, I as a provider can train someone on this. I have them shadow for a month with another nurse if they've never done ventilator care. Relatively, they're still going to make a lot less than they would in a hospital with that same skill set. So, I need to be able to possibly train up other nurses or take novel approaches. With a tiered fee-for-service based on some of these skills, for instance ventilator care or respiratory trach type care or things like IV meds. Instead of one blanket rate, having a tiered approach that is also fee-for-service and market based. So, I think looking at all those things would be the most ideal solution. Bundled payment sounds nice but a cost reconciliation approach sounds okay but I don't know for this group if that's totally possible. Maybe it is but it seems like it might be pretty complex to me.

But I think the simplest way from point A to point B, I think is to true up the pricing. If it could be geographically based, that would be really helpful because we know a house in San Francisco is \$2 million for an apartment, okay, and a condo here in Sacramento is more like \$250,000. Did that the nursing rate for IO is the same? What means, there's like no one in the city of San Francisco that lives there that gets our services. I can tell you, this is very - we almost have to tell them to move, you're going to have to move, sorry. Like, or get a Cadillac insurance plan or figure out some kind of other payment structure. So, that's why I would encourage a look at geography, even if it's like some commercial insurances have done like Northern California, Southern California rates. Or, they'll do - obviously CMS has a whole infrastructure around rates in Irvine and we've done all these other things. So, just having one rate for the state doesn't make a ton of sense but some type of blended approach, I think, would be well served. I don't think there's a silver bullet that - I'd be interested in seeing what the approach is going to be.

Connie Arnold commented: I'd like to concur with what I think Aaron Starfire said. I mean, my perspective is a little different than his. In my perspective as an end user - as a fee-for-service when it comes to - that's a much better approach than this manage care approach which is a little different than what we're talking about but I'm just telling you from

my perspective because I don't run an agency. However, this ledged approach I give where you have to promote a business perspective so that people are interested in doing these jobs. I think you also have to figure in if the governor signed an agreement that the minimum wage is going to go to \$15 an hour in 2022, you need to consider...the economic impact. If you're going to have on the rates geographically and if these low entry jobs are going to pay \$15 an hour straight up as a minimum wage and everybody can get that rate, you've got to pay above that for these services so that the people with disabilities can get the services needs that they have. I think like the person that lives in San Francisco can't find somebody for \$18 an hour and she's supplementing (unintelligible) I think you have a problem. I think if the rates for LDN's haven't changed since the 80s - it may have changed since then but according to my friend that had one for her husband at the time, they sounded like the rates were almost comparable with back - what they were in the 80s.

So, I think, depending on where you live, you've got to be able to attract people to the workforce and if you're not paying it or if it's not comparable enough to the private sector rate for a hospital or what an LDN would get there or what an LDN or an RN would get somewhere else, you're going to have a hard time getting those individuals. Then you've got to look up how a lot of the home healthcare agencies, they see it as a four hour minimum. So, I don't know if that's it works from (unintelligible) but a lot of the home healthcare four hour minimum.

Aaron Starfire commented: Yes, and I want to piggy back on what you said if you don't mind about the LDN rate and I believe it's tied to the '01 rate which is basically \$29 an hour. I used to - I was the administrator of our Santa Rosa branch in 2011 and I had to - we were losing money and I was assigned to - rather stop the bleeding. But then the exodus of providers working with the waiver or other state programs and we were about 80% Medi-Cal funded. We had about 150 nurses working for us.

I had to - really unfortunately, one of the hardest things I ever had to do, I had to reduce wages for about 50 people so that we didn't basically go out of business. It was either going to be I needed to reduce all the wages for our nurses because there had been rate creep over the 15 years. Can I have a raise, of course, we'll give you a little bit of this, little bit of that and at the end of the day we're going to maybe have to shutter those doors of that branch.

Fortunately, it's still open but let me tell you, it is just barely still open, that branch versus 80% Medi-Cal. I'm one of the only Medi-Cal service provides in Northern California north of Marin. So, that's tough. It would be great if we could be expanding that branch, helping out in Chelseaville, helping out in Lake County, helping out on the coast. That would be amazing. The real quick way to be able to expand the help would be to fix the rate issue but I just did want to echo that, that that really is, I mean, one of the top, top concerns.

TEW woman commented: Because we could be talking about the waiver but if no one is going to service the waiver (unintelligible) then this whole thing is going to be for nothing.

Aaron Starfire commented: Just so we wouldn't lose money with our overhead costs being roughly \$8 an hour plus taxes. So, we had to freeze it so that we weren't continuing to lose money. If it's the rates at 15 as a minimum wage, the LDN wage needs to go up then correspondingly and then an LDN wage might be more like 20-21, 22 might be more reasonable. So yes, I agree we have to correspond to what we're seeing in the labor market, otherwise it's an unfunded mandate.

Mary Williams commented: On the private side, we're paying \$22 an hour for an LDN.

Denise Likar commented: So, I definitely echo the (unintelligible) analysis, we just can't throw this up on a wall and figure it out at what the right structure is going to be. There's definitely (unintelligible) echo all of that. The true devil's in the details, how much money do we have to deal with - is going to be an implicit - you could sit and you could do a lot of analytics and it comes up ten dollars for a second account, it doesn't matter how you do it.

TEW woman commented: Setting that aside, I would not throw - so fee-for-service, I'm not - my idea is that a lot of fee-for-service is - well the Medi-Cal rates are under market and SOP has now entered a world in the CPI county where we're straddling two worlds, both of us. The (unintelligible) county, so we're doing fee-for-service for some people but we're doing the bundle of capitation for others. It's early but I am finding myself, with the level of care and the technical and the waiver purchases and everything we're doing, I'm finding myself leaning towards we should be looking at that as part.

So, I'm of the argument don't throw any of that out. They all need to be analyzed. One size doesn't fit all because it's capitate - the bundle rate versus the fee-for-service, in my particular organization, is - I'm able to do a lot more actually than being held and hamstrung to those fee-for-service. Now, maybe it's the design of (MSSP), the effective components - so I throw that out as knowing that for we are delivering in the case management organization and some of my other areas of business that I'm finding more of the looking at tiered and the bundling as actually stretching further to do more for more people than being hamstrung by Medi-Cal rate structure.

TEW woman commented: Diving in a little deeper on that, if the state were to take in to consideration tiers based on acuity levels or tiered based on population type where there's a higher tiered rate if you're TBI and you need that one-on-one 24 hour aggressive interventions and care versus someone - not to say they don't have care needs but maybe paraplegic who have informal support and maybe just needs that 12 hour a day personal care. That a tiered rate could reflect the different variance in health care costs and health medical need. The bundled rate could be monthly, could be daily. So, the theoretical concept - from the theoretical concept I'm agreeing with that. I don't do cost reconciliation but would love to learn about it. Wouldn't throw it out just because we don't do it.

Denise Likar commented: MSSP used kind - in the old days, as a fee-for-service, we used to kind of true up our rates within our grants and I'm assuming that's what you guys are talking about. I know sometimes work is sometimes (unintelligible)... So but you (unintelligible) and again it's the detail of, what is it? Is agency going to be given a contract

with a set 12-month amount. Those detail pieces feed in to this. How is the money flowing? When is the pot of money being used? What are the parameters around the decision points that influence these? So, that proverbial devil's in the details. So, from a theoretical concept having the flexibility, having different (unintelligible). That detail is going to influence which one of - which one works the best and plays the best - play favorably. Who's getting maximum amount of care out to individuals?

Aaron Starfire commented:I would agree with that and also as (unintelligible)...

Ellen Rollins commented: Aaron Starfire spoke to this a little bit earlier, the care management agency would not bear financial risk. So, it would actually be pretty important to do that cost reconciliation to make sure that the care management agency doesn't have to expend dollars that we're not reimbursed by the state on the cost of the population.

As an LVN who has worked the struggle since 1995 when my daughter called me home because he did not want to go to an institution. She didn't need her mother home, she needed Nurse Rollins and over the years, doing IV interventions so she's not in the hospital for 14, 15, 16 days. She gets the PIC line, I do the IV at IHSS rates. The conversation then was, oh well, the software was so ancient that we can't do tier wages. Well, the software's been changed.

So yes, the rates - and it's been hard to tell the population when they get a dollar raise over here and a dollar raise over here to - we're the next to the highest now at 13 and I know I was making 27 in 1990 as an LVN. It was hard to do that reconciliation but to look at the rates, they need to be modified and they need to be up to date in order to attract competent staff. I know an RN who worked IHSS for his wife because he didn't want her suffer the dialysis (unintelligible) that she had when he could do that for her but we accepted that kind of money and maybe that's why California has a family program versus New York is agency only.

Aaron Starfire commented:I would echo that having worked in other states, particularly Washington State. The IHSS version in Washington is roughly 50% agency 50% individual providers. It's a couple dollars more to the state for the agency but the individuals have more flexibility. They can order that, order this. Maybe they have a family member that can do it and if they don't, they're not just like waiting on help. That's kind of neither here nor there but...

Deborah Doctor commented: I'm not commenting about this methodology question but going back to the question of how the services to the consumer are calculated, I just want to express again if I didn't before, somebody's going to get paid to do case management. It needs to not come out of the service budget for the individuals unless their budgets have increased to cover it.

The second point is something that I didn't know until this week, and credit Tom Heinz for telling me that people who exit a facility from our so called money follows the person where the money doesn't really follow the person, community (unintelligible) plan that if they come

on to the waiver, according to (Tom) their costs like the \$5,000 or whatever the CCT program can spend on modifications or whatever, is deducted from their waiver budget which seems...

Connie Arnold commented: I agree with Deborah and I think I said that before, the same thing about the environmental and the active controls. You can't access the program because it's going to come out of your service budget and you need the hours of help that you need and that is a problem. In relation to the current question and the two presentations, I would like to say that, if you took a scenario and you analyzed it by each budget model that was able to be shown to each of us.

Connie Arnold commented: Here's your option, we'll take this example, we're going to apply this budget model to it, we'll apply this budget model to it, we'll apply this budget model - same scenario, that would give us a better perspective of what we're looking at here. Now, like Denise said and Aaron Starfire said and I think other people said, maybe Deborah. But I don't think anything is off the table as far as what the budgets are - budget options are on how we structure it but giving us the opportunity to see one example or maybe two examples and here's how it's going to play out. I also think rather than just limiting to the people here on the table, you have other people out in the community...

Rebecca Schupp responded: Oh yes, this is definitely going, I mean, the waiver proposal is going to be released for a 30 day public comment period to the population at large, which would be everything that we discussed about today I mean today and the entire workgroup.

Connie Arnold commented: I know that's going to happen but my point being if you put a sample out there or you make some phone calls and you get some outside input before you put that 30 day comment...already determining what you're going to put in it so that people can say here's what our opinion is. We're agencies, we serve these populations. We're from a business model perspective and we're out there as an agency and we're serving people. What is that group's perspective? Like saying, did a home healthcare industry who had their comments about the overtime business just like I did. So, at least help design it because obviously nobody wants to really say, well this would be good or that would be good...

Rebecca Schupp commented: Well, I do think we have core principles. So, reflecting back on the core principles that we came up with - that the workgroup came up with on the individual cost neutrality was that we look to achieve cost neutrality in the aggregate, that we assess and deliver services based on the participant's medical necessity. The core principles for the reimbursement model maybe looking at tiered rate based on the population type and their medical need. Potentially bundling the rates and building of those bundled rates would look at fee schedule plus negotiated market price or the market price in the geographic area. Then having cost reconciliation at the end of the year so that the CMA is requiring medically necessary services and they don't bear the financial risk on the cost of those medically necessary services.

As well as keeping in mind key points of reducing burden on the care management agency to have to negotiate service provider rates. Looking at geographically based differences which tie into economic impacts on the labor market in the area. It did kind of sound like this blended approach is a better option than we have today and then making sure that there's local flexibility. Those would be things we would keep in mind as we propose a financial model and I do agree having maybe two or three kind of advisory bodies to look over any kind of proposed model before it's released for the 30 day public comment period. Care management costs should not come from the service budget. So, that would be one of the primary things to have in the financial model.

Connie Arnold commented: I think what Deborah had said earlier, what she was also talking about some of the services that we've talked about that might need to be additional services like the - Mary said transitional services of 100 days. It could be longer than 100 days but that would be the minimum of 100 days. If you follow the whole person, each person is different.

Rebecca Schupp commented: Well what we'll do, something that we'll release to the workgroup is the list of waiver services today and then maybe through e-mail communication you guys can provide your recommendations. It would be a quick turnaround but we can do that.

Deborah Doctor commented: Well I'd like to know what's permissible.

Rebecca Schupp responded: Like from the federal government perspective?

Deborah Doctor commented: Yes.

Rebecca Schupp responded: So yes, I mean there is - and I'm probably very broadly generalizing but it would be services that are delivered in the home that would divert institutionalization. I'm sure there are more specifics, I don't have it memorized and of course the services would not be duplicating what's available in the Medi-Cal State Plan.

Deborah Doctor commented: It does not include housing in any way.

Rebecca Schupp responded: It does not include room or board. We can end the list of what services under the waiver. We can add kind of a technical guidance from CMS what permissible services are.

Connie Arnold commented: I think we have to add, and I've said it before, you have to add caregiver training. A budget - an individualized budget for the individual participant for caregiver training - potential caregiver training, because it doesn't mean you're going to hire the person you tried to train and they didn't work out. You may go through a number of people.

Rebecca Schupp responded: I mean we do have family caregiver training. Maybe have to look at the definition.

Connie Arnold commented: It's not family...It is an individualized training budget for the disabled person.

Rebecca Schupp responded: Would it be helpful to have the service title.

Deborah Doctor commented: So, in New York's personal assistance program, there actually is for each consumer, a training budget. A certain number, like 50 hours a year or something. I'm not saying that's the right amount, but that's the principle that she's talking about where it's acknowledged...It acknowledges that this is something that consumers have to do and they shouldn't have to use their own IHSS hours or whatever, because they're not getting the direct services (unintelligible).

Connie Arnold commented: I want to say, I tried to train somebody in somebody in 48 hours and that person did not work out. I tried giving them 48 hours and that person did not work out. So I know Deborah said 50 hours might not be sufficient that's why (unintelligible) individualized training...

Rebecca Schupp commented: Why have a benefit available when you can only use it a few times?

Connie Arnold responded: Right.

Rebecca Schupp commented: Okay and then permissible, okay.

Roy Williams commented: To kind of pick it back up with what you were saying. (Unintelligible) the different services, I think it's a good idea that we rotate e-mail because if we have an idea - I mean more specifically what's provided with some meds reflectability because of what Aaron was bringing out and what Mary was bringing out, they're kind of on the same page. With some things but there are some places in the waiver that have some services that are like that. We're just not familiar with them, for example, habilitations.

Rebecca Schupp responded: That's on the waiver.

Roy Williams commented: Yes, you're right, it's right from the waiver. Habilitation services are provided in the participant's home or an out of home non-facility setting designed to assist the participant in acquiring, retaining, improving self-help, socialization, adaptive skill (unintelligible). Almost exactly read that verbatim but it's all right here on the waiver. But a lot of this may not be taken advantage of. (Unintelligible).

Rebecca Schupp responded: Yes, I know, and the constraints - I mean it could also be the constraints of the annual cost limit. The person has to weigh habilitation versus (unintelligible) services.

Connie Arnold commented: It's the same problem that we had before. It's if you have any habilitation services and that's a choice to you, and the definition of that I'm not so sure is (unintelligible) transitional services like Mary was saying. But, you can't have it be something that's going to direct - reduce the direct services budget. (Unintelligible).

Rebecca Schupp responded: Yes I see your point thanks for sharing with us- to Roy's point, by us sharing the services that are already under the waiver, maybe we already have a broad enough menu of health benefits but it's just that that individual cost limit constraint that doesn't allow participants to be able to access - yes. So that's one of the purposes of why we, the state, needs to keep these core principles that you are all talking about. About flexibility, about geographic differences, about labor impacts, administrative burden, care management costs. That is all factored in to strengthening a financial model under the waiver renewal.

Mary Williams commented: However there's not enough in this talk to take care of there. What we're saying is, look at really bringing those monies together and putting it in to something (unintelligible) works much better. So, I - for instance you're using IHSS, IHO, you're using care management, you're using the (unintelligible) more modifications. It's a lot of things but not everybody knows how to get in to those things. So, look at I think, somewhat there needs to be some bundled services so that it makes it easier for somebody to get (unintelligible). It's not easy to get (unintelligible).

Connie Arnold commented: Again, it's like you have to see the whole person. So, if there's been domestic violence, if there's drug addiction, if there's, financial (unintelligible) like social security, trying to get back on disability benefits, trying to make sure that your apartment - you didn't get an eviction notice or you paid off whatever debt you owe there because of some miscalculation by the housing authority that you were in to get that person to be able to go back to their place.

I mean these are all really critical issues or some share of cost demand. Saying you only have \$600 a month to live on - the housing issues - might end up losing your housing. I mean, how can you go back if you're going to start over again with the home upkeep allowance and those (unintelligible) situations. Somebody in a nursing home, they had a place to return but they couldn't have a home upkeep allowance that was reasonable to allow them to retain paying for their home expensive so they had a home to return to so they lose their home. Come on these things are no brainers but they are things that have to be fixed. Critical in the infrastructure of making sure people can access these services.

Then you've got this whole thing of the - you got the whole thing about the regulations. Don't overburden people with too much paperwork and too much regulation or they won't want to do it. Then, you have the overtime issues. The reason for the bargain for your 2022 for \$15 an hour, which who knows could change. I laughed when I heard it. It could change by 2021 or we can't do it because it's all based on the economic environment. But these are things that were meant to stay off of a \$15 an hour initiative - two of them going forward in the state. So, all these little impacts eventually going to impact you later on and you've got to build in

the system. Additionally, the provider raise issues - it's not just a provider rate issue for the agencies but the provider rates per hour regionally or the caregivers (unintelligible) to even stay off the waiver. Or those that aren't significantly disabled and on the waiver and need the waiver services to be able to recruit people to work for you. Not carry - take out people, I'll go work for this person that needs rest services and I don't have to do much work. So, I mean...

Rebecca Schupp responded: Yes, we hear what you're saying.

Aaron Starfire commented: Can I say one quick thing about the care management approach? What you were saying about utilizing resources that are somewhat untapped resource of the home health supervisor. So, any agency that has RN's that are in patient's home every month. They're required to by law to do a care conference every 60 days and a home visit every 30 days, it's written in to the statutes for home - for being a licensed home healthcare agency.

It's supposed to entail coordination among all providers. Then the primary doctor funds it. So, there's built in coordination but that gets stressed thinner and thinner and thinner as we've this rates thing for the last 15 years. So, what I want to say is that with just a basic (unintelligible) rate that allows for better care coordination. But CMS's issue is a code to be able to bill for care coordination type services.

If the state could adopt such a code, existing agencies - you don't need a new agency, you don't need new requirements. Which is, we can do that too, create a new thing, that's awesome but the apparatus that exists is already required by law to do these things but they just do them rather ineffectively. When home health companies are audited - this is a frequent citation in the state of California, how come you're not doing (unintelligible) care coordination? What is with these missed shifts?

This is like the same if you talk to 100 home health (unintelligible) they'll all tell you this. This is what they're being noted for in their audits by the state but to fund the mandate of that what's already written in to the statutes around what a home health agency is supposed to do could go a long way. Simply making available a billing code for care coordination. Once that is out of the bag and it's X amount of dollar charge, all of a sudden the market will start to respond with, oh great well I see I'm getting a call from a nursing facility. Normally I wouldn't take this call very far because I wouldn't have a way to bill for it and I know that I can't find a nurse to do it. So, hey thanks so much for the call, we'll put you on our wait list of Medi-Cal patients. We'll call you within the next few months just with an update on recruitment or if there was code for care coordination, I could say oh I see it's worth it. Let's send an RN out there, we'll do an evaluation and all that kind of.

Isn't that that part of a case management and care coordination? Well I'm saying if there was - I think there is a small - let's say able to bill once a month and you can make about \$40, okay. There is like a T10 and I think it... Is that the one? I think you only bill it one or two hours a month. There is an existing - a small fractional amount for oversight. Or if they're on

the waiver and this is available. One can create a new care management agency or you can utilize - and I don't know if that's substantially different...

Rebecca Schupp commented: In the waiver world today it gets back to Deborah's point of care management has a direct impact on the service budget and so I think Aaron Starfire is trying to put a discretion of the difference of the two, care management a function that should be layered on top of the services beneficiaries.

Aaron Starfire responded: I'm saying you could do both. You could go to the (unintelligible) house and new care management agencies and you can also utilized resources that are there because...Let's say there's 3,000 waiver participants. Is everyone going to go jump on board the care management agency, I don't know, but if there could be some - 20,000 (unintelligible). But I'm saying, let's not forget to maybe also utilize that resource that's already there for the patients already on the waiver, already have an RN in their home every month. If there can be access to that code that CMS issued, that would be helpful as part of this redesign potentially.

Ellen Rowland commented: Yes, I'm - my understanding for CCI intervention is that there is care coordination in those plans in the counties that are on right now. That was my earlier comment, was that that care coordination doesn't exclude the coordination the consumer already has but it begins to work with them. Our experience is that either you sign on to this or you don't have it at all.

Rebecca Schupp commented: Yes, I think the nation and the healthcare delivery system has found that care coordination could be the potential secret sauce and we're finding that care coordination is popping up in all of the programs and all of the delivery systems. But then it gets to the point of who's coordinating the care coordinators. Adding a fifth care coordinator to the member, how much is that fifth care coordinator going to have an impact on the four other care coordinators?

Looking at a better integrated system and having that managed care plan as one of the ultimate authorities should play that role of coordinating all the care coordinators. I think this isn't a CCI conversation but those are things that the department of healthcare services is looking at with rolling out our comprehensive strategy for CCI.

Deborah Doctor responded. : But only for the duals, Ellen.

Rebecca Schupp commented: Let me clarify here that the benefit is carved out of managed care. The member is a part of managed care for their other LPSS services in CCI counties. If it's the managed care Medi-Cal product that would be IHSS and CBAS or their skilled nursing. For non-CCI counties, it would depend upon the managed care model type and if the beneficiary is a dual eligible. I mean, it's not an easy system to navigate and that's one of the things that you guys all talked about in what the care management agency needs - what (unintelligible) tool in their tool shed that they need to have as a part of being a care management agency is understanding the Medi-Cal dynamics and the eligibility systems.

Deborah Doctor commented: Well, it's never been clear to me what the function the managed care plans are playing in the non-dual folks, the people who are on the waiver who have a care manager currently at least would have a care manager who might be more involved in the future. Yet the managed care plans are getting paid and they're at risk for the long-term services and support. So a non-dual member is beyond just the long-term services and support. So Medi-Cal only...

Rebecca Schupp commented: So what we're talking about is long-term services and support. So, the waiver services and support that the managed care is supposed to be managing are in the waiver budget. So, it's never made sense to me like who's on first here. Yes, we've had the conversation that we want to get away from this annual institutional amount that include IHSS and that our waiver participants have to deduct their cost of IHSS in to the annual institutional (unintelligible). We really need to have care management agency be responsible for the waiver services and the cost of the waiver services. IHSS being of course part of our cost neutrality but not having an impact on the medical necessity of our waiver participants and the services - the access to the services that they would need.

Deborah Doctor responded: That's all good, but I'm not sure that it addresses there are two - there would be in the future two entities with what seems to be overlapping responsibilities where - are the managed care plans not getting - I know they're not getting paid for care coordination but I never understood what they are getting paid with long-term services and support. They're not managing...So, I don't think the waiver is the appropriate vehicle to kind of further explain the care coordination across other delivery systems. Maybe it would be like a part of our manual with the care management agency of...Who is going to manage - you've got two entities with the same responsibility, managing a budget of long-term care services.

Rebecca Schupp commented: They're different benefits though.

Deborah Doctor responded: Yes, but they're the same services.

Rebecca Schupp commented: But, agency manages, we put a care manager on each individual case.

Deborah Doctor responded: No, the care management is outside of that. (Unintelligible). There are a case manager looking at a case manager.

Rebecca Schupp commented: From a health plan perspective, I mean the health plan still has that member relationship but the health plan is the ultimate - has ultimate responsibility for convening the interdisciplinary care team and this of course is dependent upon the Medi-Cal member's enrollment in to...

Deborah Doctor responded: That's in the duals. But I'm talking about outside the duals where the plan where we put hundreds of thousands of people in to managed care (unintelligible) or their long-term services and support...

Rebecca Schupp commented: It's only three benefits that are home and community based. One being MSSP where someone on NF/AH is not on MSSP, CBAS which is not a benefit available under the NF/AH and then IHSS but it's authorized and assessed through the county so...

Deborah Doctor responded: I just want to make sure that we're not paying two different entities for the same thing and that when it comes IHSS we have managed care plans (unintelligible) have their fingers on it to some degree and are supposed to know their patients that might be calling, maybe they're not in this out of the duals calling the company and saying so-and-so needs more IHSS or needs more - less of it. Yet, you're also going to have a care manager and another agency who's supposed to be doing the exact same thing?

Rebecca Schupp commented: Not for IHSS but for - because IHSS is a capped benefit and someone may be at 283 hours per month. So, waiver participants needing additional hours beyond IHSS, that's the benefit or hours for observational care - specific services under IHSS, that's the services that the CMA would manage. I mean the care management agency under the NF/AH waivers.

Aaron Starfire commented: Like she says, they're relatively more hands - the managed care plans are relatively more hands off when it's a waiver participant is my experience on the ground level.

Deborah Doctor commented: We play hands off on the duals part of it - on the - in the duals demonstrations. They're - the people on the waiver are not exempted from the mandate to belong to managed care for purposes of their long-term services and support which also included (unintelligible). So, if I say to you I want you to be the care manager for this person, which means to me coordinating all the possible services and yet somebody - you get what - why do we have two...

Connie Arnold commented: So it's the collaboration and the coordination with the managed care plan of the NF/AH care managers to say, this person needs more IHSS hours. I have that relationship with the manager. Is there something that you would request of the state to help clearly delineate roles and responsibilities? Well, the first thing that comes to mind is take away the mandate for people to be in managed care for their long-term services and support. I'm sure there are other people who would object to that, especially when we get 20,000 (unintelligible).

Connie Arnold commented: Deborah, just a comment on what both of you are saying here and that is, at the last assembly of health and human services sub-committee meeting. Anne Lutwich was testifying on behalf of the members of this managed care assistance to get them to approve and increase IHSS services for their recipients or something like that. Do you remember that, Deborah? That was UDW - is that related to this? You were there Rebecca.

Rebecca Schupp responded: People on the waiver are not in the duals program so the optional benefits don't apply to them, is that perfectly clear? So, Care Plan Options (CPO)s are provided through Cal MediConnect, which is the integrated Medicare/Medi-Cal product. People on the waiver are not on that.

Connie Arnold commented: I'm not talking about people on the waiver, I'm saying that they were petitioning for an increase in funding for those people to get additional IHSS services. It's not in funding, it's that there is no mechanism to get paid.

Rebecca Schupp responded. This is not a waiver issue. So, great conversation, and we're open to it, if the state has the ability to contract out care management. It's not just there'll be a contracted relationship, but in addition to that contracted relationship would be a manual clearly explaining the roles and responsibilities. We could have an exhibit in there about the relationship with all of the other delivery systems, the managed care plans and if it's an ask of the workgroup to have a very crosswalk between what is the managed care plan providing in care coordination versus what would a CMA provide under NF/AH.

I mean, that is administratively we could provide. So, we are getting very close to time, I mean and we have had some really great discussions the last couple of workgroup. This concludes our workgroup here for renewing the NF/AH waiver. I will Connie have one minute...

Connie Arnold commented: One concern I have is about this issue about care management when it comes to alternative resources and are shifting or packing this up based on comparable benefits like a third party care situation. So, this happens all the time. You could say it would be the partner rehab say, oh well you have a comparable benefit you can get a (unintelligible) we don't need to have you - provide you services. So, I'm very concerned about the care management situation tying up the needs of a person with a disability in terms of saying, well we see that you have this other benefit. It's a comparable benefit so go get the services over there from them.

So, this happens all the time, okay. People have Social Security benefits, they have pass plans, they have department of rehab benefits. They have Medicare benefits, they have Medi-Cal benefits and - or some other insurance like a third payer kind of situation. They'll say, well it says that you have all of these things. We see that you have this so therefore you can go this from this other comparable benefit.

So, instead of the person getting their needs met, they get shifted over to the other silo and say, you can get it from them. Then, there's another battle to try to get what the person needs instead of getting it for them. (Unintelligible) shifting to alternative resources or passing the buck and saying, well if you're eligible for this over here. I don't know if Aaron Starfire's had to deal with that but it is a concern because if people have immediate needs and you're just going to go, well we see the list of your benefits and you have a comparable benefit here, so go over here to get that.

But going over here to get that is a big battle to get it. I'm not going to wait for a wheel chair repair if I can go charge it on my credit care because I don't have time when my chair isn't running. To wait for some (unintelligible) or some ridiculous thing like this, so...

Aaron Starfire commented: So, I agree - I think just to take it back real quick, it does seem like that could be an obstacle with rolling out a care management agency approach. Is that what you're saying?

Connie Arnold responded: I'm trying to say that, yes. Then on the cash and counseling, the model of the fiscal agent you can't reduce a person's budget by saying we're going to make this (unintelligible) your fiscal agent and it charges this amount we're going to charge to your budget and therefore reducing your direct services by X. That's it.

### **Charter Overview**

Rebecca Schupp commented: So, we're going to reflect back on the purpose of why we all convened and our roles and responsibilities within this workgroup. So, we want to wrap up having you all know that you accomplished your goal and that you really helped to guide the state in areas of primary focus and opportunities for change. So, looking back at - if we could pull up the charter - looking at did we achieve our purpose and mission - the purpose and mission was to engage experts including advocates and consumers for their recommendations to DHDS long-term care division on renewal of the NF/AH hospital transition and diversion waiver NF/AH. From my perspective and hopefully you all as my peers, I believe we did achieve this mission. We had some very good conversations and did receive a lot of recommendations and consensus. So then did we work towards our objective?

So are the objectives that we had set out to achieve – to advise and make recommendations to ensure the proposed NF/AH waiver meets waiver participant's needs. I mean, I think we talked at length about making sure participants have access to needed services and that they have providers to deliver those needed services that care management is comprehensive and whole person care - or whole person, person centered care management models provide a waiver participant and community perspective and be a sounding board for entities involved in the NF/AH renewal process.

I don't think we could have had a more robust set of stake holders, workgroup members and such a diverse composition of workgroup members. Objective three, recommend and propose solutions to achieve the desired goals of the NF/AH waiver by improving quality of care, increasing access and improving waiver participant outcomes to remain in or be transitioned to home or community and minimize avoidable institutionalization. That was a big goal but a lot of the things that we talked about were care management approach and the goals of intensive and comprehensive care management.

Then opportunities to look at new individual cost limits to avoid institutionalization and promote transitions from institutionalizations as well as looking at financial models that take in to consideration increasing access and improving waiver participant outcomes. Then, last did we accomplish our outcomes, demonstrating understanding of the challenges with the

NF/AH waiver. I don't think we could have had a better set of workgroup members and persons who participated by phone to talk about the challenges and then propose recommended solutions.

We definitely heard on recommended solutions on strengthening the care management structure - ensuring care management was done at the person centered care planning process. Looking at the whole person, looking at ways to enhance or increase waiver capacity and what is the recommended methodology to come up with waiver capacity. Then what we talked about today looking at the care management agency standards of participation. Making sure that if we are going to have care management agencies, they're experienced and they're knowledgeable and they understand the vast array of participants that we serve.

Then, opportunities for individual - selecting an individual cost limit in the aggregate so that waiver participants can receive the services that they need and being flexible with having a financial model that is very flexible at the local level and the geographic areas. Was that the first one? We have eight more.

Establish recommendations that recognize waiver participant's needs that include independent living self-direction and ability to live in the community. That definitely was very apparent, and you all really focused in on that. Provide a list of consensus recommendations on ways to meet the holistic needs of every individual, and that's what I stated in outcomes number one.

Provide recommendations on opportunities to enhance or transform existing policies, procedures and tools. One thing that really came out of that was looking at a sub-workgroup on opportunities to streamline assessment tools and streamline enrollment processes.

Then, of course enhance the person-centered approach to align the centers for Medicare and Medicaid services final rule. We talked a lot about making sure if there is localized care management that it does have that person-centered approach.

Outcome number five, recommend and propose solutions that take in to consideration future trends, population demographics and characteristics and waiver participant's needs. We really heard, when we were talking about waiver capacity and how do we look towards annual waiver capacity needs?

Outcome six, provide a list of recommended strategies or solutions for DHCS to present to CMS on ways to improve the delivery and efficacy of NF/AH. Again, in reference to the care management structure, the waiver capacity, the individual cost limit and financial structure.

Then ensure recommendations and solutions adhere to existing federal rules and regulations. There was a lot of conversation around SSI and SSP and that isn't something we can achieve with a waiver renewal, but you all are the experts and know those rules and regulations and so it was very key to have your insight.

Then be active participants in meetings and contribute to the group discussion. I don't think we achieved that outcome at all. No, I think this is one of the most active workgroups that the long-term care division has had. So, we appreciate that and it builds a better product. So we - so you all have been very active. Then be considerate of input from all stakeholders. Yes, with that...

Connie Arnold commented: Can I make one more last comment, and this is the last of my last. I think it's really important for Department of Healthcare Services to know and understand the workings of the 250% working disabled program because a lot of people, including myself, people with disabilities want to work. We go to school, we want to work, we're trying to get jobs and things like that. Some do.

There's a lot of - there's a lot of non-publicity of this program and it takes somebody to know about the program because once somebody starts working they get SSI. Overpayment letters, I'm dealing with a bunch of them now for somebody that attempted work. There are so many rules, and yet this program is a really good program to get individuals on it so they don't lose their waiver services, they don't lose their IHSS and Medi-Cal services. They have a zero share of costs and they can feel like they're productive human beings and live a normal life of going to work and things like that no matter what the severity of their disability is or their age or anything like that.

So, the NF/AH waiver contributes to the ability of individuals with disabilities if you can get your needs met and your hours met so that you're able to do those things like Mary was discussing, the person getting a job and working and just living a normal life like everybody else. So, some of the barriers to that is this overpayment thing addressed in my letter. So, we just - I mean overtime issue...

But anyway, I think it's important to note because these hours that we get helps our quality of life and our ability to go do these things if we get our needs met? But like, you can come in to a place and say, hey I need a caregiver with me so that I can go to the bathroom during the day. It's something everybody takes for granted but those of us with disabilities cannot take it for granted. Not only not having the help that we have, if we don't have the help we need or we don't have accessible facilities and then we run in to barriers on a day-by-day basis. These are really major issues and this workgroup I think has a chance of really making a difference for a greater number of people and expanding and changing the program to have a better benefit and outcome for individual life.

Rebecca Schupp commented: Yes, you all had wonderful recommendations and feedback and, there's a lot that we heard from you all over a period of three meetings and so now it's time for the state to go back and draft a proposal based on your feedback and your input and, that we be maxed out because there are some things we committed to doing even though the workgroup meetings end. There were some things that we did commit to continue to share as you all being kind of our technical experts and workgroup members.

Deborah Doctor commented: Do we get to answer those questions?

Rebecca Schupp responded: Yes of course. Do you want us to pull up the charter again, or?

Deborah Doctor commented: No, I think we did some of that really well but I think there were some issues that were really addressed very briefly or just touched on or not at all, like (unintelligible) today. About what services are included in the waiver. I think as far as what you would record as our recommendations, we really didn't have much of a formal process which maybe is what people wanted, but I don't think we ever discussed that. I don't know what you would record as our recommendations today about funding, the level of funding for the waiver.

So, that's what I want to say about that. Also, while I'm - in order to be considered a technical expert, I feel as though - at least I and my colleagues could have been used more in between meetings and discussions and also I'm getting the materials (unintelligible) more of a (unintelligible) discussion of some of these issues. So, I think we did really well on some of them and could have done better on others.

Rebecca Schupp responded: Okay, thank you. Valid point, thank you for that. So, we are going to open it up for public comment. Operator, is there public comment on the phone?

### **Second Public Comments**

Operator stated: I see no comments currently, but if you would like to share a public comment please press Star 1 and record your name.

Carrie Able commented: Hi, my name is Carrie Able and I have public comment based on this waiver. I'm a consumer of NF B and IHSS, IHO services and previously I was in the CCT program. Anyways, one of the biggest problems, and I wasn't able to listen to the whole webinar, that I see from my perspective is the fact that there's a huge gap between the acute care hospital waiver and the NF B waiver. That people like myself who obvious (unintelligible) who have higher demands for physical needs are not falling in to the category.

I've tried to make it work for 18 years by borrowing people, trading services, doing a million things to try to stay in my home. The stress of it eventually shut my body down, put me in a nursing home for seven months. The nursing home care wasn't better than the at-home care because I lived home I could train caregivers how to (unintelligible) me and take care of my body in the way in which it needs to be taken care of.

The nursing home put me in the hospital three times with pneumonia and the third time, just that hospital and the rehab hospital following that pneumonia, just that one bill was \$170,000. Now if I looked at just seven months of nursing home care plus the other three hospitalizations, you're looking at around \$500,000. So, cost effective - it's not cost effective at all, I believe, in the state of California for us to be skimping on looking at how - What is the need of someone for a nursing home facility care waiver?

Even if you just looked at straight nursing homes, what they make compared to the \$48,180 that we're supposed to be cost neutral at. It's just not comparable, it's not realistic and frankly

it's not right because I've watched friends, family, one after another try to be my night care. Tried to (unintelligible) me after ten hours a day when I'm completely paralyzed from the neck down and for people who are walking and able-bodied, imagine yourself strapped in a wheel chair on good days for ten hours - for more than ten hours, 18 hours a day probably.

But ten hours a day supposedly meaning - able to take care of myself at home and my hands didn't work, my fingers didn't work. It's like putting a pair of boxing gloves on and strapping five pound weights around each of my hands. I know because I used to be able-bodied and I've been paralyzed for a little over 18 years. So, sometimes I (unintelligible) that you're doing but I really believe that this is an area that needs to be addressed. This is an area where there needs to be a middle ground and there needs to be better assessment.

As far as home based caregiving training, 18 years maybe ten years on the IHO, never once did myself or any of my caregivers receive training from any home based agency. So, I do understand what she - the other person said about DOR because I've been through DOR and I had to be trained to do a lot of different things. I want to work, it's a great desire of mine to work but if you're not getting enough of the in-home support that you need so you can figure out how to even sleep through a night decently and/or be without care all day long - I mean it's either choice for me. Then it's really hard to do all the other stuff it takes to get back up in the workforce in the ways in which we want to. So, that's all I have to say.

Rebecca Schupp responded: Thank you, Carrie. Yes, we did talk extensively about the current institutional cost limits and ways to overcome those challenges. So, those are some of the primary things that we focused on in this workgroup and will continue to focus.

Rebecca Schupp commented: Are there public comments on the phone? Operator can you guide our public on how to go in to the queue for submitting public comments?

Operator responded: Yes. Again, if you would like to provide a public comment, please press Star 1 and record your name. I see no comments at this time.

Rebecca Schupp commented: Okay.

### ***End of 2<sup>nd</sup> Public Comments***

Rebecca Schupp commented: Our public comment and our stakeholder engagement does not end here. We are letting you know we want to have multiple opportunities to reach as many of our participants and our stakeholders that we possibly can. So, the timeline has shown what we have done up to date. The green being today, our final technical workgroup meeting and then the stakeholder engagement that continues.

~~May 9<sup>th</sup> through June 9<sup>th</sup>~~ May 14<sup>th</sup> through June 13<sup>th</sup> will be our 30-day public comment period. July 2016 we will have five in-person meetings and the little asterisks there on bottom says the counties which the meetings will be held. September 2016 DHCS will submit the waiver renewal to CMS. Then January 1, 2017 is the proposed date of the waiver renewal. The next slide is just showing the timeline in a written format.

## **Re-Cap Summary**

### **1<sup>ST</sup> Next Step – Action Items**

Rebecca Schupp stated: So, I really quickly just want to recap our next step that DHCS has as recommendations from the workgroup. The first one being add an eighth care management qualification that includes a requirement for governance on the care management agency with a consumer representative. Some of the things that the workgroup highlighted on options for care management scoring is experience, understanding population member outcomes, consumer satisfaction, person-centered model history and systems.

The second point being knowledge of disability rights laws in the system, knowledge of the vast array of participant's needs with a clear understanding of different delivery models. Also we need to look at opportunities for experience with cash and counseling or abilities to do cash and counseling. That is the next step that the state would follow up on, is research the structure and other programs or states that do cash and counseling and then member outcomes.

Aaron Starfire commented : Can you add the qualification for scoring financial solvency. Jonathan and I had also both commented that, unless there's (unintelligible) to open up the bids to for-profit companies and agencies. We should evaluate all options.

Rebecca Schupp responded: Yes, that's correct.

Debra Doctor commented: So, this is an example, are you listing that as a recommendation of the group?

Rebecca Schupp responded: I'll list it as feedback and consensus recommendation that we received from the group.

Deborah Doctor commented: Exactly, and as far as cash and counseling goes, I think we need to look at the existing advanced patients (unintelligible) with IHSS because there's already a vehicle similar to the cash and counseling with monthly timesheets, advance money, which is preferred.

Rebecca Schupp commented: We got into the overview of cost neutrality and the state taking a look at the institutional peer group payment, looking to see if AB1629 - the add-ons are included in the institutional payments. A request a workgroup member to determine if the state cost neutrality that is identified in SB643 is something that is going to be a part of the overall cost neutrality of NF/AH.

Then we talked about what are some opportunities for change with the NF/AH cost neutrality. Do research and look at the developmentally disabled model. I think the recommendation from the workgroup is the aggregate cost neutrality, as well as the second recommendation from the workgroup being assess participants based on medical necessity.

Feedback received was global budgeting and DHCS research how states are doing this global budgeting. Then when we got in to the financial model, feedback for consideration is to not have - depending on what the financial model is, to reduce administrative burden on the care management agency. Then when we looked at alternative financial models available, we received feedback on looking at tiered rates based on population type, bundled rates and then cost reconciliation. All should be a blended part of financial model. I think the recommendation we heard from this is that the state needs to consider looking at a blended financial model across the alternative arrangements.

We also heard as a recommendation that the financial model needs to reduce burden of negotiating service provider's rates. That the state needs to consider geographically based rate structure or impacts - geographically based impacts that include economic and labor markets. Another recommendation was to have local flexibility.

The recommendation from the workgroup is that whatever proposed model is put forward, that it is discussed with some advisory workgroup members here at the table before it is released for the 30 day public comment period. Also recommendation that care management costs should not come out of the service budget. Our next step was to share services that are available under the waiver, their definitions and then what are the permissible services and sharing that with the workgroup and then getting your feedback via e-mail.

## **2nd Next Step – Action Items**

Rebecca Schupp commented: The second next step is we will clearly delineate what was feedback over the last three workgroups compared to what we presume what was recommendations and then get your feedback through e-mail on that as well.

Connie Arnold commented: Can we get the minutes to this?

Rebecca Schupp responded: We can, it is a very lengthy document, but we will get that to you soon.

Connie Arnold commented: Then the existing minutes from February, can I still give input because I missed those few minutes here before the meeting started where it says a woman stakeholder said and it was me that said it. So can I just e-mail...

Rebecca Schupp responded: Yes.

Connie Arnold commented: Okay.

Roy Williams commented: I just had one question, it may not be for this conversation and you can let me know if it's not. I know the majority of us were talking about how rates impact everything, especially the waiver and what we're trying to do. Is there anything coming up that we can give some sort of insight? Is there some kind of rate committee that's coming that we can give some sort of insight as far what we can - just give greater input on what we're doing here from our point of view depending on what kind of provider type (unintelligible) that you might be aware of?

Rebecca Schupp responded: Not that I'm aware of but I definitely think that when the state takes in to consideration the feedback we received today that are the core principles of what the financial model needs to allow, that that proposal will be shared with some key advisory people around the table. I understand the provider payment relationship and the care management intensity and scope. I think looking at the timeline we could have discussions and we're open to dialogue further down, probably past the 30 day comment period around what is the actual rate and how was that rate built? I know we don't have that on the timeline right now but...

Connie Arnold commented: Well Rebecca, just getting back to what I said earlier, and I would like to hear what Deborah has to say about it. You gave us those examples, we can have a fee-for-service, we can have bundled this, we can have this, this, this. If you could do a scenario of this is what it means, this is the scenario for fee-for-service which is the same scenario. This is what it means for this scenario for this type of budget. You're just applying to the same scenario how you would calculate the budget to help... I mean a logical scenario of a person (unintelligible).

Rebecca Schupp responded: We could definitely share the methodology behind building a budget.

Deborah Doctor commented: I think what Connie's asking is, when it gets down to how the participant experiences the waiver, what's the difference between these methodologies because it's a been a little bit abstract and so, what she wants to know, what I'd like to know and maybe others would, how does it filter down? If you start with the same \$1,000 or \$10,000, what ends up available for services that's getting right down to how does it affect the participant?

Connie Arnold responded: Well I mean, even if you took Mary's scenario of transitional services and you said, okay well here's a quadriplegic and this is their level of care and this is what it means to the case management agency but if we paid according to this fee-for-service. This is what it means if we paid the case management agency for this person according to bundled rates. This is what it means - whatever the five or six payment methodologies - what does it mean for each individual for that same person what does it mean for the agencies because I don't know if the there's a mix and everybody was saying don't throw anything out, Deborah said that, (unintelligible) the mix. But, maybe it would be better for Aaron Starfire's agency, or maybe it would be better for Mary's agency. (Unintelligible).

Connie Arnold commented: ASAP may have a preferred thing that they'd like their payment structure to be. Maybe the DDS (unintelligible) is a certain payment structure. So it just - if we could have some examples. Take one person, participant, and this would be what we would pay to Aaron Starfire's agency or (ATS) or (EE) services or.

Rebecca Schupp commented: Yes, I think we also have to take in to consideration when we talk about the burden - unnecessary burden on the local care management agency, the

burden on the state administration as well. What's the feasibility of having a different financial model for every provider that we have...

Connie Arnold responded: But since we're trying to pick a mix, what mix do we pick? I mean - since everybody doesn't know what's going to be the thing for us to recommend for the waiver. I mean, what do you think Deborah, or Aaron Starfire or...

Aaron Starfire commented: I think I agree. I somehow (unintelligible) thought maybe we'd have a chance to review stuff like that at the meetings, but it doesn't seem like that's how it's shaking down. I assume there's some backend work to be done at the department. So we've got to see maybe what are you going to shoot out there, right?

Rebecca Schupp responded: It wouldn't be bad to run a feasibility by this group just to get a real-world sense of how the downstream (unintelligible) in your capable hands.

Connie Arnold commented: Because there's different paperwork here with a different perspective, and but you can take the same quadriplegic, just pick one, okay. Say, here's your client, here's the participant...

Deborah Doctor responded: Well, if we're going to do this, how about we pick an array of services rather than a disability? Frankly, I'm just more interested right now in knowing about the cost cap and the money and the slots so I'll confess that those things I understand more readily than - but I absolutely agree with you, it would be good to know what downstream the impact on the consumer.

Rebecca Schupp commented: Yes, if you guys are all okay, we might not reconvene in person but continuing to be that advisory body until we submit the waiver, we are open to keeping that communication pathway.

Connie Arnold commented: Okay, we had that whole issue with DE community saying the provider rates are too low and these business were going out of business and, in order to prevent that kind of thing, it would be good to know what mattered to that group. Somebody like Tony Anderson at the Ark of California might have a perspective that can be shared here as well from his regional area boards, they have a perspective. And since we're looking at those - or these (unintelligible) things like that for the waiver, then if we could - what am I trying to say Deborah?

Deborah Doctor responded: I think you said it, that you want to know what the impact is and there's a few different was to hug it and we have supportive living providers, we have home health providers, we have a variety of providers who could express what it means to them and their business. But that doesn't translate to us as what does it mean to the consumer.

Rebecca Schupp commented: Right, I don't think we want to pigeonhole any provider or care management agency in only having a financial model that works for a certain provider type. We would want more of a - it's not global payment but it would more of a global

financial model that can allow different structures between the care management agency and the actual provider of services that the beneficiary selects.

Connie Arnold responded: So basically a mix.

Rebecca Schupp commented: I was thinking I would probably have you all weigh in on once we get closer to maybe a proposal is that the reimbursement relationship between the state and the care management agency could look vastly different than the payment relationship from a care management agency to the actual service provider, to the supportive living provider, to the home health agency to the personal care agency or to the handyman who's doing the home modifications.

What we're talking about more is the financial relation - the financial structure between the state and the care management agency but not to say if the state doesn't go the care management agency route then it becomes the state to the direct service provider relationship and we still have to think about that end user at the end of the day regardless of the intricacies and levels of waiver administration. Yes, so I mean we did say that we would...

Deborah Doctor commented: I'm just trying to figure out for myself when it comes to a final package - and your billing to a final package - are the stakeholders having any say in this discussion about what fiscal model you're choosing or are you doing it behind closed doors and taking for everybody because of what you think is best? But then when it comes down to a final recommendation, even if it's an array of budget models, about myself providing input when I'm not in that position of a care management agency to analyze it from the perspective of a fiscal budget model that you're proposing.

Rebecca Schupp responded: Yes, I could have made it more clear but stakeholder engagement and stakeholder feedback continues up until we submit the waiver application through the administration for approval and then to CMS. So, we have those other iterations of public comment and, we do hope because you guys are all around the table. You are all invested in the details that we did get in to in the primary challenges that we have in the waiver today to continue to be a part of that stakeholder engagement process and send us your feedback.

So, thank you everyone and, look for our e-mail on the action items that we committed to sending out and we look forward, to continuing this stakeholder engagement process with you all until we submit a waiver application to CMS.

Group commented: Thank you.

Operator stated: Thank you for participating, you may disconnect at this time.

END

