April 3, 2015

California Department of Health Care Services
Waiver Renewal
Attn: Mari Cantwell
PO Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

The SCAN Foundation (Foundation) welcomes the opportunity to comment on California's Medicaid Section 1115 Waiver renewal application – hereinafter referred to as Medi-Cal 2020 – that was submitted to the Centers for Medicare and Medicaid Services (CMS) for consideration on March 27, 2015.

The Foundation is dedicated to advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. Medi-Cal 2020 embodies critical principles that seek to improve California's health care delivery system through three core components: 1) delivery system transformation and program alignment across the continuum of care; 2) shared savings with the federal Centers for Medicare and Medicaid Services (CMS); and 3) a redesign of reimbursement methods for California's public hospital systems. In particular, we appreciate the emphasis placed on meeting consumers' needs by addressing health care needs as well as long-term services and supports (LTSS), behavioral health, housing and others with an emphasis on the role of care coordination in achieving the desired objectives.

Our comments below focus on the role of care coordination, assessment, and performance evaluation in achieving Medi-Cal 2020's core objectives.

Care Coordination for High Risk, High Utilizing Populations*:* Domain 2 of the Public Safety Net Transformation and Improvement Program (page 18-20) recognizes that care coordination is a fundamental element of delivery system transformation, particularly for high utilizers of care. Given the critical role that care coordination plays in service delivery system, we believe that - first and foremost - the state should establish care coordination guidelines and strong accountability standards for all related elements of Medi-Cal 2020. Further, the state should specify where and how an individual can access care coordination, identify which entity(s) is/are responsible for ensuring this access, and establish an appeals process in the event that

needed care coordination service is not delivered. Specifically, we recommend the following considerations be taken into account regarding care coordination and related issues.

- *Develop a Common Definition:* We recommend that the state define what constitutes care coordination, as multiple definitions exist across departments.
- *Ensure Access to Care Coordination for High-Risk Dual Eligibles:* For most vulnerable older Californians, their first interaction with LTSS often begins with a trip to the hospital. A report from California's Medicaid Research Institute (CAMRI) shows that this experience is particularly true for individuals covered by Medicare and Medi-Cal. The findings show that health systems have an opportunity to change the trajectory of care for those at risk for hospitalizations by identifying these individuals with LTSS needs in a timely manner. Targeted care coordination is the cornerstone to improving care for people while lowering delivery system costs. This means having the staff and operational models to properly screen for potential high-health care use, and identify those who have a need for further evaluation in real time.
- *Target Services and Role of Assessment:* A recent report by Avalere Health describes the value of (1) targeting services based on a comprehensive assessment, and (2) implementing person-centered care coordination. While this report focused on a high-risk Medicare population, lessons learned can be applied to the Medi-Cal and dually eligible populations in managed care systems that use risk assessment tools to define need. The research demonstrated that an enhanced health risk assessment (HRA) used by Medicare plans that assesses medical, social, and functional needs can be used to identify individuals who could benefit most from care coordination. This research also analyzed the return-on-investment (ROI) for various care transition and care coordination models when targeted to high-cost individuals, and found that each model studied resulted in a positive ROI.
- *Leverage Current State Universal Assessment Efforts:* For individuals in need of LTSS, care coordination should be driven by the results of a standardized assessment process to appropriately target services to their distinct needs, including functional need. Universal assessment is the basis for sound care planning across a range of providers to which a consumer needs access. California has started the difficult, yet critical task of developing a universal assessment. The state needs to shepherd this body of work to completion as it is vital for transforming the integration of health and LTSS systems.

Access to Housing and Supportive Services Program (pages 24-26): This program would reimburse managed care entities for a new set of tenancy-based care management services for targeted at-risk beneficiaries, to be delivered in partnership with Medi-Cal managed care plans. The state anticipates that Medi-Cal managed care plans will see cost savings through this approach, and can then reinvest in the necessary supportive services. We are pleased to see the state recognize the critical role that housing and support services play in keeping people in the community, avoiding institutionalization, and in their transitions from institutional to home and community-based settings. As such, we offer the following suggestions.

- *Clarify Relationship to Other 1915c Housing/Support Service Programs:* We recommend clarifying how these housing and supportive services relate to other services offered under California's Medi-Cal home and community-based waiver programs, including the Assisted Living Waiver and the Developmental Disabilities Waiver. Several of the services mentioned are similar to those offered under these 1915(c) waivers, and we believe such services could be consolidated or expanded under Medi-Cal 2020.
- *Allow for Tenancy-Based Care Management Services:* We recommend that the state clarify what constitutes tenancy-based care management services and care coordination. Further, the proposal indicates that the level of care provided would be tiered based on the level of acuity and need of the individuals. We recommend clear guidelines as to what constitutes care management/care coordination across the tiers of need as well as clarification for which entities are responsible to deliver services.
- *Create Meaningful Access to Non-traditional Services:* The proposal indicates that managed care plans may pay for non-traditional services (e.g., nutritional services, continuous nursing, personal care, habilitation services) to the extent that such services improve health outcomes and reduce reliance on institutional-based care. This approach appears similar to what is offered under the Cal MediConnect program whereby plans are given the option of providing "Care Plan Option" services to reduce the overall cost of care. We recommend that the state analyze data from the existing Cal MediConnect plans to determine the extent to which these optional services have been delivered, and what impediments may be preventing plans from delivering such services today.
- *Apply Best Practices:* The Health Plan of San Mateo has developed an innovative housing project in partnership with the Institute on Aging and Brilliant Corners, a housing services provider. This partnership has successfully identified housing for individuals transitioning from institutions to the community, as well as individuals at risk of institutionalization by providing access to housing and the accompanying social supports, including care coordination. We recommend that Medi-Cal 2020 build off this model, identifying potential for replication and expansion under the 1115 waiver.

Regional Integrated Whole Person Care Pilots (pages 27-28): Through this program, regional partnerships would provide "whole-person care" for high need patients, coordinating care through individualized care plans with access to all needed services across the continuum of care. The Foundation believes that care coordination models that include person-centered care and use of a comprehensive assessment offer a more organized care delivery experience, increase beneficiary engagement, and create better health outcomes. Key components of person-centered care are inclusion of the individual as an active member of their care team where the individual directs their care to the extent possible, as well as inclusion of his/her family caregiver when requested by the individual. We are pleased that Medi-Cal 2020 acknowledges the value in developing individual plans of care in addressing a range of needs, and offer the following recommendations.

- *Incorporate Non-Medical Factors in Assessment Process:* Plans would be responsible for identifying an individual's range of needs through the assessment process, which will

then inform the individualized care plan. We recommend that the assessment incorporate medical and non-medical data to more fully understand the varied needs of individuals. Based on findings from the Avalere Health report, *Effective Management of High-Risk Medicare Populations*, Medicare managed care plans currently have the ability to assess for both medical and non-medical characteristics (e.g., functional ability, cognitive impairment, behavioral health, lifestyle, and social support) through the HRA process. Collecting both medical and non-medical information provides a more comprehensive picture of the individual and helps providers improve care while lowering cost by better targeting high-risk beneficiaries for care coordination activities.

- *Develop Integrated Data Systems:* Gathering data is critical to understanding how consumers have accessed services, and how service delivery improves under these pilots. To this end, we encourage the development of a data system that includes self-reported outcomes, accommodations, preferences, and naming of the caregiver(s) as a part of the delivery system. Additionally, we recommend the development of a data system that collects and manages both quantitative and qualitative data that can be used to inform an individual care plan and evaluate quality of care. Further, we recommend the development of data systems that give individuals the opportunity to decide how and to whom their health information is shared. For example, this recommendation would allow the individual to identify the members of his/her personalized care team (doctors, specialists, LTSS, mental health, etc.), and then designate who has access to what information, including family caregivers.
- *Build on Lessons Learned in the Coordinated Care Initiative (CCI)*: Managed care plans have confronted a number of challenges in completing HRAs for enrollees in the CCI, with a low completion rate to-date. Because the HRA and assessment process is a central component to this initiative, we recommend that the state consider lessons learned from the CCI and apply them to Medi-Cal 2020.

Performance Evaluation/Evaluating Quality: Proposed payment reform strategies outlined in the proposal include pay-for-performance (P4P) and shared savings in managed care (page 15) based on obtainment of core quality metrics and optional measures reflecting plan member population and provider readiness.

- *Evaluate Quality in an Integrated System of Care:* We recommend that the state consider the role of quality in an integrated person-centered system of care. At present, there are no established measures for integrated systems across the continuum including home and community-based LTSS. The National Committee on Quality Assurance is in the process of developing quality measures to apply to integrated person-centered systems of care. In the absence of such standards, we recommend that the waiver should include a goal to create quality measures for home and community-based service and person-centered care.
- *Utilize quality measures that are Relevant to the Person:* Existing quality measures are typically driven by the care system's needs and values, and not those of the individual. As such, quality measures need to shift from measuring the system's vision of success to

measuring the individual and their family's vision of success. Quality measures should be developed to measure against an individual's goals over time in relation to their environment.

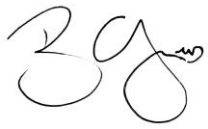
Workforce Development: Medi-Cal 2020 recognizes that in order to achieve better outcomes through whole-person care, the Medi-Cal provider workforce must become more integrated and coordinated across the full spectrum of services: physical health, mental health, substance use disorder services, and long-term services and supports (pages 22-24). Medi-Cal 2020 outlines a number of strategies to achieve this goal, such as integration, team-based care, enhanced provider participation, and training.

We appreciate the recognition of non-physician providers in the service delivery system, and recommend that this definition be expanded to include the unpaid family caregivers who are often the forgotten workforce of the health and LTSS system. Nearly 6 million unpaid caregivers – typically family and friends – provide LTC in California, valued at $47 billion annually. Despite the strength of California's In Home Supportive Services (IHSS) program, there are Medi-Cal recipients who do not qualify for IHSS but for whom family caregivers are critical partners in service delivery and who sacrifice jobs and income to provide care. Therefore, the needs of all family caregivers, including those providing care under IHSS, must be addressed in order to support the population's workforce needs.

- *Incorporate Family Caregivers as Part of Care Delivery Team:* We recommend the state focus on engaging the family caregivers as part of the care delivery team, which could include:
    - Identifying caregivers in medical records; and
    - Assessing caregiver needs as part of developing a comprehensive care plan.
- *Facilitate Development of Targeted Training*: Medi-Cal 2020 includes voluntary training, and in some cases certification, for a range of non-physician health care providers to help improve their skills or gain new skills as appropriate. We recommend that training opportunities and other incentives include the unpaid family caregivers in recognition of their role in service delivery. This training could include developing targeted training for unpaid family caregivers that seeks to develop skills for supporting loved ones at home.

We appreciate the opportunity to comment on the proposal and look forward to continued partnership with the state in meeting the objectives set forth in Medi-Cal 2020.

Sincerely,



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