SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
DUAL ELIGIBLES TECHNICAL WORKGROUP
Meeting #2 – Wednesday, May 19, 2010
10:00am – 3:00pm
Sacramento Convention Center, Room 104

The meeting convened at 10 AM.

Attendance

Technical Workgroup members attending: Maya Altman, Health Plan of San Mateo; Richard Chambers, California Association of Health Insuring Organizations and CalOptima; Bonnie Darwin, California Culture Change Commission; Sandi Fitzpatrick, California Commission on Aging; Brad Gilbert, Inland Empire Health Plan; Nancy Hayward, California Association of Health Facilities; Janet Heath, MSSP Site Directors' Association; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority; Cynthia Jackson Kelartinian, Heritage Clinic, Pasadena; David Kieffer, SEIU; Marty Lynch, LifeLong Medical Care; Jackie McGrath, California Council of the Alzheimer's Association/Chronic Care Coalition; Santiago Munoz, UC Hospitals; Cheryl Phillips, On Lok/PACE; Kevin Prindiville, National Senior Citizens Law Center; Dawn Myers Purkey, Woodland Healthcare/Yolo Adult Day Health Center; Timothy Schwab, SCAN Health Plan; Rick Slaughter, Molina Healthcare; Jennifer Spalding, AltaMed Health Services; Patricia Sussman, Contra Costa Health Plan; Sarah Takahama, California Association of Physician Groups; Suzanne Tavano, California Mental Health Directors Association; Mary E. Whitehead, Scripps Health; Casey Young, AARP.

Others attending: David Maxwell-Jolly, Director, DHCS; Gregory Franklin, Director of Medi-Cal Operations; Alice Lind, CHCS; Paul Miller, DHCS; Brian Hansen, DHCS; Eileen Carroll, DSS; Lora Connolly, CA Department of Aging; Penny Knapp, CDMH; Carol Risley, CA Department of Developmental Services; Gretchen Alkema, SCAN Health Foundation

Public in Attendance: 11 individuals attended in person, and 33 people called in on the listen-only telephone line.

Welcome and Introductions

Bobbie Wunsch, PHCG, welcomed the group and members of the public participating in person and by phone. Due to a scheduling conflict, the agenda was revised to move David Maxwell-Jolly's scheduled presentation on the 1115 Waiver Implementation Plan, the trailer bill language and the May Revise from first on the agenda to later in the meeting.

Federal Health Care Reform: Impact on HCBS, Creation of Dual Eligibles Integration Office

Gretchen Alkema, Vice President, Policy and Communications, SCAN Foundation

The SCAN Foundation published an issue brief on federal health care reform in January 2010 that analyzed continuum of care provisions in the House and Senate health care reform (HCR) bills. The Foundation's second policy brief, published in March and available at

http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/TSF%20Policy%20Brief%20No%20%20%202%20Mar%20%202010%20-%20Side-by-Side.pdf, focuses on the continuum of care provisions in the final legislation and the reconciliation act. Gretchen Alkema noted that some issues relevant to dual eligibles, such as Medicaid physician payment, are not discussed in the brief.

Gretchen Alkema highlighted several key provisions of federal HCR for dual eligibles (page references are to the issue brief linked above):

- Office of Dual Eligibles (page 3) – Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within CMS. This has been needed for a long time, as states have struggled to understand and coordinate the requirements of Medicare and Medicaid, and to work with CMS on both programs.
- Center for Medicare and Medicaid Innovations (page 4) – The purpose is to research, develop, test and expand innovative payment and delivery arrangements. This will allow CMS to select models that reach the goals of quality and cost, and allow them to move through the process much more rapidly. The fact that it's explicitly for Medicaid as well as Medicare is an important acknowledgment that dual eligibles are a priority for this office.
- CLASS plan (page 1) – Establishes a new, public, voluntary LTC insurance benefit that people can purchase/buy into.
    - 5 year vesting period.
    - Available to enrollees who meet specified disability criteria (in statute as 2-3 ADL).
    - Premiums will be age-rated based on date of entry.
    - Conceived of as a floor benefit with supplemental products available.
    - Important here because it speaks to people who can purchase now. It is scored well by CBO because of the backside savings to Medicaid program, since it allows people potentially to avoid spending down to Medicaid.
- Medicaid HCBS provisions
    - Community First Choice Option (page 2) – Creates HCBS as state plan option (not a waiver option). States that choose it are required to provide HCBS for all eligible, and must implement statewide. Provides an additional 6% FMAP for states that choose it.
    - 1915(i) program (page 2) – Gives states the option to provide more types of HCBS through State Plan amendment rather than waivers. Requires statewideness of the HCBS State Plan benefit, but enables States to target benefits to individuals with selected conditions. Enrollees don't have to be nursing home-certifiable.
    - State Balancing Incentive Payments Program (page 3) – Designed to provide incentives for states with low HCBS spending relative to total LTC spending to shift beneficiaries out of nursing homes and into HCBS. States with <25% total LTC expenditures in HCBS can receive 5% increase in FMAP; those with spending between 25 and 50% can get 2% FMAP increase, but California *not eligible* given all its waivers.
    - Spousal impoverishment protection for HCBS beneficiaries (page 3) – Allows well spouse of someone receiving HCBS to maintain some assets (as is currently the case when ill spouse is in SNF). In California, would allow well

spouse to keep approximately $109,000 in assets and $2700 monthly income.
- Money Follows the Person Rebalancing Demonstration (page 2) – Extended through 2016.

Marty Lynch, LifeLong Medical Care, asked whether California is actively working to implement any of the options that would increase FMAP. He also questioned the assessment that California's HCBS spending accounts for 54% of its LTC spending. Paul Miller, DHCS, said that DHCS is investigating all options, but awaiting further guidance from CMS in many areas. He said that California's HCBS/LTC percentage is 52-54%, calculated by DHCS without input from CMS. Gretchen Alkema said that, under federal regulations, the assessment is based on spending under federal 1915 (c), (g), (i) and (j) waivers as well as anything in an 1115 waiver that speaks to HCBS.

Eileen Carroll, CA DSS, asked whether beneficiaries need limitations in three activities of daily living (ADLs) to qualify for LTC benefits under the CLASS plan. Gretchen Alkema replied that the legislation says 2-3 of the 6 ADLs to receive benefits, though details regarding exact qualifications will be worked out in regulations.

Mike Humphrey, Sonoma County IHSS Public Authority, asked for more detail on the medical home transitions program (page 5) and other care coordination initiatives. Gretchen Alkema said that the Medicaid program on medical homes is particularly relevant to SPD populations. She said it was not clear whether statewideness would apply, or whether this program would be by application or open to all states. The legislation includes a planning grant.
The community-based care transitions (page 5) were designed to bring forth a coalition of medical and social service providers outside hospital settings who would work in collaboration with hospitals to help Medicare beneficiaries transition from hospital to home. In the legislation, the program is specifically tied to hospitals high readmission rates, but this could open up a little in the regulations.
The patient navigator program (page 5) is part of the broader quality aspect in the bill. The goal is to create demonstrations to think through patient navigator services. The concept is not detailed in the law – it is not clear if it will operate at the state or community levels -- but is worth keeping an eye on.

Bonnie Darwin, CCCC, asked what happens to MEDPAC under the legislation. Gretchen Alkema said that federal HCR has no effect on MEDPAC, but does expand the authority of MACPAC (the Medicaid PAC created in SCHIP renewal, see page 3) to dual eligibles as far as its research and reporting. This is a huge step forward, since while MEDPAC was thinking about dual eligibles, it had no statutory authority to do so. MEDPAC, MACPAC, the Office of Duals, and the Center for Innovation together have the potential to transform the delivery system.

Marilyn Holle, DRC, said that one of the advantages of IHSS is the nurse practice act waiver, and asked how this would be incorporated in CLASS. Gretchen Alkema said that it is not fleshed out in the legislation, and that she would like to learn more about what should be included in regulations.

Rick Slaughter, Molina Healthcare, asked whether the legislation included any information on the composition of the Office of Duals, and what DHCS' expectations are for that Office. Gretchen Alkema said that bringing forward good thinking about how to structure that office is a SCAN Foundation priority. Currently, however, there is not a lot of communication with people outside of CMS, pending the arrival of an administrator. *Greg Franklin, DHCS,* said that the Department is looking forward to having a direct portal to CMS, and that California will be able to get its dual eligibles initiatives in front of the Office of Duals as soon as possible.

Gretchen Alkema announced that the SCAN Foundation is sponsoring a policy forum on federal health care reform and long-term care on June 11th. The meeting will be held from 10 AM – 12 PM at the CSAC Conference Center in Sacramento and may be available by internet as well; details and registration are available by contacting Susan Doles at (562) 308-2868 or sdoles@thescanfoundation.org.

Panel Discussion on HCBS in Organized Delivery Systems

Michael Humphrey, Sonoma County IHSS Public Authority (Moderator/Commenter)
Tim Schwab, MD, SCAN Health Plan
Maya Altman, Health Plan of San Mateo
Bradley Gilbert, MD, Inland Empire Health Plan (Panelists)

Michael Humphrey introduced the panel and asked a series of questions to which each panelist responded:

- What operational structure does your plan currently have to integrate or link to home and community-based services HCBS (IHSS, ADHC, MSSP, etc.)?

Maya Altman, HPSM, said that San Mateo County has been thinking about HCBS linkages for a long time, and while the Plan has made progress, they recognize that there is more they could do.

Context:

- San Mateo County has for many years had a vision of building a HCBS system.
- HCBS services (IHSS, MSSP, and AAA) are consolidated in the health department, which makes it much easier for the Health Plan to coordinate with those services.
- HPSM is a COHS, so everyone on Medi-Cal is a member of the plan, including SPD.
- HPSM's enrollment is 42% SPD, the highest percentage of any health plan in the state.
- HPSM's high numbers of SPD led to their interest in developing a Medicare SNP, since that provided an opportunity to integrate some Medicare funding for dual eligibles.
- The SNP began in 2006, and currently approximately 60% of eligible members are enrolled.
- It's in the context of the SNP that the majority of HPSM integration has occurred.

Current structure:

- HPSM does not have a formal HCBS structure, but works with Aging and Adult Services (AAS) around referrals for IHSS and MSSP.
- HPSM has case conferences as needed with colleagues in BH and AAS.
- HPSM has a care transitions program for people who are leaving the hospital and returning home.
- While they have no designated liaison, HPSM staff meet regularly with the Regional Center.
- They also have a consumer advisory group that includes people from AAS.

Brad Gilbert, IEHP, said that his plan does the following:

- 30,000 SPD beneficiaries have voluntarily chosen to enroll in IEHP, of whom 20,000 are persons with disabilities.
- IEHP has a SNP with 2500 members.
- IEHP works with an active disability collaborative, which advises the Plan and other members on what's available in the community and facilitates collaboration. DMH, rehabilitation services, Loma Linda and other entities come together in that group, in some cases for the first time.
- IEHP's PWD workgroup has advised the plan for a number of years. Members bring a consumer perspective on barriers and needs, and educate the plan on community resources.
- An IEHP social worker is based full-time at the Regional Center, and has access to both the RC and IEHP systems, allowing for complete coordination. As a result of this placement, 5000 RC members have chosen to enroll in IEHP.
- IEHP's health navigator program has 5 individuals who work in community settings to assist people in navigating the health care system. It is a new program, currently focused on kids and access to primary care, but is a good model for community-based activities for PWD.
- IEHP does *not* have a good bidirectional connection to IHSS. The Plan has a good referral mechanism, but can't access the IHSS worker's knowledge. The same is true for MSSP, although they participate in the disability collaborative.

Tim Schwab, SCAN Health Plan, provided history on the Plan and an overview of current HCBS efforts:

- Begun over 30 years ago by activists in collaboration with USC geriatricians.
- Operates first and largest MSSP program in state.
- 1985-2008 part of Medicare demonstration program in which Medicare seniors (approximately 5% also Medi-Cal beneficiaries) received a social case management model including HCBS to keep frail nursing home-certifiable people in their homes.
- Anticipating the end of the social HMO, SCAN helped design the SNP. In that model, SCAN provides all HCBS needed to keep people in their homes. That model had 90,000 members, 25% nursing home certifiable living at home, and of those roughly 5% were dual eligibles.
- Worked with state to create a fully integrated dual eligibles SNP, of which there are only a handful.

  - SCAN provides LT nursing home placement, HCBS, and all acute Medicare and Medi-Cal services.
  - 7,000+ members in 3 counties.
  - SNP has: a transition management program, which reduces readmission rate; a geriatric health management program; frail elderly ILP (independent living program) shown to reduce LT nursing home placement compared to the FFS population.
  - A paper evaluating the SCAN SNP will be released in June 2010.
- Barriers:
  - This model is designed so that SCAN is responsible for everything – as a result, everyone is contracted with SCAN and there is not much coordination.
  - The SNP doesn't connect with IHSS, and in fact is not allowed to enroll individuals who are IHSS clients (though they can give up IHSS to receive services through the SCAN SNP). SCAN has tried to contract with IHSS but has found that it is not easy for a not-for-profit plan that is outside the county system.
  - Finding services remains difficult, and SNP clients can't be put on waitlists. SCAN initially contracted with AAA, but their wait lists were unacceptable so SCAN had to find private contractors in the community to deliver those services.

Mike Humphrey asked whether SCAN's MSSP clients can get IHSS. Tim Schwab replied that there is a mini-firewall between MSSP and the plan – an individual can't be in both.

- What have been the barriers to effective coordination or linkage of HCBS in your structure?

Maya Altman, HPSM, said that the Plan's philosophy is to minimize carve-outs and eliminate categorical programs to the extent possible. HPSM has a good relationship with IHSS, but they are two very different programs. HPSM is moving toward allowing their care coordinators access to the case management system at IHSS, but their real goal is something more extensive.

With CalOptima, HPSM is trying to initiate a complete LTC integrated program. San Mateo has been thinking about this in general terms for a long time, but now see some hope to actually pilot it (in HPSM and CalOptima). This would look like SCAN, but build on existing county structures. HPSM is working on how to contract with IHSS, as well as with county AAS and other HCBS services. Under the model as conceived, IHSS workers would be part of the care team and reimbursed for their participation. IHSS is consumer-directed, and it is a challenge to bring that into a medical model. The Medicare program requires an interdisciplinary team, so HPSM already has social workers and other providers, but that they don't want to duplicate structures that already exist at the county.

Michael Humphrey commented that it is a good challenge to bring social-model HCBS into medical-model health plans without losing the social model in the process.

Brad Gilbert, IEHP, agreed that integration of the social model is difficult. He also noted the following barriers:

- Carve-outs: On the Medi-Cal side in the 2-plan model, there are significant carve-outs, including mental health, LTC except for in the month of admission and month of discharge, and others. As a result, the plans have few incentives in those areas. IEHP recently brought behavioral health (BH) services in-house. Now the BH team sits next to the care management team, and their assessments go directly to the primary care physicians. That doesn't happen in the carve-out situation.
- The PACE program makes the argument that all the money needs to be in one place – all services don't necessarily have to be, however. IEHP tried to do a LTC integration program 5 years ago, but the entities couldn't come together around money. The trust factor wasn't there.

Tim Schwab, SCAN Health Plan, said that in contrast to the other plans, SCAN started from the social side. They brought medical services in after several years, but the social model is woven throughout their services. Significantly, SCAN in California carves out Medicare beneficiaries under age 65. 40% of their enrollees are nursing home certifiable dual eligibles, while the other 60% are healthier dual eligibles. SCAN can put programs in place to find them as they age into disability, or to prevent them from doing so. In Arizona, by contrast, their SNP carves out healthy dual eligibles, and serves only disabled individuals.

- How have your plans integrated behavioral health (BH)?

Maya Altman, HPSM, said that San Mateo County Behavioral Health (BHRS) is the BH subcontractor for HPSM's Medicare SNP and, as such, coordinates the Medicare/Medi-Cal mental health benefits for Medi-Medi consumers. As of July 1, 2010, HPSM will assume responsibility for all Medi-Cal Mental Health pharmacy as well, as part of the plan's contract with DHCS. HPSM will subcontract with BHRS to handle pharmacy-related services for Medi-Cal only and Medi-Medi members, but will use HPSM's Pharmacy Benefit Manager (PBM) for all medications.

- What disincentives exist that result in bias toward institutionalized care?

Maya Altman, HPSM, said that COHS have a LTC institutional benefit. They get a high capitation rate for institutionalized people, but the community rate when people leave the institutions. As a result, there is no incentive to keep people out of institutional care. Like SCAN, HPSM has had great outcomes through their SNP, and if they could reinvest those savings in HCBS everyone would be better off.

Tim Schwab, SCAN, said that in their plan, while the Medicare and Medicaid services are integrated, on the payment and regulatory side, they are not. Both sides require the plan to separately account for and deliver services paid by that entity. While this is hopefully invisible to the member, it is costly for the program. If it were possible to use hospital savings (Medicare side) to fund HCBS (Medi-Cal side), there would be savings on the LTC side.

Maya Altman, HPSM, said that anyone who runs a SNP would agree that it's very difficult to work with both systems, but the bigger problem is that the SNP is a Medicare Advantage program and those are targeted. HPSM is facing financial constraints in its SNP already, and may not be able to continue it long term.

Brad Gilbert, IEHP, agreed, saying that if they can't leverage both sides of the funding and Medicare reimbursement continues to decline, it will make it difficult to continue the program.

David Kieffer, SEIU, said that regarding the future of SNP, the HCR legislation includes a section on a fully integrated dual eligibles SNP. There is limited flexibility to get something done on the Medicare Advantage side — the flexibility is in the state Medicaid program, where we can make changes to make it easier to achieve real integration.

Tim Schwab, SCAN, said that some kind of risk-adjusted payment is needed – currently, the plan is paid one of two rates. Everyone in SCAN's plan is a voluntary enrollee, but a move to mandatory would necessitate making sure that payment to a plan correctly reflects individuals' needs. California can do that even without changes on the federal side. He asked for clarification on whether the fully integrated dual eligibles SNP was only for the three states that originated it.

Brad Gilbert, IEHP, said that, regarding BH, they just pay their providers, but the Medicare benefit is a limited benefit – so IEHP integrates it from a care perspective, but has a rate driven by rate development process in state. The money is important, but at a minimum the plans need clear standards that work for both programs. Medicare drives the standards in SNPs. Alignment of requirements and some flexibility in funding would help.

Maya Altman, HPSM, added housing to the list of barriers. Currently, the plan can't pay for assisted living or board and care, and thus are paying $100,000 annually for SNF care for people who can't go home, but would do well in an intermediate setting, far less costly than a SNF.

- What incentives could be used to create HCBS to reduce acute care and institutional placement?

Maya Altman, HPSM, said that another areas that HPSM is trying to figure out in regard to IHSS coordination is the training of IHSS staff. They are looking at wage tiers tied to training, etc. Michael Humphrey said that IHSS training had been curtailed as a result of budget cuts, but that it needs to be brought back.

Brad Gilbert, IEHP, said that plans are motivated in terms of reducing ED use and acute stays. Most helpful would be bidirectional information and early warning.

Tim Schwab, SCAN Health Plan, said that the system already has incentives to reduce acute care. The SCAN model blends rates for home and nursing home care, so they have a financial incentive to keep people out of nursing homes.

Janet Heath, MSSP, asked whether ADHC was carved out and how that coordination works.

Tim Schwab said that the SCAN model doesn't carve anything out, and that the challenge in terms of ADHC is availability. In rural areas, it's very difficult to find ADHC services within a reasonable distance. SCAN can use adult day cares as well, so where individuals don't need medical support and ADHC isn't available, they can provide a service that is more like short-term day respite, and pay on the Medicare side. SCAN only has 7,000 members, so they can generally find services through private contractors, but if the program were going to be much bigger and/or mandatory, they would need to work with IHSS and all the others to find these services. Mike Humphrey asked whether SCAN enrollees could choose their own providers for the IHSS-like services that the plan provides. Tim said that beneficiaries have to use one of SCAN's contracted providers, and within that group can work with a case manager to find someone. In the past, they were able to use family members for these services, but that option was eliminated. Members thus have only limited choice of provider.

Brad Gilbert said that IEHP doesn't have the flexibility that SCAN has; ADHC is separate. They have done limited referrals to the program and had some successes, but since the IEHP SNP population is primarily younger individuals with disabilities, this has not been a big issue for them yet.

Maya Altman, HPSM, said that there are four ADHC providers in the HPSM area, and their SNP enrolls about 8,000 people. They work directly with ADHC on referrals, but both the HPSM and the ADHC entities are interested in having HPSM be the payer for this program.

Richard Chambers, CalOptima, said that in retrospect he regretted that the plan did not integrate ADHC in 2002. CalOptima is also planning a PACE program in Orange County, at multiple sites. Although CalOptima is the Orange County MSSP provider and they are collocated, since their staff reports to the Department of Aging they may as well be in Sacramento. CalOptima hopes to get a great deal of flexibility via the proposed pilot. In particular, they hope that as they intervene on the BH side, the state doesn't carve the savings on the acute care side back out of their rates.

Marty Lynch, LifeLong Medical Care, proposed looking at a different type of organized system, the FQHC model that might become the organized delivery system in non-managed care areas, or the provider part of the system in already-organized areas.

- LifeLong Medical Care has an Over 60 health center, founded on the idea of integrated care. Have put together onsite primary care, primary geriatric, social worker case managers, nurse case managers, and mental health, among other services, in order to provide a package of care that will keep people in the community. Provides linkage to IHSS and other HCBS services, and has its own ADHC sites,
- IHSS is still the county-based PA model. LifeLong has a sub-registry of IHSS providers that their care managers help negotiate on behalf of patients. LifeLong works collaboratively with the Public Authority – on the home health side, the PA provides LifeLong with a person who participates in team meetings at least once a month, so in that meeting most of the key partners are represented.

- Currently, Over 60 serves about 4,000 elderly patients, of whom about 1,000 are dual eligibles.
- Collocation is critically important to integrated care. We can integrate the finances, but if a case manager doesn't ever talk to a physician or NP, integration can't happen. This is also true for MH.
- More and more, FQHCs will be the health homes for complex populations, and they may be able to complement other systems.

Brad Gilbert, IEHP, said he agreed that the delivery of care management is best done at the provider level, but questioned the administrative capacity of small providers whose office staff may not have much education or experience. He also asked how a plan could reimburse for the services Marty described: if the plan capitates the FQHC, it will be only for medical services.

Cheryl Phillips, PACE, said that financing alone makes a common paycheck but doesn't integrate care. She suggested that one administrative possibility for a larger plan is to create a common care plan – the current system, with multiple care plans, confuses both providers and seniors. A lesson from PACE is that while collocating services is great, virtual teams with a common care plan can also work.

Bonnie Darwin, CCCC, asked how the dual provider networks – IHSS' and plans' --- should optimally be combined. *Maya Altman* said that the solutions would vary by location. LifeLong's plan is great, and inspired the senior care center in San Mateo, but every place will be different. HPSM is a vehicle for organizing a system. They want to include all their seniors, and then the onus is on them to figure out not only who is nursing home certifiable, but who is going to be there soon. HPSM wants one uniform assessment, referrals through contract arrangements (AAS, PA for IHSS, etc.)

Bonnie Darwin, CCCC, asked whether IHSS would become a vendor like any other. *Dave Kieffer, SEIU,* said that the ongoing conversation in San Mateo is about not over-medicalizing the model and destroying the program's value in terms of self-determination. There's a local ecology of health care delivery, particularly for this kind of population, and solutions should not come from the top. *Mike Humphrey* agreed that the issue is local, that it is complex and requires significant relationship-building, with mutual interest in a person-centered outcome as the goal.

Janet Heath, MSSP, said that her program can communicate directly with UC Davis and providers there, but can't talk to IHSS because of HIPAA restrictions. Confidentiality policies need to be better understood and in some cases changed. They need direct access to records in order to do a good job of case management. Michael Humphrey noted that this is another example of variation: in Sonoma, MSSP is collocated with IHSS and the PA and several others, so they're back and forth regularly during the day, which is optimal.

Jennifer Spalding, AltaMed, said that their system is an FQHC with 48 locations in Orange and LA Counties, with 28 clinic sites, 7 ADHC programs, 3 PACE sites, and MSSP and other programs. They train family caregivers of individuals in the PACE program through a program called CGSS. AltaMed's own programs have been siloed for many years, but

Jennifer now directs Senior Care Services, and is working to coordinate all the programs. Training and education are ongoing. AltaMed benefits from having many ADHCs located near clinics, and uses *promotoras* in the community.

Cynthia Jackson Kelartinian, Heritage Clinic, asked how SCAN handles behavioral health. Tim Schwab replied that in California they contract with delegated medical groups (IPAs), and mental health services are provided within that network. Their dual population is all over 65, so access problems are not as severe as in Arizona, where the population is mostly disabled. Some IPAs use statewide MH providers.

Marilyn Holle, DRC, noted that people with SMI tend to be overlooked in discussions of IHSS, but the service has been critical to keeping people engaged and keeping costs down. Whether SMI is a primary diagnosis or comorbidity, it is essential that plans and SMH systems do a better job of documenting that need. Regional Centers provide an example: they do a pretty good job of working with IHSS, doing assessments of areas of need, and providing that documentation to IHSS.

Kevin Prindiville, NSCLC, said he was concerned about repeated assumptions that aligned financial incentives would lead to better care, saying that that was a focus more on the plans' problems than on the beneficiaries'. He cautioned against focusing too much on any one model, and urged particular caution about the concept of melding funding streams, since it is not certain that mixed money will be available.

Michael Humphrey concluded the discussion, saying that he appreciated everyone's participation and that while there is much more to discuss, he looked forward to continuing conversations. He reflected on the ongoing challenge of maintaining the social model in HCBS, and noted that that concern is shared by the entire Workgroup. He also suggested that participants adopt the term "*person*-centered" in lieu of "*patient*-centered."

Update on 1115 Waiver Implementation Plan

David Maxwell-Jolly, Director, DHCS, updated the group on the waiver Implementation Plan, trailer bill language, and May revise.

Responding to Kevin Prindiville's comments about not assuming any one particular model, or thinking that pooling money alone would solve all problems, David Maxwell-Jolly said that DHCS recognizes the complexity of the task. He said that efforts to rationalize/expand/unify HCBS over the years have been frustrating, and that he would like to try unifying some of this money locally. This is not something that DHCS proposes to do on a large scale, but they are interested in proceeding carefully and learning from what happens.

The draft dual eligible service integration projects trailer bill language (available at http://www.dhcs.ca.gov/provgovpart/Documents/DRAFT%201115%20Waiver%20Dual%20Eligible%20Integration%20Projects%20Trailer%20Bill.pdf) is intended to authorize that first step. It takes advantage of places where dual eligibles are already enrolled, and tries to unify the administration of that to the extent possible while increasing enrollment. Evaluation will be a central concern.

Based on conversations with CMS, David Maxwell-Jolly said he believes that the project will proceed slowly. The shape of the projects will not be finalized in 2010, and the intention in the 1115 waiver is to open the window for planning efforts. This will require continuing stakeholder conversations. The trailer bill language will provide a good foundation for the ongoing conversation as DHCS develops more concrete models. It is informed by where CMS wants to go on both the Medicaid and Medicare sides.

Regarding the state budget and the May Revise, David Maxwell-Jolly said that the overall situation is no better than it was in January, and that while there have been no major increases in caseload, and some successes in getting money from the federal government, the state still faces enormous shortfalls. As a result, the Administration is proposing a number of utilization controls in Medicaid, which are permissible and which will be very painful.

Casey Young, AARP, said that the May Revise contemplates $136 million in savings by enrolling SPD populations in managed care in the 2010-11 budget year, and asked what that entails. David Maxwell-Jolly replied that it assumes the scheduled enrollment of approximately 400,000 individuals over the 12-month roll-in period. Some of the savings would result from changing the payment timing (moving some payments into 2011-12), but the majority is due to a discount off the FFS rate.

Cynthia Jackson Kelartinian, Heritage Clinic, asked where behavioral health fits in the trailer language, and whether it is carved in. David Maxwell-Jolly said that the SMH will stay in place, with no changes to the fundamental delivery of BH services. SPD plans will be expected to establish effective liaisons with SMH, and in the HCCI context, some plans might enroll people with SMH needs who currently get those services from the counties, providing an opportunity for a unified delivery system.

Cynthia Jackson Kelartinian asked whether the trailer language suggested mandatory enrollment. David Maxwell-Jolly replied that DHCS does not intend to take on the question of voluntary enrolment in Medicare managed care – people will not be locked into Medicare managed care plans.

Kevin Prindiville, NSCLC, said that he and other advocates had been surprised by the trailer bill language because it is more specific and more prescriptive than what is in the Implementation Plan. It does not include mention of other organized care systems, for example, and in general seems to go beyond what has been discussed to date by the Dual Eligibles Workgroup. David Maxwell-Jolly replied that it is a proposal, and open to discussion, but that DHCS had to put something in writing. Kevin Prindiville asked why it is necessary to have any legislative language at this point, and David Maxwell-Jolly said that it is helpful in the state's conversations with CMS to have something concrete to discuss. There will be an opportunity to come back and design other, non-health plan based models, informed by the experience in the plan pilots. Kevin Prindiville said that he felt strongly that the conversation should not be rushed, and that it will be difficult to vet the ideas fully in the compressed time frame. David Maxwell-Jolly replied that while the bill does to some extent determine the future direction of conversations, the way it is framed does allow for significant influence on the final design: it can be up to four pilots, with a variety of models, and an implementation date of 2012. At the same time, the bill is necessary both for the waiver negotiations process and for the budget discussion, and both those processes are

moving quickly. David said that he expects that the dual eligibles piece of the waiver will still lack detail at the time the waiver is signed.

Suzanne Tavano, CMHDA, said that it is hard to see how the reduction of long-term institutional care can be discussed in the context of cuts to all the HCBS that would allow such a reduction.

Small Group Discussion on HCBS

The Workgroup divided into four small groups, each of which discussed the following question:

> What specific actions need to be taken by DHCS and by managed care organizations/organized delivery systems to ensure strong linkages to HCBS?

Group 1:

DHCS

- DHCS must resolve the ADHC issue (state plan amendment v. waiver) with CMS. Since the Administration proposed elimination last year, DHCS' efforts have slowed.
    - ADHC one of the most cost-saving programs out there
    - New Lewin evaluation finds it saves $56 M in SNF annually.
- ADCRC should be brought back.
    - Even less expensive was already cut, less expensive than ADHC, and needs to be brought back.
    - Some centers have patched it together to keep the program, but many have not.
- Can't take away programs that you're simultaneously asking to do more.
- Housing: Need more flexibility to provide additional housing options – this has to be part of 1115 waiver.
- DHCS needs to focus on the delivery system and rates.
    - In the delegated models, groups are becoming financially insolvent because they're getting so little from the plans. How will they be paid to deliver the kind of care that people need and deserve? Of the $2B DHCS is requesting, what part goes to delivery system?
    - HCR helps with the primary care rate (for two years), and *may* provide 90% FMAP for chronic illness (though provisions are vague).
    - Concerns about state's capacity to handle this kind of complex rate-setting – DHCS has Mercer but is that enough?
- What happens to rate-setting etc. if IHSS included in HPSM?
    - Actuarial process a black box – push to make it transparent
    - HPSM would be payor but state still negotiates with unions

    - Decisions about level of care become joint state/plan responsibility – decided by team
- DHCS should draw upon the recommendations re: comprehensive care coordination.
    - In SPD group, DMJ said that there would be more specificity in contracts, but need to see what DHCS is thinking.
    - This is urgent for the SPD population, but also relevant for dual eligibles.

<u>MCOs/Organized Delivery Systems</u>

- Standardized assessment
    - Could use MSSP assessment. Even for BH, MSSP assessment would be adequate.
- One case manager
- One EHRS
    - CAPG: A lot of groups pre-invested in EHR (prior to ARRA) – there is some uniformity (Sutter is all on one platform) but still a lot of variation.
    - Solo practitioners have nothing. You have to apply by yourself (if you're solo), wire yourself up, etc. Who provides TA? A lot of solo practitioners take a lot of Medi-Cal but aren't even members of medical societies.
    - LA: mental health picked a platform, but every single mental health provider has to pick something to link up with it. Each picks their own. Money isn't a problem – everyone's getting money for it, but coordination is.
    - DHCS should be the lead on an EHRS
        - Trying to move on it within Medi-Cal – working with LA Care about how to deploy – but no focus on integrated systems for integrated care
- On IHSS issue: unanimity that there are no plan partnerships around IHSS.
    - A challenge is that you don't negotiate it locally – driven by SEIU at state level.
    - Maya Altman, HPSM:
        - Situation is different than in 2005 – hopeful that it can work
        - Orange County has AFSCME – but Orange less unionized anyway
        - One thing working through with SEIU is what actual practices can be changed?
            - Having the IHSS workers in the middle of the IDT is very important
            - Training piece is critical
            - Wages tied to training
            - Have some examples of programs in other states that show what personal care assistants can do
            - Part of it is survival – IHSS not sustainable in this budget.

        - If you had control of IHSS through your ACO, would it decrease home health costs? Similar conceptual issue.
- To what extent do the linkages that HPSM, IEHP have exist in other plans?
    - It's easier in COHS than in other models, arguably.
    - Thinking of it as a system is very helpful.
    - It's a leadership issue.

Group 2:

- MSSP
    - CDA's rules are prescriptive and inflexible on staffing, square footage, auditing requirements, prior requirement of a public health nurse.
    - Aging manages to DHCS and CMS requirements but they do not talk about how to more effectively communicate/collaborate.
    - One solution: counties could do pilots as incremental steps, such as convene MSSP Site Association to talk about how to make MSSP more flexible and integrated.
    - The combination of MSSP and managed care is inefficient in that 2 care managers for one client is inefficient. In a fully integrated system, the need for MSSP would go away, which is problematic, because MSSP has an advocacy role that the health plans don't have. There must be an advocate or navigator at the health plan level in the absence of MSSP.

- There are levels of case management based on individual consumer needs. One size doesn't fit all.

- There's a saying about practicing at the top of one's license. Why use a nurse to do something that a social worker or other can do? If the 510 MSSP clients in Orange County become members of CalOptima, there would be efficiencies of funding streams.

- IHSS

    - Assessment of beneficiaries discharging from a hospital can take 4-6 weeks. In an integrated system, health plans would have options other than IHSS from which to choose. In an integrated system, IHSS can be a vendored service either with IHSS, the public authority, or another entity. The concept of contracting out is a reality.

- There is not one right way to do things in California. We should define the essential services and how best to provide them. Some services may go away in a coordinated system.

- The state needs to build relationships – get people to quarterly meetings, establish councils. Local relationships = local solutions, and the state regulatory framework needs to recognizes that.

- To survive, HCBS providers at the local level need to work with managed care plans to establish different lines of business and funding streams.

- DHCS should mandate incentives – by paying COHS and managed care organizations for preventing ER visits, rehospitalizations, etc., through increased capitation for home and community-based services.

Group 3:

- DHCS should not eliminate money for support services.
- DHCS will need to include other state departments to make effective linkages. Though there is control by DHCS, there are still department silos: DDS, DSS, CDA.
- DHCS nurses do not understand the "social model" and they often countermand CDA's policies and/or more social model style of operating their programs.
- DHCS needs to apply flexibility to determination of "level-of-care." This is a civil-rights issue for people to determine where they live. The DHCS nurse determinations are inflexible.
- The state and plans must create clear lines of accountability and the only way to do this is through financing arrangements – this is the way to achieve care goals and savings.
- Small providers and doctors will not be able to accept full downside risk, but they can do a less-than-full risk incentive program.
- Treatment of moderate mental illness works with the standard medical model, which Medicare is designed to provide. The seriously mentally ill need a different model that is social support oriented, with strong community supports. Medicare does not do this – the state could address this if they took over the Medicare benefit or got a waiver to do it
- Long Term Care and Mental Health need the funding streams integrated into one plan.
- The state will need to protect support services if they are integrated to ensure that the funding and the care are not sucked out of the programs and capitation rates.
- Some states have successfully addressed this issue, including Bob Masters in Massachusetts and the Minnesota model. The Brandeis study of the original Dual Medicare Demonstrations in Minnesota, etc., documents these programs. The State should talk to these folks to ask them how they negotiated the hard issues.
- The people who have gone into managed care are happy, but those still in FFS who are fearful or managed care.
- Plans will need to create relationships with the key support providers.
- IHSS workers can be trained to do more complex semi-medical functions, but the state must find a way to get beyond the nurse "scope of practice" rules that keep IHSS workers from being allowed to perform these functions. The state may need a change of legislation or a waiver of the "Nurse Practice Act."
- DHCS should clarify HIPAA rules to its partners and providers so that these entities will feel more free to exchange information, which will improve care and

coordination. Plans like Kaiser have been good at doing this and that is a benefit of managed care.

- The state needs to explore how HCBS providers will be linked into Electronic Medical Records.
- When IHSS participants are carved out of plans, like SCAN, then the plan has to pay more for personal assistant services, the services are not truly self-directed, and the plans do not have the benefit of the "Nurse Practice Act" waiver.
- The disability rights community is fearful of eliminating siloed funding for support/HCBS because they believe the funding and rights will be eroded and sucked away – more difficult to protect. They have had to fight hard for these services for many years – under constant threat of cuts. But they do want better integration. From the plan perspective, the funding could be integrated with proper protections.
- DHCS needs to better enforce beneficiaries' rights

Group 4:

<u>DHCS Role</u>

Examples of issues for case management:

- Problems with lacking communication about available resources or being able to access them; critical for moving people along the continuum.
- Low MD reimbursement is an issue for access to specialty care. (Health plans pay what they need to in order to get access to specialists.)
- Low reimbursement for SNF's – can't get patients admitted.
- Would be great to have data on other services the patient is receiving – if the state is paying for a service, why doesn't the health plan have access to the information (e.g. mental health, LTSS)?
- The "cloud of benefits" a person is receiving should accompany them when they are enrolled in a health plan: the person-centered benefit package approach.
- AHDC a good example: one care plan, centrally managed.
- Clinical care management date would be useful as well. "Myth regs" prevent sharing of info (NOT in HIPAA).

What can the state do to improve the integration of IHSS?

- Certification of care provider would make them more of a resource to the care team (raise their level of skills so they are more than an early warning system).
- Could county help establish standards (a la NCQA)?
- If a population is being managed in common (across health plan and county) could they share care plan information, eligibility info, need for number of hours of care, assessment information?
- A shared assessment tool would be a good goal – or at least establish common screening tools across systems.
- Currently, systems use tools to screen people OUT of services; need to establish assessment based on need for services (whatever they are).

- In Health Reform, rebalancing pilots mandate elements that should be in place: single point of entry, common assessment tool, etc. One-e-App already in place for certain services (WIC, food stamps) – could build on that for eligibility to IHSS, MSSP, ADHC.
- Care plan would still need to be separate from assessment, but at least the common platform for determining HCBS eligibility would help.
- Suggestion to state: once the assessment form is agreed on, need to let go of requirements for other assessment tools to be done. Local ecology needs to be taken into account.
- Strong accountability needs to be built in – health plans have MOUs with community providers now, but requirements will have to be more stringent for link to providers.

Health plan role

- What can be done to incentivize health plans to provide more linkages?
- One model: could the state establish expectations based on tiers of need? For example, the state sets expectation that a certain percentage of enrollees will need IHSS, ADHC, etc., based on a corridor of need, then can check that those services are in place for clients within that corridor.
- FQHCs as organizing entities – could deliver a package of services.
- Services need to be organized according to individual needs. Plan held accountable for meeting the needs of the individual.
- Aggregation of payment will help to hold plans accountable. From health plan perspective, prefers to have assessment and care management at the provider or health plan level. Fundamental concept behind ACO or NC model – if you do a good job, you share in savings.
- To overcome challenge for social service providers, have a social care model provider within the health plan, and make sure the health plan values the social perspective.
- Is there a role for Health Information Exchange? E.g., to connect data from EHR to pharmacy, hospital, lab, radiology?
- New sentiment that people are more willing for health plans to take risk for HCBS.

Behavioral Health and Dual Eligibles

Cynthia Jackson Kelartinian, Heritage Clinic, provided a case study of a client. She also offered the following comments:

- With older adults, we often think just of depression and anxiety, but often it's serious persistent mental illness, complicated depression, or complicated anxiety, plus changing issues as Baby Boomers age –different kinds of substance abuse, for example.
- The prevalence of older adults with comorbid SA and mental illness ranges from 21% - 66% of those with SA disorders (somewhat lower when mental illness is the primary diagnosis). Heritage does not think of SA and MH as separate services.

- Clients have both long term and late-onset mental illness. Many have physical limitations and may be homebound, frail. Others are homeless or at risk of homelessness.
- Service gaps include:
    - primary care integration
    - dementia services integration
    - IHSS, MSSP, ADHC
- There is a shortage of good California research on the impact of field-based BH interventions on medical side costs. However, there are certainly savings to be found, if only because older adults often hospitalized in medical/surgical facilities even when the issue is MH-related.

Marty Lynch, LifeLong Medical Care, commented that since very few people are trained in geriatric mental health there are significant workforce issues in this field. Integrating MH and dementia care makes sense as population gets older. At LifeLong, they have trouble getting older people, and especially minorities, to accept MH referrals – warm hand-offs (to collocated services) are far more successful. This is true for everyone, but truer for older adults.

Suzanne Tavano, CMHDA, said that low/moderate MH needs should be separated from high MH needs. For people with severe mental illness (SMI), much more than medication is needed.

Michael Humphrey, Sonoma County IHSS-PA, commented on challenges in IHSS related to mental health. In a program designed to have the client hire, fire, and manage their own caregivers, individuals with SMI may not be able to do so. In Sonoma County, some managers on the PA staff help them manage: interviewing caregiver applicants, assisting with timesheets, etc.

Rick Slaughter, Molina Healthcare, said that many dual eligibles are young, and substance abuse is frequent. Washington has a successful program in this regard, working with community mental health providers.

Janet Heath, MSSP, said that until recently, her area had a geriatric network that provided home visits to people over 60 with SMI. Many people have issues identifying as having MI, but also had problems getting to the provider. That program was very valuable in that it had staff who understood the geriatric population with mental illness.

Marty Lynch, LifeLong Medical Care, said that his clinic is trying to allow the health care home to be the mental health provider. LifeLong puts a primary care provider into a MH agency that serves the elderly population, and can reach some people with MH problems who are older and don't go into medical settings.

Louise Rogers, Director, Behavioral Health Services, San Mateo County, and Member, BHI TWG, discussed San Mateo County's experience as a COHS for dual eligibles, and the outcomes of the BHI TWG. Her presentation is available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/RogersMay19_(3).ppt.

Penny Knapp, CDMH, offered these comments from CDMH's perspective:

- Philosophically, DMH supports parity. Federal parity law is going to rewrite the rules. It should make integration of care easier, but it will not happen tomorrow.
- Prop 63 has as a core tenet the integration of MH and health services. CalMEND, funded by MHSA $ to DHCS, has as a principle the integration of, and is launching a learning collaborative in 7 counties. Target patients are those with SMI and physical disease, among whom a number will be dually eligible.
- Under 1915(b) there's a narrow gate to qualify as SMI. For a variety of reasons, the SMH system is only seeing a fraction of the people with true SMI. For individuals who have dual eligibility, many SMH services are provided under the rehab option, and it's difficult to bill for them.
- The quadrant model is valuable, but it's important to remember that people don't stay in one place. We need a stepped care system that moves with the individuals as they get better (or worse).

Suzanne Tavano, CMHDA, noted that the SMH system provides services everywhere -- in police cars, under bridges, in schools – and not only in clinical settings.

Rick Slaughter, Molina Healthcare, said that the strict Medicare model of what MH treatment is does not align with what is most effective. A peer model may be best in some situations, but Medicare will not pay for it. One of the main challenges for the new CMS Center for Innovation or will be to address issues where the Medicare and Medicaid models need to be changed for maximum effectiveness.

Gretchen Alkema, SCAN Foundation, said that the role of law enforcement is important as a first line of defense and a major player, and as a cost center. Savings from improved BH services would accrue both in the areas of acute care and hospitalization but also in the area of law enforcement.

Brad Gilbert, IEHP, said he had been impressed by some of the data around the use of CBT and non-medical therapies for seniors, and asked whether county SMH programs were using these methods. Penny Knapp, CDMH, said that there is no incentive to use the evidence-based modalities. Louise Rogers, San Mateo BH, said that community mental health has made a substantial investment in evidence-based practices in most acute populations. There is a fair amount of CBT activity in the systems, but the most significant focus is on the most acute population and evidence-based practices that work for that group.

Brad Gilbert, IEHP, raised the issue of data-sharing, saying that IEHP has a terrible time getting information from county mental health. If SPD are enrolled in Medi-Cal the plans and county MH will have thousands of members in common, and no way to share information.

Richard Chambers, CalOptima, said that Orange County Behavioral Health has for many years contracting out services to Pacificare. United Health is not going to renew the Pacificare contract, so the county has asked CalOptima to take it on, and the new arrangement will begin in 6 – 8 weeks.

Cynthia Jackson Kelartinian, Heritage Clinic, said that there is good evidence for CBT, short-term psychodynamic, and interpersonal therapies in older adults, among others. Sometimes long term savings require costly services up front, and that is disincentivized in all systems.

Jackie McGrath, Alzheimer's Association, said that the original concept paper includes a reference to revisiting the mental health carve-out, and that she is encouraged that there is a proposal for experimentation with models. For people with dementia, realignment and carve-out were a double whammy, because they were not eligible for SMH. As dementia is better understood, it is clearer that there are mental illness issues as part of dementia, but since MH doesn't cover dementia people who experience it typically don't get a MH evaluation.

<u>Next Meeting</u>

Bobbie Wunsch, PHCG, thanked presenters and DHCS staff.

The final meeting in this series will be held on

- June 3, 10:00am – 3:00 pm, Sacramento Convention Center, Rooms 104-105.

Bobbie encouraged Workgroup members to send ideas for that meeting's agenda. The current plan is to focus on core elements in the context of a variety of organized care approaches. Some are in the CHCS paper, but the Workgroup is not limited to those models.

The meeting was adjourned at 3:00 pm.