**Olmstead Advisory Committee Meeting**

**August 30, 2012 Meeting Summary DRAFT**

##### Department of Rehabilitation, Room 242

721 Capitol Mall, Sacramento, California

**Members Present:**

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| Brenda Premo, Chair  Tony Anderson  Pat Blaisdell  Mareva Brown  Howard Chavez (by phone)  Deborah Doctor  Nancy Hall  Robert Hand  Barbara Hanna  Michael Humphrey  Mary Jann (by phone)  Kathy Kelly (by phone)  Eileen Kunz (by phone)  Lydia Missaelides  Sunny Maden | Nina Nolcox (by phone)  Marty Omoto (by phone)  Elsa Quezada  Teddie-Joy Remhild  Theresa Renken  Michelle Rousey  Ellen Schmeding  Tim Schwab  Richard Smith  Robert Taylor  Greg Thompson  Ed Walsh  Kate Wilber  Kathie Zatkin (by phone) |

**State Staff Present:**

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| Secretary Diana S. Dooley - *California Health & Human Services Agency*  Director Toby Douglas - *Department of Health Care Services*  Director Tony Sauer - *Department of Rehabilitation*  Director Lora Connolly - *Department of Aging*  Director Will Lightbourne - *Department of Social Services*  Director Terri Delgadillo - *Department of Developmental Services*  Jane Ogle - *Department of Health Care Services*  Megan Juring - *California Health & Human Services Agency / Department of Rehabilitation*  Eileen Carroll - *Department of Social Services*  Kiyomi Burchill - *California Health & Human Services Agency* |

**Agenda Item 1: Introductions**

Brenda Premo, Committee Chair, welcomed members and announced a new appointment to the Committee, Mareva Brown, Chief Consultant, Senate Human Services Committee. Committee member Howard Chavez announced on the phone that he would like to make some early remarks because he was unable to stay for the entire meeting. Howard requested that the Committee collaborate more to find solutions to improve health care treatment and diverse health care needs. Brenda Premo called for introductions of members and staff.

**Agenda Item 2: Welcoming Remarks**

California Health and Human Services Secretary Diana Dooley called for a review of the minutes from the March 29, 2012 Committee meeting. The minutes were accepted with no revisions.

A moment of silence was held to acknowledge the passing of member Sunny Maden’s son, Marc Maden, who was a resident of Lanterman Developmental Center.

Secretary Dooley recapped the adopted 2012-13 state budget.

Secretary Dooley described the Let’s Get Healthy California Task Force. In May, Governor Brown issued an Executive Order to establish the Let’s Get Healthy California Task Force. The task force currently consists of 45 members with the goal to make California the healthiest state by the end of the decade. The task force is in the process of determining the best way to measure this goal. Once they know, they will begin to set targets to reach the goal.

Secretary Dooely announced that pursuant to the priorities the Committee has previously discussed, the Committee has established three workgroups, on Data, Housing, and Transportation.

Secretary Dooley announced that the California Health and Human Services Agency recently applied for a grant to expand the Aging and Disability Resource Connections (ADRC). If successful, California could receive over 4 million dollars over the next 3 years. Grant awards will be announced in September 2012.

Toby Douglas, Director of the Department of Health Care Services (DHCS), reported on the transition of Community-Based Adult Services (CBAS). Just under 80% of class members have been found eligible for CBAS. DHCS built upon the existing fair hearing process for eligibility appeals. The transition of CBAS participants to managed care has been completed in the County Organized Health System (COHS) Counties. In 2-Plans and Geographic Managed Care (GMC) Counties, the transition will begin soon. DHCS has been educating beneficiaries about the transition to managed care, and especially educating them that this does not affect their Medicare benefits.

Jane Ogle, Health Care Delivery Services Deputy Director at DHCS, stated that this question on Medicare benefits keeps coming up. By November 1, everyone who wants to change to Fee-for-Service benefits can. DHCS is doing outreach through centers and physicians instead of yet another letter. They also have a website: [www.calduals.org](http://www.calduals.org).

Committee member Robert Taylor suggested that the Department of Developmental Services (DDS) should add a link that will take consumers directly to the [www.calduals.org](http://www.calduals.org) website.

Toby Douglas discussed California’s application for the Section 811 Rental Assistance Demonstration. DHCS has submitted a proposal to the United States Department of Housing and Urban Development (HUD) to provide rental assistance to individuals transitioning from nursing facilities to the community. This grant would provide rent for 335 2-bedroom units. DHCS continues to rebalance between community-based care and institutional care for seniors and persons with disability. One of the challenges DHCS has experienced is the availability of affordable housing for those in nursing facilities who are ready to return to the community.

Will Lightbourne, Director of the Department of Social Services (DSS), reported on the Case Management Information Payrolling System (CMPS) and Community First Choice Option (CFCO). The pilot for CMPS began at the end of July in 2 counties. Non-pilot counties will transition in December. The state plan for CFCO was submitted last December. The plan went through two periods of questions. The regional office sent a recommendation to Washington and DSS expects to have a response by September 1. If the response is positive, it will provide $300 million to California. This money is already accounted for in the budget and is not new money. CFCO will enhance Medi-Cal's ability to provide community-based personal attendant services and supports to seniors and persons with disabilities to certain enrollees who otherwise would need institutional care.

**Agenda Item 3: Coordinated Care Initiative: Vision, Summary and Roles**

DHCS Director Douglas and DHCS Deputy Director Ogle provided an update on the Coordinated Care Initiative (CCI). DHCS is working with Centers for Medicare and Medicaid Services (CMS) on the Memorandum of Understanding (MOU) for the Dual Eligibles Demonstration. The MOU is expected to be finalized roughly by the end of September 2012. They are still considering staggering Medi-Cal and Medicare components. No decision has been made on this yet. The draft transition plan was submitted and DHCS is soliciting stakeholder feedback.

DHCS reported it has held approximately 25 public meetings since April, and has been innovative in its stakeholder engagement through emails and Twitter updates. Stakeholder input has led to important changes, such as identifying populations that should be eligible for passive enrollment in the demonstration. DHCS made adjustments and now is estimating now that enrollment will be closer to 500,000 people in eight counties. Implementation will now occur no sooner than March 1, 2013 and no later than June 1, 2013. Through stakeholder input, and under the Secretary’s leadership, several state departments have joined forces—DHCS, DMHC, DDS, CDA, DOR—to coordinate work. There will be regular reports to the Legislature on a transition plan, readiness, and ongoing monitoring.

DHCS is also ramping up efforts to educate beneficiaries and providers about the upcoming changes. DHCS has learned that community-based outreach is critical and it will be a priority moving forward.

DHCS is still sorting through all of the people that may be eligible, but it is anticipated to be about 500,000 – 550,000. After finalizing the MOU, DHCS will determine enrollment strategies and plan readiness.

Committee members commented on the importance of informing hospitals, providers and local physicians about the transition. Deputy Director Ogle ensured the group that DHCS has started provider outreach that includes bi-weekly phone calls. Because it is so important that questions are addressed in person, DHCS is in the process of developing a provider outreach calendar where DHCS can provide on-site information to providers, associations, medical office managers, etc. DHCS welcomes any input on ways to provide educational outreach.

**Agenda Item 4: Coordinated Care Initiative: Long Term Services and Supports**

DSS Director Lightbourne discussed the transition of In-Home Supportive Services (IHSS) to a managed care benefit through the Coordinated Care Initiative (CCI). Currently, the eight counties in CCI represent 65% of IHSS recipients in California. DSS and the eight counties are working with DHCS to determine the scheduled timing of how these individuals will transition into managed care. The scope of services under IHSS will remain the same for the recipient. The recipient retains the right to hire, fire, or retain a provider; appeal denial of services; and request reassessment. The county will be responsible for conducting assessments and developing MOU’s on how they will interact with managed care health plans. The hope and expectation is that the managed care plans may refer to the counties for the assessment for authorization of services. Other support services can be provided outside of IHSS to avoid institutionalization kinds of care.

Counties are given flexibility to maintain contracts with the IHSS public authority. Local authorities will retain function of registry and conducting background checks. They are given flexibility under the legislation to continue to contract with public authorities. They will refer providers to the statewide authority for purposes of wages and benefits. DSS will retain its role in paying wages to providers and maintaining the CMPS system and sharing recipient data with managed care plans. Care coordination teams will work at the local level to maximize the delivery of required services to individuals. A statewide authority will be created for purposes of collective bargaining within CCI counties. There will be representation from the Directors of DSS, DHCS, as well as Governor’s appointees. This authority will become responsible for labor agreements of IHSS workers for recipients who have transitioned to managed care.

As of January 1, 2014 DSS will create training curriculum to increase the quality of the program. Starting in June 2013, DSS will work with stakeholders to create community-based assessment tools and provide mid-point reports to Legislature. Using this statewide curriculum would be voluntary for IHSS providers. The procedures for adding IHSS hours will be outlined in MOUs between counties and health plans. The plan cannot reduce hours that have been previously authorized by IHSS.

Committee members expressed concern regarding assessments for home modifications. A primary concern revolved around who will be conducting the assessments and whether or not the assessor will receive adequate training on how to conduct the assessment so that the most beneficial information is collected.

Jane Ogle, Health Care Delivery Systems Deputy Director at DHCS, provided clarification on the assessment process and stated that the health-risk assessment will be completed within 90 days of enrolling in plans. Health-risk assessments are comprehensive and plans are required to have Member Services read materials in person’s language and fully inform them of their benefits and services they are receiving.

Deputy Director Ogle discussed the ways in which DHCS is working to improve the accessibility of documents. The basic assessment documents can be provided in Braille and there is also a CD of all the information and text-to-speech option (Daisy technology) that can be shared with people who need it. It was agreed that the DHCS will be pulling together stakeholders to get correct alternative formats in place. California Council for the Blind will be part of this workgroup. In addition, it was suggested that Lighthouse and other blind agencies are used to promote availability of alternative formats and technology.

**Agenda Item 5: Coordinated Care Initiative: Consumer Protection and the Appeals Processes**

DHCS Director Douglas began his presentation by noting that consumer protection must be at the heart of the Coordinated Care Initiative (CCI). It is important to make sure plans have all consumer protections in place. A workgroup was developed that focuses on standards around protections. The workgroup provides significant review of plans to make sure plans are abiding to the protections. There must also be protection around engagement and informed decision making. It is important that timely access standards are in place. DHCS is working with the Centers for Medicare and Medicaid Services (CMS) on appeals and grievances. DHCS is combining processes from Medi-Cal, Medicare, and IHSS to provide the same amount of consumer protection as we do in our current system but hopefully more simple to navigate. The state is providing strong oversight and monitoring. State departments are working very closely in tandem with CMS to have a team approach.

**Agenda Item 6: State Experiences with Uniform Assessments**

The SCAN Foundation’s Lisa Shugarman presented on the implementation of uniform assessments, also known as universal assessments, in four different states, and what California can learn. Universal assessment is a uniform set of data elements to gather consistent information across different populations trying to access long-term services and supports. In California, different assessments can take place based on setting of care. One of the important benefits of universal assessment is the ability to do quality monitoring.

Automating information like CMPS for IHSS enhances the value of the assessment. If information is automated, it can be used for better resource planning, understanding the population as a whole, and quality monitoring.

There is not a singular uniform assessment in California and assessment varies depending on the program. Information that is not automated in only useful at the local level, which means if a consumer is eligible for multiple programs they must be evaluated separately by each program for care planning. Universal assessments try to address improving the system and experience for the consumer. More than half of all states use universal assessment tools for at least a component of the population. The SCAN Foundation supported C.E. Reed and Associates, a consulting firm in Washington state to analyze the evolution of universal assessment in four states: Washington, Minnesota, Arkansas, and New York. These four states represent geographic diversity and different levels of universal assessment models.

One of the things learned from analysis of universal assessments is that a critical role in the process is stakeholder engagement to discuss all aspects of implementation of the assessment. The state of Minnesota created its own assessment tool from scratch and it took eight years to implement. Minimum Data Set-Home Care (MDS-HC), Community Health Assessment, and other assessments were used to build their assessment tools from a common platform of minimum data set for nursing homes. 17-20 states use some version of the NDSIC assessment tool. The resources needed for the assessment varied from $1.4 million to $4.8 million, which did not reflect total costs including staffing. There was no formal evaluation on the impact of implementing a universal assessment in the case study states. Washington has been able to identify some efficiencies in implementation.

Beginning June 2013, CDSS and CDA will begin a stakeholder process on universal assessment, which includes counties, managed care plans, consumers, CBAS staff, legislative staff, etc. The universal assessment would be built upon the IHSS assessment process and be automated within CMPS. Many steps would need to be taken before the pilot begins in January 2015, and consumer consent would be required before the universal assessment could be implemented.

Lisa Shugarman provided recommendations for California’s universal assessment:

* Use an “off-the-shelf” assessment as a core instead of starting from scratch.
* The stakeholder process is critical and should provide for meaningful engagement.
* Sufficient time should be built into the process. The stakeholder process cannot begin until June 2013 and be mindful of timeframe.
* Provide quality measurement and monitoring over time; assessment should be build towards what you would like to measure & vetted in stakeholder process.
* System automation is critical to capture data and use information gathered from assessment for better allocation of resources in a more equitable way statewide.

**Agenda Item 7: Workgroup Report Outs**

**Data Workgroup**

Kate Wilber, Chair of the Data Workgroup provided a status update and encouraged members to join the workgroup. The workgroup has met twice since its creation in June 2012, once to hear The SCAN Foundation’s presentation on its funded research on universal assessment and a second time to discuss the kind of programs that the workgroup should look at and the types of data that may be available for those programs. Chair Wilber described the activities of the workgroup, detailed in the workgroup meeting summary.

**Housing Workgroup**

Bob Hand, Co-Chair of the Housing Workgroup, provided a status update on its first meeting when they discussed priorities for the workgroup, and heard a presentation from state staff on California’s application for the Section 811 HUD grant. The workgroup is focusing on obtaining a better understanding of funding sources for affordable housing in order to assist people in maintaining their housing and living independently in their own homes. In addition, the workgroup would like to focus on increasing the supply of affordable and accessible housing.

**Transportation Workgroup**

Richard Smith, Co-Chair of the Transportation Workgroup provided a status update. The workgroup would like to look at the differences between older adults and younger people with disabilities and the issues that each group faces with transportation. When disabilities come later in life, transportation issues become a new problem because previous issues were not experienced. Another issue the workgroup will focus on is the location of transportation services and how that can become a barrier to healthcare services. The less concentrated a population is and the great the distances apart the more expensive and difficult transportation is. The workgroup will also look at existing transportation modes as well as alternatives that are less expensive and more effective. The next meeting will review ten transportation service alternatives that have operated successfully throughout the country which have provided successful and cost efficient health access transportation and examine best practices.

Committee Chair Brenda Premo suggested that the workgroup should have a discussion with local entities that have a successful transportation plans and focus on ways to emulate the plans. She noted that it is important to think of transportation as part of a system of care that an individual is receiving rather than a separate service.

**Agenda Item 8: Legislative Review and Watch List Distribution**

The Olmstead Legislation Watch List was reviewed. The list included legislation, identified by Committee Members, that either impedes or advances the Olmstead decision. It is compiled by California Health and Human Services Agency staff.

**Closing Comments:**

Committee Chair Brenda Premo provided closing comments that included an invitation for members and outside experts to join workgroup meetings that will be held in September and October and a request for input on other areas that may need to have dedicated workgroups.

The meeting adjourned at 4:00 p.m.