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ASSOCIATION OF
HEALTH FACILITIES

CAHF©

Supporting People, Health and Quality of Life

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October 28, 2011

Peter Harbage
President
Harbage Consulting
Email: info@calduals.org

Subject: California Dual Demonstration Project

Dear Mr. Harbage:

This is in response to your email requesting comments on the California Duals Demonstration Overview and the proposed frameworks.

The California Association of Health Facilities (CAHF) is a non-profit professional association founded in 1950 to serve as a statewide organization for long-term care providers. CAHF's membership is comprised of more than 1,300 licensed non-profit and proprietary long-term care facilities serving a wide spectrum of needs in settings which include skilled nursing, intermediate care, subacute, mental health, and services for persons with developmental disabilities. Nearly 100,000 trained medical professional and support service staff care for 300,000 Californians in these facilities each year.

California currently has 3.5 million people over the age of 65—the largest older adult population in the nation. This number is expected to increase to more than 6 million by 2020. The greatest growth will be amongst the age cohort most reliant on nursing facility services—the elderly population aged 85 years and older. Our members play a leading role in the continuum of care that has evolved to meet the short- and long-term medical needs of this population. Medi-Cal and Medicare comprise 80 percent of the revenue for skilled nursing facilities, and Medi-Cal funds almost 100 percent of the care for people with developmental disabilities that reside in institutions.

California Facts

Home- and community-based services are clearly a preferred choice in long-term care, and people able to benefit from this care should have access to a full range of options. Facility-based services are also a core element of the health care continuum, and those who require a level of care unavailable in the community should have access to facility-based services appropriate to their individual need.

Far too frequently, those anxious about preserving home- or community-based services find it necessary to vilify facility-based care. Their passion is understandable; however,

their criticism is largely misplaced. The following information is provided to help inform the discussion around California's current situation relative to facility- and community-based services:

- California is a leader in "balancing" Medicaid funds between nursing facilities and home- and community-based services; 54 percent of all Medi-Cal long-term care funds are spent in the community while 29 percent are directed to facilities. Additionally, more Californians per 1,000 elderly now receive personal care in the community than in any other state.

- In-Home Supportive Services (IHSS) is a "social model" licensed by the Department of Social Services (DSS) to provide personal care which, by definition, excludes any medical services. The Multipurpose Senior Services Program (MSSP) and Adult Day Health Care (ADHC) do have a health-care component, but it is limited to case management, referral and/or short-term medical services.

- Nursing facilities are a "medical model" licensed by the Department of Public Health to provide comprehensive 24-hour health care to persons who require nursing, rehabilitation and specialty care services for complex medical or chronic conditions.

- The scope of services offered by community-based long-term care providers is not equivalent to nursing-facility care; their services are appropriately designed for a generally healthier population that requires intermittent care and often also relies on other medical and social services from public and private providers in the community.

- Eighty-nine percent of all nursing-facility admissions come from an acute hospital; almost 80 percent of all patients are currently discharged from the facility within 90 days of admission.

- California ranks 10th highest among states in average resident acuity. As a result, residents require substantially more care and supervision than those in most other states.

- In the four years since its inception, the Community Transitions Program (Money Follows the Patient demonstration) has only been able to divert less than 1% of the residents in targeted facilities to the community and most of the diversions were developmentally disabled residents transferred to community facilities through the Regional Center system at the same or higher cost.

- California has comparably fewer nursing-facility beds per 1,000 elderly than other states (43rd in the nation) and, in spite of California's aging demographics, the inventory of facilities/beds has actually declined in the last decade.

- There are currently fewer than 15,000 empty nursing-facility beds available in California, and they are irregularly dispersed throughout the state, largely in non-urban areas.

- In state-to-state program comparisons California clearly outperforms other states in managing nursing-facility bed supply, creating/funding community-based alternatives and minimizing nursing-facility utilization.

- Estimates of "savings" from nursing-facility bed reduction or patient diversion efforts based on programs undertaken in other states are typically overstated because they do not factor in California's strict Medi-Cal utilization controls, emphasis on community-based services, significant loss of Medi-Cal patient share-of-cost revenue, additional medical care costs in the community (physician, therapist, transportation, pharmacy, etc.), and relatively higher use of personal care hours or frequent participation in multiple community programs by transitioned patients.

SPECIFIC COMMENTS THE FRAMEWORK

Long-Term Care Coordination: CAHF has a concern with the proposed framework. We have suggested revisions, which are attached. The framework fails to include skilled nursing facility care as part of the long-term care continuum and focuses solely on home- and -community-based care. While we agree is important to have the client self-direct their care, there are situations when the consumer may prefer to receive post-acute services in a facility-setting or may not be safely cared for in the community. The framework should recognize that skilled nursing facilities have evolved over the years to care for two distinct populations: (1) short-term rehabilitation and medically complex patients and (2) long-stay chronic care patients.

Short-term patients require rehabilitative services following surgery, such as a hip or knee replacement, or comprehensive care to recover from cardiac, pulmonary and neurological conditions before returning home. Skilled nursing facilities have become the dominate provider of these types of post-acute services in the Medicare program. The framework and the pilot programs need to recognize that skilled nursing facilities play a critical role and represent a "lower cost" provider for post-acute care. These facilities reduce the cost to care for patients that would otherwise continue their care in the general acute care setting. A hospital discharge to a skilled nursing facility for short-term care may enable a consumer to have a better outcome so that they can return to independent living in their home. Without aggressive rehabilitative services or comprehensive care that is necessary to improve a consumer's health status, costs for acute care stays and expensive re-hospitalizations may increase significantly.

The framework also needs to recognize that long-stay chronic care may be medically necessary. In recent years, the availability of community-based options has allowed individuals with less complex care needs to remain at home or in an assisted-living environment. Consequently, long-

stay chronic care residents in skilled nursing facilities have complex medical needs or severe behavioral health issues such as dementia. These individuals may not be able to receive adequate care in the community.

Mental Health and Substance Use: One of our members, Crestwood Behavioral Health, provides inpatient long-term behavioral health services in skilled nursing facilities with special treatment programs for the mentally disordered (SNF/STP) and in mental health rehabilitation centers (MHRC). They also provide short-term acute inpatient psychiatric services in psychiatric health facilities (PHFs). In addition, they provide residential care services in adult residential facilities (ARFs) and in residential care facilities for the elderly (RCFEs). The majority of clients they serve are Medicare/Medi-Cal (dual) eligible because of their mental disability.

Clients in their SNF/STPs and MHRCs have been conserved by the court and ordered to receive involuntary care in a locked/secured setting. Decisions about their care are made by their conservator and the county. The counties are the primary source of funding and county case managers coordinate and manage client services. Case managers approve lengths of stay, decide when a client is ready for discharge to a lower level of care, or can benefit from less restrictive community-based services.

Under the pilots, care coordination will be through some type of managed care or medical home model. Since their clients care is already coordinated with conservators and managed by county case managers, there would be little benefit for them in the demonstration project. However, in planning the demonstration project, planners should be aware of the unique nexus between the counties and public guardian's office for this population of dual eligibles. They will need to decide whether to carve them out of the demonstration, or how they would successfully integrate this population into demonstration project.

GOALS

As discussed with you and my staff on October 14, 2011, CAHF hopes that the future discussions and the demonstration overview include the following principles:

- Recognition that both Medicare Part A post- acute care and long-stay Medi-Cal skilled nursing care are critical components of the long-term care continuum.
- Pilots should demonstrate an understanding of the Medicare services and reimbursement systems, not just Medi-Cal.
- The health plans will continue to pay Medicare Part A reimbursement rates and AB 1629 reimbursement rates to skilled nursing facilities.
- Savings should be because of utilization changes, not rate reductions.
- Any willing provider should be able to provide care.
- Pilots will be expected to provide extensive case management/disease management, including preventive care.
- Pilots should implement financial incentives to reduce hospital readmissions from both community and institutional settings.

- Consumers should have access to 24-hour advice line.
- Pilots should assure that nursing facilities have access to physicians on weekend/evenings to prevent emergency room visits and hospitalizations.
- The health plans should recognize that consumers need access to therapy services beyond what is provided by Medi-Cal.

SITE SELECTION

CAHF supports the "Request for Solutions" site selection process. This allows the state more flexibility in their ability to administer and monitor the demonstrations. We also support that the entities selected have experience in providing Medi-Cal services to the senior and persons with disabilities.

POTENTIAL DEMONSTRATION PARTICIPANTS

As provided in Senate Bill 208, mandatory enrollment should only be applicable to the beneficiary's Medi-Cal benefits. Dual eligibles should have the option to enroll in the pilots for their Medicare benefits. In that even that DHCS adopts a policy of passive enrollment for both Medi-Cal and Medicare, the consumer should be able to opt out of the program. There should also be an exemption process to prevent enrollment because of continuity of care and/or medical reasons, at the request of the consumer.

We suggest that the initial implementation of the pilots exclude clients that are residing in long-term care facilities, similar to the exclusion implemented as part of the mandatory enrollment of seniors and person with disabilities. As discussed above, the pilots should exclude consumers in SNF/STPs and MHRCs that have been conserved by the court and ordered to receive involuntary care in a locked/secured setting. CAHF is in the process of developing a position on enrollment of the developmentally disabled persons in the pilot because their care is managed by regional centers and their special needs.

DATA ISSUES

We read in the a recent report published by Californians for Olmstead, that you have promised advocates representing consumer-drive agencies a meeting with Mercer, the actuary responsible for rate-setting for the dual eligible pilot projects. We are requesting a similar meeting in order to understand how the state proposes to reimburse health plans for both Medicare Part A and Medi-Cal skilled nursing facility services.

In addition, we are requesting expansion of the data, delineated by aid code, provided on page two of the Overview paper:

- Hospitalization rates and costs (Medicare)
- Drug costs (Medicare)
- Physician services (Medicare)

- DME costs (Medi-Cal and Medicare)
- Medicare Part A skilled nursing facility utilization and costs for dual eligibles, including the types of services rendered (RUGS classifications)
- Medi-Cal skilled nursing facility utilization and cost for dual eligibles
- Re-hospitalization rates for duals after a Part A stay in a skilled nursing facility
- Hospital admission rates for duals admitted from a Medi-Cal stay in a skilled nursing facility
- Hospital admission and re-admission rates for duals coming from the community, and costs
- The number of duals that were in a skilled nursing facility as a Medi-Cal patient, then admitted to a hospital for a three-day stay, and subsequently admitted back to the same facility as a Medicare Part A patient, including cost and RUGS data.

Thank you for the opportunity to provide input on the implementation of these demonstration pilots. If you have any questions, please contact Darryl Nixon, Director of Reimbursement, at (916) 346-7284 or Nancy Hayward, Assistant Director of Reimbursement, at (916) 441-6400, ext. 106.

Sincerely,

James H. Gomez
CEO/President

Attachment

Framework for Understanding
Long-Term Care Coordination
in California's Duals Demonstration

DRAFT

The process of developing California's duals demonstration criteria should be more than a listening process. It must be an open dialogue that fosters an exchange of information between the state and others. This interactive process should inform the ultimate design. These concepts have been drafted to set the stage for a conversation around coordination of long-term care and supportive services.

1) Consumer Choice. Building on the current system, the demonstration should consider the need for consumers to self-direct their care and be able to determine where they receive care. Home- and community-based services (HCBS) provide a health care benefit to the consumer by allowing them to stay in their home. Given all factors (medical/social/financial), HCBS may not always be the best alternative.

- At each step in the care delivery system, there should be clear thought about how that step affects the ability of the consumer to stay in their home and community. By improving preventative care and maintaining HCBS, the consumer is able to stay at home and use less acute care services.
- All entities in the system should have the incentives and resources needed to promote hospital discharge to the most appropriate level within the post-acute continuum, including short-term skilled nursing facility care. When possible, discharge into their homes and community is preferable, so beneficiaries can better maintain a high quality of life.
- Consumers should be allowed to choose their health care provider. Family matters.

2) Care Coordination. Care coordination and consistently implemented policies will reduce administrative costs and increase quality of care.

3) Access to services. For consumers at risk of institutionalization, the demonstration should offer a structure for them to access HCBS, when HCBS is the most appropriate level within the continuum for meeting their needs and maintaining a high quality of life in the community.

4) Consumers as part of their coordinated care team. The demonstration should consider how the consumer is included in an organized delivery system that meets his or her unique social and medical needs.

- Improved understanding of the different needs of each population is needed.
- Post acute reforms should aim to improve both economy and efficiency with emphasis on care coordination, health care services delivery and access, and consumers' quality of life.

5) Oversight and monitoring. The demonstration has the potential to realign the current health care system's poorly aligned incentives around beneficiaries' needs.

- The new system can stop the county-state-federal cost shifting.
- The state must aggressively monitor the demonstration site for quality and access.

6) Workforce training. This demonstration has the potential to improve care and curb unnecessary costs by offering home workers basic training in areas such as dietary needs, wound care, and care management.

- The demonstration should consider an investment to have the right workforce at the right place at the right time.
- There is an opportunity to create different levels of care within HCBS with tiered levels of training and certification designed to ensure beneficiaries receive the appropriate level of care. Program design should consider that some workers will not want any training.
- Consumer privacy should be considered in developing these different workforce levels, including consumer control on who speaks to medical providers on consumers' behalf (if at all) and consumer control on who provides even the most basic care.

7) Financing. Arrangements should be developed with a focus on aligning incentives to deliver the right care in the most appropriate level within the post-acute continuum.

- Care coordination has the potential to rebalance service delivery away from the institutional setting. However, re-balancing service delivery toward HCBS should never take precedence over the need for placement of a consumer to the most appropriate level within the post-acute continuum.

Coordinated models should consistently focus on economy and efficiency while ensuring delivery of high