CALIFORNIA COLLABORATIVE FOR LONG-TERM SERVICES & SUPPORTS (CCLTSS)

THE COORDINATED CARE INITIATIVE:
Informational Round Table Discussion
and Feedback on Changes in Governor's Proposed Changes
Held on February 17, 2017
At the Regularly Scheduled Meeting of the California Collaborative

Overview

The California Collaborative, which has been involved with the Coordinated Care Initiative (CCI) since its inception, held a meeting on February 17 to understand, comment and provide feedback regarding the action taken by Governor Brown to officially end the program and plans to re-configure it with new language in the state budget process. This is a summary of the discussions as well as the feedback given to the Administration and officials from the Centers for Medicare and Medicaid Services (CMS) who participated in the meeting.

Hilary Haycock, President of Harbage Consulting, Speaking On Behalf of the California Department of Health Care Services

The Department of Health Care Services (DHCS) has been working on the trailer bill language and is hoping to release something soon. The Department is not planning on making any significant changes to the program design beyond those made to the In-Home Supportive Services program (IHSS), which is a purely financial change. It will be a shift in rebalancing the cost from the state to the counties based on changes that occurred in IHSS that were not related to Cal MediConnect or the Coordinated Care Initiative. So that will be primarily what the trailer bill language addresses.
While the state and the counties will change the way that IHSS is financed it will not actually change the way the IHSS program will operate. The counties will still determine hours, beneficiaries will continue to be able to manage their own IHSS caregivers, and as

far as IHSS, Cal MediConnect and the CCI are considered, the department definitely still wants the plans to continue to coordinate with the county, with the county case managers, to include people on the care team as appropriate, and definitely continue to rely on the plans to help identify members who can benefit from additional IHSS hours and refer those folks to the county. The Department is releasing the finalized Health Risk Assessment (HRA) questions for LTSS referrals and those questions include risk factors that would make someone eligible for IHSS. So that's how the Department is approaching it. There aren't other programs design changes that the Department is intending to make. The MSSP program will continue as its been. That transition has been delayed and there's a whole separate process that is going on about what the integration of MSSP into the plans would look like.

In terms of stakeholder input on the language, I would say that it's not going to be any different than in the past in terms of stakeholder input, often the stakeholders will work with the department on language but the primary way that legislative language is debated and amended is the legislative process with hearings and talking to your legislators and submitting comments etc.

In terms of the policy question about care coordination: we're working closely with the plans on care coordination and trying to think through how it's all going. The plans are working closely with their interdisciplinary care teams. We think that there has been a lot of strides made towards improving care coordination and of course it varies by plan but it's all about improving communication and I think that's something that all the plans are tackling and working through. One initiative we feel has been very successful, and we want to thank the California Hospital Association, is our work with them on the hospital case manager toolkit. This is a very in-depth set of materials, presentations, and training that we've been doing with hospitals that are seeing Cal MediConnect patients. It is designed to help them understand how best to connect to the Cal MediConnect care coordination process take advantage of the care coordinators and case managers and all of the additional resources that are available to Cal MediConnect beneficiaries for those types of transitions of care. That is the kind of on-the-ground work that plans are doing with their providers to improve care coordination.

In addition, another of the things that we're doing more broadly to help people better understand what's happening in Cal MediConnnect is working on revamping the

performance dashboard. We're thankfully to have more data actually released. We know that's been a bit of a lag. So again, the program design is not changing. The budget proposal did not imply a program change. It really is to provide financing; there's no intended revamp of the care coordination process. That process is a topic that we're going to continue to work on with the plans in the best practices meetings.

Regarding unmet long-term services and supports (LTSS) needs in the program, the Department was very concerned by the unmet needs identified in the evaluation. That was definitely a part of all of the work that the Department announced in the 2015 comprehensive strategy for collecting data on LTSS referrals and this whole process we've gone through with the LTSS workgroup. The Department announced that they wanted to set some standardized questions in the HRA that would drive at LTSS referrals. Some drafts were released as part of the comprehensive strategy last year.

The overwhelming stakeholder feedback was that we really need to put together a workgroup and that it needed to be a more thoughtful process than just submitting comments. So we did put we put that workgroup together. It was composed of representatives from various agencies overseeing LTSS services, stakeholders from the LTSS provider community, stakeholder advocates, and of course the health plans. We brought in experts as needed on specific questions including Alzheimer's of Greater Los Angeles and Family Caregiver Alliance, to give us expert advice on specific questions.

The group went through a process of first identifying what the risk factors are for needing LTSS services, and then cross-referencing those risk factors with exiting questions in the HRA's. This robust process of really talking those through resulted in a really good set of questions. The workgroup really wants the plans to look at it as a suite of questions and not a one-off. There are some questions that should lead to a direct LTSS referral, particularly the questions at the beginning that have to do with the ease of living that are also directly correlated with needing IHSS or other types of SSP or other types of CBAS. But there are also questions that aren't necessarily a direct flag for needing LTSS services but that in combination with other factors puts someone at higher risk of needing LTSS Services. We think this is a really good approach, and that it captures beneficiary need in a broader context. We are providing that advice to the plans with the expectation that they will take these questions back and try to work them into their overall HRA's. The memo that was released today describes that process and

the risk factors. We took the questions developed by the workgroup and had them rewritten by a health educator to be more appropriate for beneficiaries, to be simpler and to meet standards of accessibility. With that memo, the department is going to be revising the Duals Plan Letter on HRA's.

These questions will also be used in the Medi-Cal plans serving seniors and persons with disabilities with managed long-term services and supports (MLTSS) in non-Cal MediConnect counties. We really are pushing the learning and the best practices out to serve the entire population. This is definitely something that the Department is concerned about. That is why we released the revised LTSS data requirements to the plans. It's just a little early, we don't have that data back to better understand how the processes are going; I'm also not sure that there really is plan data around social determinants like housing and meals. This is part of a larger process of trying to work together to rethink what a health plan needs to do to help beneficiaries with social determinants and move beyond the medical model into and connecting beneficiaries with those other services. The Department is definitely concerned about it and pushing the plans to be thoughtful about these things. One of the things that you see in any LTSS referral questions is trying to get at some of those social determinants and asking people about their financial security, about isolation and abuse and neglect.

That's all part of the process as we're moving forward. We are going to do a best practices meeting that will directly address these LTSS questions. We did one recently that was aimed at targeting care coordination to high risk enrollees -- we had some expert speakers come in and talk to the plans about best practices and had a presentation from the plans about their stratification process. The plans are continuing to get significant technical assistance in this area.

I think one big reason why the Department wanted the plans to be both Cal MediConnect and MLTSS plans if possible is because there are really important learnings on both sides. MLTSS-only plans are a little bit more limited in what they are able to do because they aren't directly contracted with the Medicare providers, so it's a little bit harder to do some of the coordination across those two different programs. That's the whole purpose of Cal MediConnect. But there's definitely an expectation that plans will be taking some of these learnings from Cal MediConnect and applying them in their MLTSS programs. The goal across the program for all beneficiaries participating is trying

to improve the coordination to ensure that they're getting services that are managed, and trying to move us all towards that towards whole-person care.

Kerry Branick, Deputy Director, Models, Demonstrations and Analysis Group of the Federal Coordinated Health Care Office, Centers for Medicare and Medicaid Services

How do we know if care coordination is working and how are we looking at that? At CMS we are in the process of working to release data on plan performance nationally across a number of different measures. It's not every measure that is being collected and monitored within the California plans, but it includes those measures that we're looking at it across the country.

I'm hoping that that data should be public in early spring and we will certainly give you a heads' up on that when we have a more definitive date. It will include the 2016 CAPS Results. CAPS is the Consumer Assessment of Health Care Providers Survey. It's a beneficiary satisfaction survey essentially. We previously released the results from 2015 but a number of the California plans didn't yet have sufficient enrollment to meet the threshold to be able to administer that survey and have a sufficient number of responses to have data that really give us any meaningful information in 2015. We just had a handful of those plans like San Mateo that started a bit earlier. In 2016 we have pretty comprehensive results across most of the plans except for Cal Optima, because the survey is administered in the first half of the calendar year and they didn't yet have sufficient enrollment. With the other plans, not only do we have 2016, but for some of them we can actually look at any changes from 2015 to 2016 and then we can look at comparisons nationally as well.

Overall, we're pretty happy with what we're seeing in California. A number of measures including these are composite measures (they're made up of a number of separate measures that roll up to something more comprehensive). In metrics like getting needed care, getting appointments and care quickly, we saw a general improvement across the plans from 2015 to 2016 and for several of the plans a pretty significant jump in improvement. There is a care coordination composite measure but in addition to that we added supplemental questions for Medicare/Medicaid plans more specific to our population to the survey that for now we call the "care coordination supplemental" –

we will probably have a better name when we release it publicly. On that measure in particular we saw a pretty meaningful improvement from 2015 - 2016 as well.

Nationally one of the measures is a rating of your health plan: *On a scale of 0 to 10, how happy are you with the services that you're receiving?* Two of the California plans are among the top five Medicare/Medicaid nationally, San Mateo and Inland Empire. It's nice to see a couple of California plans at the very top. Most of the California plans grade quite well with those measures as well. That data will be part of the larger suite of planned performance data that we're looking forward to releasing soon.

Athena Chapman, Vice President of State Programs, California Association of Health Plans

I think one of the most important things that the plans report is happening are the new relationships that have been built. This includes relationships with hospitals; allowing health plan staff to be located there so that they can transition or divert people from inappropriate ER use, as well as working with community-based organizations and social services providers who can help with social support needs. We really don't want to lose any ground with these relationships. We see the changes to the CCI as strictly financial, and not actually changing how IHSS is run. But it is a priority to maintain the relationships that have been built with the county and the IHSS programs to make sure that we are working together as much as possible, in order to continue integration of services.

We are also waiting for the MSSP transition to happen when it is determined to be appropriate: I think you know we have worked hard and we don't want to lose any ground in that area either. We continue to build on what we have. It takes time. I think this year we talked about the fact that we're not in the pilot phase anymore but I would argue we're still in the pilot phase. The reason for the extension was that there hasn’t been enough time yet to really determine if all the demos have been effective and I think that's fair. It takes a long time to build those relationships one-by-one to change health plan culture and policies as well as system provider behavior and beneficiary behavior, and we're just starting to see that tip. We're really thankful to have another couple of years to really figure out more best practices and think about what we do

when we get to the end of that two years. We have to think about how we make that a permanent part of the Medi-Cal program as well as Medicare.

We're looking forward to having more data. I think it was compelling when we did our legislative meetings with the administration for them to see we have at least some directional data about where beneficiaries are receiving services. The care coordination is not perfect but that is why it's a pilot, and we're hoping that we can continue to grow and learn. We don't want people to think because IHSS was taken out or the poison pill language was pulled that somehow that means plans are going to take a step back. They really want to still keep moving forward on the care coordination.

We are aware there are a lot of unmet needs, and plans have been working hard to meet them. The SCAN Foundation has provided a grant that enables the plans to meet to share strategies and learning. We started meeting quarterly and now we're trying to meet every other month. I bring the plans together and talk about best practices, how they collaborate, and what they can learn from each other. Housing is a big unmet need that's really difficult. You can't help somebody adhere to their medication if they don't have housing and they don't even have a place to keep their medication. The plans are very aware of that. They're trying really hard to figure out how to meet those needs.

Again, it's a big cultural shift for a plan to be worrying about food stamps and housing and all these things. We've seen some great relationships be built. We obviously have some plans that have been faster than others, that have been more involved with their county previously, and maybe had previous relationships that helped expedite that process. They're all doing it, but one by one. It's one beneficiary at a time. Because the needs are so unique you really have to think about how does a plan move this person; the next person may be similar but not exactly the same. We've really got a lot to work on but I think there are some good indications that we are moving in the right direction.

The HRA'S are a good measure of initial contact with the plan. What I've heard from the plans at our last Collaborative meeting was that the focus on the HRA's publicly as a measure of how we're doing is a little frustrating. It's a good measure of one piece but it's really just checking a box. If you really want to know if the plan is actually delivering on that promise, you have to look at the individual care plans that came out of that HRA -- did the person actually get what was identified in their individual care plan and their

needs? That's a lot harder. It's not going to be easy to aggregate. It's much more of a quantitative, more laborious analysis.

We're just trying to tell the story as much as possible, that there really is more than just saying whether the HRA was completed or not. Some beneficiaries also don't want to complete it, so there are other reasons besides the plans just not doing it. We want to make sure that participants get what they need so we are continuing to build in this area.

We've found that the learning collaborative is a great place for the plans to get together. We brought experts from other states where they have MLTSS plans to come and talk about their best practices. Plans found that really interesting and useful. We've also had the National Committee for Quality Assurance talk about how they are developing measurements related to MLTSS; we are giving input on the front end to ensure that what gets measured is what matters. We want to make sure that they're aligning their measurements with what really impacts the members so that we can show results.

Several of the plans who participate are not in CCI counties. There are some MLTSS across the state in varying degrees but in the seven CCI counties is where it's really complete, you have it all. Those plans in other counties take those lessons and can apply them to other kinds of services. For example, plans like Anthem or Health Net that are in several counties across the state are obviously leveraging those lessons learned even in non-Cal MediConnect programs. We can build on that and we think we will increase access to MLTSS as time goes on. The MLTSS footprint can be confusing because of CBAS and lots of other things that are being rolled into MLTSS over the time in county by county. Right now, some have long term care and some don't. It's important to know that there is more going on than just CCI but that is really where the focus has been -- how do we pilot it and improve it and then it can be expanded to other counties.

Finally, we're continuing our actuarial work, we have contracted with Milliman again to do a deeper dive and provide a comparison of our results to the Medicare 5% sample, to see how we're doing and think about how we can use that data to further tell the story. We are focusing on emergency department costs and long-term care costs and hospital admissions, because that's where the state wants to see the reduction. What we are

hoping to see is that where these costs are reduced you will be able to tie it to more MLTSS received in order to support community living. We're continuing to evaluate; we're interested in the focus group results. We continue to build on what we know so far about the beneficiary experience and think about how we can improve that going forward.

Amber Christ, Senior Staff Attorney, Justice in Aging

Before the Governor came out with his budget proposal, rumors were circulating that the state was going to move forward and terminate the Coordinated Care Initiative in order to make the IHSS funding arrangements. The rumors were that no matter how the numbers were cut, plans weren't going to be able to make up that cost that the state had taken on with the IHSS financing arrangement. I think we came into the budget thinking that the entire CCI delivery system reform might be abandoned to just undo the IHSS maintenance of effort, and really not on its own merits. In that case, the elimination of CCI wouldn't be based on the goals of the program, either meeting health system savings targets or meeting the goals of rebalancing from institutional settings to home and community based settings. The most alarming development we feared from a consumer advocacy position was that there wouldn't be a plan to replace the delivery system and there would be no ongoing commitment to care coordination, and that it would be hugely disruptive to beneficiaries who are enrolled in the program.

In a way it seemed a little bit like the Affordable Care Act in a microcosm, a major program repeal with no plan for replacement, particularly because consumers would have to undergo a transition to something new but there wasn't anything new to transition into. We didn't think that the Department would have the bandwidth to adequately develop a transition plan and that in the end, beneficiaries being harmed.

This is particularly the case because the Department has a lot of things going on. There are the federal threats obviously, but there's also the coordination efforts that are happening at the state level including the 2020 Medical waiver, the Whole Person Care pilots, dental transformation and the Health homes program. With all of these different coordination efforts that the state has taken on, we didn't think that there would be the ability to develop a transition plan that would help move people out of the Coordinated Care Initiative program. So, we were just a bit relieved to see the actual details, and that

the Governor's budget proposal to continue the commitment to delivery system reform thru the Cal MediConnect program with no major changes that beneficiaries would really feel as a result of the transfer of IHSS funding to the counties.

From our perspective now that we have seen the Governor's proposal, the overall delivery system and the coordination shouldn't really change from for beneficiaries on the ground. That's not to say that we don't think that there are significant areas where the Coordinated Care Initiative needs improvement. There are major areas that need improvement and we want those to be addressed. However, we're somewhat reluctant to push for those changes through the trailer bill, mostly because we think that there is a huge risk that in pushing for major policy changes through that process, could open the entire CCI open to re-litigation. We could see a lot of things come in that as consumer advocates we might oppose, or it could open up so far that there will be no general consensus and we could see the whole thing go down the drain because we can't come up with some sort of new legislation to get it passed.

So we are proceeding with caution. We want to wait until the trailer bill language is actually released and if there's language in that trailer bill that we oppose we're certainly going to make our opposition known. There are also items that we could push for in the event that there are opportunities for improvement, and we would take that opportunity to push for things. Examples include stronger care coordination standards, the delegation issues that we've seen, dealing with rates, and ensuring appropriate incentives for rebalancing are in place, as well as specific reporting requirements. All of those things would be on our wish list to include. Ideally, we would be working collectively to develop those policies with regard to the Coordinated Care Initiative, but perhaps not through the budget, which is kind of a pressure cooker process.

A clear example is that of this is that because the CCI came up through the budget process in the first place, it included the poison pill language. So it is not a very effective means of developing health care policy. We're also seeing that play out at the federal level -- the budget process isn't where we should be making good health care policy. So we're waiting until we see that trailer bill language and proceeding with caution.

On the IHSS component, we are tracking that separately and are concerned that that shift of cost from the state to the counties could be harmful and have unintended

consequences. I think that the Governor's budget proposal did tacitly recognize that the counties couldn't absorb that high cost. We're hoping that the Governor started with his worst-case scenario and that counties have some wiggle room to offset and lessen or mitigate the amount of money that they're going to be responsible for. IHSS is a mandated program so they can't really reduce IHSS, but we still worry that administratively there may be delays in administering the benefits and that other programs that the counties administer could be harmed in that process. We're tracking the IHSS and county cost shift separately and plan to advocate to ensure that beneficiaries aren't negatively impacted.

Susan DeMarois, State Policy Director, The Alzheimer's Association

I am speaking for a number of organizations who are weighing in on the CCI proposal. It is not a perspective of the entire Collaborative but represents a significant number of the membership, so there are overlapping issues and concerns.

We believe there's a delicate balance looking at the reality that the CCI was created in the budget process. We are now entering our 6th year and there has not been a legislative opportunity to have that more thoughtful conversation. The Assembly Aging and Long Term Care Committee has been meeting since the fall and has created a series of workgroups. One of the groups was tasked with looking at long term services and support infrastructure; that group also anticipated the elimination of CCI and changes to the program. We started by looking at how Cal MediConnect could remain viable in that event, as well as some of the opportunities in the budget to strengthen the program with the recognition that Cal Mediconnect is a model for other counties outside of the seven counties.

That group identified opportunities in the budget process to get some clarity around Cal MediConnect, as well as some transparency. I have circulated our draft letter. The four areas we identified are: 1) Strengthening care coordination; 2) Ensuring access to home and community-based services; 3) Maintaining choice in enrollment options with regard to PACE; and 4) Focusing on developing an LTSS infrastructure plan.

The overall context in which the work is proceeding is missing, especially from a statewide perspective, because our conversation has been so narrowly focused on the

seven Cal MediConnect counties. The Health Risk Assessment would be one example. This was reinforced while listening to the stakeholder call yesterday and hearing the importance of the Whole Person Care pilots about the standardized assessment. It is only yesterday that we have seen the draft recommendations for this five-year-old program that is still a pilot and a work in progress, and the assessment is still evolving.

Our letter is intended to help it evolve to all counties, and to engage the Legislature; many who care about our population and many who are new and unfamiliar with it. Our concern is that the haste of the budget process, new members and champions for our population will miss the opportunity to act in the best interests of beneficiaries who need LTSS. Anyone who wants to know more about this letter, reach out to me. We'll be formally inviting Collaborative members to join us in signing the letter.

Additional Feedback and Input from the Collaborative

Lydia Missaelides

Thank you to everyone who presented this morning for a really valuable conversation. On the point of referrals and care coordination, I did participate on the LTSS standards workgroup, and we still have not faced a fundamental flaw in the MLTSS structure and particularly for our CBAS programs that have had a mission for 40 years to serve duals. The foundational problem is with financial incentives, because the health plans who are financed outside of Cal MediConnect have a disincentive to make referrals for LTSS. We're not seeing referrals. Part of the problem as we talk to our health plan partners is that financially they have no incentive because they're not at risk for the high cost care of duals; that is all on the Medicare side. Athena and I and our members can't solve this problem on our own. We have to keep talking about it because we've got disincentives for a LTSS referrals not just for CBAS, but for other community-based services where plans are not at risk. As long as this persists, we will not see appropriate LTSS referrals.

Laurel Mildred

I noticed that the California Center for Health Care Strategies released a memo today, discussing how Massachusetts has just launched a new Accountable Care Organization program that combines provider-level shared savings and capitated payment arrangements with explicit incentives to address social determinants.

Lydia Missaelides

We have had many conversations with health plans about value-based pilot projects. They love with what we're doing with our Community-Based Health Home. However, at this point we are not in a position to enter into a value-based contracting. It's more workload for them, they don't see the return on investment. So we are really kind of stuck until there is appropriate alignment of financial incentives for the plans.

Athena Chapman

The incentives have to be aligned and there are some plans more worried than others about the IHSS being taken out even though it was just a financial decision. We have to make sure that there's still the incentive there to coordinate. IHSS is just one example but it's true across all the services and all the things that we're talking about. We want the incentives to be aligned as much as possible and plans have been supportive of more integration, including Medicare. To the extent that the plan doesn't have the ability to incent a provider or a member to act a certain way then we don't want to be held liable. If our hands are tied, how we incentivize them? And then we can't say, "Plan you aren't doing that," because we can't force people to act in a certain way.

Peter Hansel

In terms of incentives it really comes down to outcomes. From a plan perspective, I would think, you are at a risk for the outcomes and you are at a risk financially and that is the ultimate incentive.

Sue North

One perspective that we don't have at the table today is the counties, and it worries me greatly because the match on Whole Person Pilots comes from the counties 100 percent, and we could be chasing our tail here. I'm not sure whether it's the right time to ask the question but clearly we need the voice of the counties, to tell us from their perspective what's going on and if they're engaging with the state on finding a funding mechanism that will allow this cost-shift not unravel other things.

Athena Chapman

We are obviously happy that our portion of the CCI was continued in the budget, but we are also very concerned about the counties. They are our partners in lots of ways and

we want to be supportive of any solution that can help with that. We realize that the big budget hole is for them.

Susan DeMarois

Looking at the Health Risk Assessment recommendations that came out yesterday, we were surprised that cognitive impairment was listed in Tier Two, and that it's considered a contributing risk factor instead of a stand-alone risk factor. All of the utilization data that we have seen in our experience working in Cal MediConnect with our federal Administration on Community Living grant would suggests that cognitive impairment is the primary driver of LTSS services, and it's a major risk factor for hospitalization and nursing homes placements. We were surprised to see that it was listed in Tier Two and we are concerned that under-detection and recognition will persist. As we have seen in our grant work, health plans and providers will be surprised when they discover people with cognitive impairment in the emergency room and the cycle of discharging to a nursing home and shutting the door on home and community-based services will continue.

Hilary Haycock

Just because it is listed as a secondary risk factor does not mean that we do not think the plans need to take it into account. We really see this as a holistic approach.

Marty Lynch

I want to address care coordination. We lost an issue from the agenda earlier on, which was making care coordination an actual benefit with an actuarial rate attached to it for the plans, versus something administrative they do as coordination of benefits. We don't see the ability for every member who needs care coordination to get it. It's kind of up to the plan and of course there are incentives to manage. When it comes to social determinants we would be in a better situation from the consumer point of view if care coordination was actually a benefit that members have entitlement to, and was identified with an actual rate cell in the plan's rate.

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