



# **The Future of Care Coordination in California:**

A Synthesis of the  
"Beyond the MSSP Waiver" Convening

May 2009

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## Introduction

Seniors can face confusing care options in their efforts to remain in their homes as they age. To support these efforts, the California Health and Human Services Agency (CHHS) and the California Department of Aging facilitate the coordination of medical, social and other community support services for seniors living at home through a range of programs. As the longest existing care coordination program for the elderly, the Multipurpose Senior Services Program (MSSP), is a critical part of this long-term care system.

MSSP began as a four-year research and demonstration project in 1977 with the goal of preventing or delaying the premature institutional placement of seniors at a cost lower than that of nursing facility care. The MSSP waiver requires that the costs of services and care coordination for clients, all of whom are eligible for placement in a skilled nursing facility, be less than or equal to the cost of care in an institution. Since 1977, the program has expanded to 41 MSSP sites in 50 counties statewide, and can serve as many as 11,789 clients every month.<sup>1</sup>

Despite the importance of MSSP in supporting both the elderly and the overall long-term care system, there are challenges. Growing demand for services and shrinking public budgets create stress in the community support system for older adults. Funding for MSSP has not kept pace with rising costs and inflation, and California’s 2008 budget cut the program funding by 10 percent, consistent with cuts in the full budget. The resulting challenges to get seniors needed services may lead to rising costs through the increased use of institutions, and reduced quality of life for seniors, ultimately placing even more stress on the entire long-term care system.

To help address these critical issues, The SCAN Foundation held a one-day convening in Sacramento facilitated by Harbage Consulting, LLC. The goal of the convening, as outlined by Lynn Daucher, Director of the California Department of Aging, was to ask leading long-term care practitioners for their thoughts on how to improve care coordination for seniors, as well as how to expand it to more people in California. This paper will synthesize the day’s findings, first presenting the system challenges that MSSP and the entire long-term care system face, and then offering a framework for how care coordination can be improved.

With the benefit of presentations by national leaders, a range of California’s long-term care stakeholders—including practitioners, academics, advocates and policymakers—engaged in an interactive discussion across a range of issues impacting the Home- and Community-Based Services (HCBS) system. This discussion revealed four broad categories for action in California to improve care coordination and maintain HCBS for seniors through MSSP, while keeping in mind the budget context. These are:

- **Developing a System-wide Plan.** Local MSSP programs could benefit from a system-wide effort to improve coordination and integration across the long-term care system.

<sup>1</sup> CDA, MSSP contact list [http://www.aging.ca.gov/programs/mssp\\_contacts.asp](http://www.aging.ca.gov/programs/mssp_contacts.asp).

- **Maintaining Local Innovation.** While system-wide coordination is important, local programs must also have the flexibility to adapt to their communities, and explore innovative ways to improve services for their clients.
- **Investing in Efficient Infrastructure.** California can invest in both workforce and technology to improve the efficiency of care coordination programs, including MSSP. A more diversified workforce could help target resources more efficiently, and an information technology (IT) infrastructure could help streamline the program in order to both lower costs and improve quality.
- **Tracking Data to Drive Improvements.** California policymakers and MSSP practitioners need better information on trends in the population of potentially eligible seniors, as well as on the costs and quality of the MSSP programs themselves. Gathering that information can help MSSP programs efficiently target resources for reform.

## Approach

This paper represents a synthesis of the thoughts presented at the convening. Except for those who gave formal presentations to convening participants (who are listed on the agenda of the day available in Appendix I), none of the individual ideas are attributed to those who discussed them. The focus here is on the ideas of the convening, and no outside research was done as part of this paper. The credit for the ideas discussed and described below belongs to all those at the convening (available in Appendix II).

## System Challenges

As the Secretary of the California Health and Human Services Agency, Kimberly Belshé stated in her opening remarks to the convening, there are critical contextual challenges facing efforts to improve long-term care in California:

- **California's Financial Challenges.** The state is facing massive budget shortfalls and a limited ability to raise revenue, resulting in simply less money for all state-funded social services, including MSSP and long-term care.
- **Changing Demographics.** While resources are shrinking, the demand for these types of services is growing due to the aging of the population, as well as the prevalence of chronic conditions among seniors.
- **Government Accountability.** While MSSP is an efficient and cost-effective use of taxpayer funds, there is a lack of consensus in the public about what services the government should provide, as well as diminishing confidence in the government's ability to solve problems and provide necessary services.

More specifically, there are nationwide long-term care and HCBS system challenges that reduce access to services, as well as the effectiveness of care coordination activities. As part of his lunch keynote address, Steven Lutzky, a national long-term care expert and President of HCBS Strategies, presented a framework for the three key different perspectives on the HCBS system: the process for consumers, the process for providers and overall systems management. There are challenges under each perspective, although the three are interconnected.

- **Consumer Process:** This is the process of moving seniors through the HCBS system: from outreach to eligibility determinations to assessments to provider selection and service provision. Each step presents its own challenges.
  - **Access/Eligibility:** Despite limited resources, there is no systematic, state-wide process for targeting the highest need seniors, or those most likely to benefit from care coordination services.
  - **Assessment and Service Planning:** There is also a lack of a standardized process for determining what services seniors need, and then tracking what services those seniors are receiving—and what services they still aren't receiving. The system also suffers from an inability to tailor levels of care management services to individuals.
  - **Provider Selection:** Sites providing HCBS differ in their capability and sophistication, as well as their cost. Seniors do not have enough information about providers or provider quality to make informed decisions. There are too few safeguards to ensure that no matter which provider is selected, seniors will have consistent access to the high quality services they need.
- **Provider Processes:** Providers experience much of the same system failures as their clients as they work to deliver the care their clients need. But providers also experience the administrative dysfunction of the system. There are limited requirements for provider training in the system, and limited ability to track or measure their performance. It is also difficult to negotiate provider rates, which correspond to the actual costs of providing services.
- **Systems Management:** Together, challenges show the limits of managing the entire system with little system-wide information. There is a lack of performance based outcomes, a lack of core infrastructure to understand what is going on, and an over-reliance on arcane rules and multiple forms.

The convening participants discussed the ways in which the MSSP program faces many of these challenges as a part of the HCBS system. However, California's MSSP is also starting from a position of strength in seeking to improve its processes, and operate more efficiently. In particular, MSSP has a strong network of agencies that are integrated into their communities, and they have built the capacity to manage their budgets as well as their risk. In addition, MSSP has a well-developed assessment process. An assessment team, including a nurse and a social worker, fully documents enrollees' health and other needs in order to develop a care plan, which is tailored to each enrollee's specific needs.

### **Framework for Improving Care Coordination**

Improving care coordination is critical to the sustainability and success of the MSSP program. As explained by Professor Andrew Scharlach, Associate Dean and Professor of Aging in the School of Social Welfare at the University of California at Berkeley, there are many definitions of care coordination, but they share in common the effort to help people access the services they need so they can stay in their homes and out of expensive institutions. (See Appendix III for a copy of Scharlach's presentation.) Care coordination is necessary all along the continuum of long-term care to help vulnerable seniors receive the right care at the right time in the right setting.

Sharlach outlined three types of goals for care coordination:

- **Client System Goals:** Helping seniors increase their functional capacity and quality of life while remaining in the most desirable environment.
- **Administrative System Goals:** Reducing costs, and moving utilization away from expensive services to more cost-effective treatments.
- **Service Delivery System Goals:** Increase the efficiency and accessibility of service provision.

Creating a better long-term care system can be achieved by targeting care management resources to maximize outcomes for clients. For example, the intensity of care management activities should be matched to the particular needs of each client situation.

To better achieve these goals, convening participants offered their ideas on how to move forward. While many suggestions were given, they broadly fell into three categories: creating a system-wide plan, investing in infrastructure efficiencies and measuring program outcomes.

## 1. System-wide Planning

Like our national system, California's long-term care system has too many silos. There are many different programs at the state and local level, which serve overlapping clientele, but which have different goals and purposes. MSSP, as a coordinator of many types of services, could greatly benefit from breaking down barriers between the many programs providing services to MSSP clients. Any reform plan should try to incorporate systemic changes which can streamline MSSP and create efficiencies, but must also maintain the flexibility for local programs to innovate and respond to specific local needs.

- **Uniform Assessment System:** Convening participants discussed a uniform assessment system, perhaps designed using IT, which could help ensure that fewer seniors "fall through the cracks." This system should allow for a uniform understanding of client acuity to help target the appropriate level of care. Given the waiting lists at every MSSP site, this could also help the state identify where additional resources could most effectively be targeted.
- **Coordination Among HCBS Agencies:** Improving coordination among agencies was another recurring theme in the convening. MSSP and the In-Home Supportive Services (IHSS) programs have a great potential for consolidating activities where they serve the same clients. Of the 420,000 IHSS participants, approximately 11,000 are also MSSP recipients. MSSP beneficiaries thus receive a functional assessment to determine the hours of in-home assistance they are eligible for twice—once from IHSS and once from MSSP. In addition to this duplication, any divergence in findings between the two agencies requires resolution. One convening participant suggested that IHSS might be able to reduce state costs by allowing the more comprehensive MSSP assessment to be used in place of the IHSS assessment for MSSP clients. This change could require possible legal changes.

- **Exploring Managed Care Expansion:** There may be a role for managed care to play in MSSP. One of the convening work-groups suggested that the Medi-Cal Managed Care delivery system could serve as a platform to serve the MSSP populations. Both MSSP and its clients could benefit from the efficiencies of leveraging the service integration functions of managed care options. Despite some success in improved quality and cost-savings, this option has been politically controversial in the past, and it is likely to continue to raise some concerns among stakeholders and MSSP clients. Any managed care expansion must ensure MSSP clients would have continued access to their physicians and all required services.

## 2. Local Innovation

Every local MSSP program has the advantage of knowing the needs of its local seniors, as well as knowing the resources of their local community, including other community and county organizations. In addition to better statewide coordination, local MSSP programs should have the flexibility and be encouraged to better integrate MSSP into the local service provision network and tailor services to meet local needs. For example:

- **Community Outreach:** Riverside County identified the need to perform better outreach during hospital discharges, and has placed liaisons in the hospitals to help perform an initial screening for potential MSSP enrollees. Nurses and hospital discharge planners have also been educated about the program to help identify seniors who could benefit from MSSP services.
- **Integration within the County:** Sonoma County has worked to create an agency which has integrated MSSP with other county services, ultimately improving and strengthening MSSP's ability to serve its clients. For example, MSSP now receives referrals from IHSS services, and individuals eligible for skilled-nursing facilities are given a multi-disciplinary evaluation to determine eligibility for other programs.
- **Maintaining Community Integration:** Budget shortfalls have led some County MSSP programs to close, and others to be taken over by not-for-profits and healthcare plans. This can sometimes be a benefit to the MSSP programs, which can be operated in a less costly and more flexible environment by private organizations. However, this can lead to the further fragmentation of services, according to Paula Butler, the Chief of the MSSP Branch at the California Department of Aging. (See Appendix III for a copy of this presentation). It is critical that the private MSSP programs maintain their connections to county-run services such as IHSS to ensure continued service integration and coordination for the seniors they serve.
- **Targeted Program Improvements:** Los Angeles County identified medication management and mental health services as two areas for improving client services. One MSSP program obtained a grant to start an in-home mental health program, and hired a part-time pharmacist to participate in the assessment team. The pharmacist is able to review clients' medications in real time to prevent overmedication. The pharmacist has also helped ensure the safety of medications imported from Mexico, which are often used by the program's many Latino clients. The program is able to address issues quickly, and this early intervention prevents unnecessary trips to the emergency department.

### 3. Investment in Infrastructure Efficiencies

There are both efficiencies and quality improvements to be gained from investing in improvements to the MSSP infrastructure, including both the workforce and the development of IT systems. Participants acknowledged at the onset of this discussion that they are limited by the many regulatory barriers in MSSP. There was interest in the possibility of Centers for Medicaid and Medicare Services and the federal government in allowing more flexibility in the MSSP model.

#### Workforce

Convening participants identified inefficiencies in the waiver's structure of the MSSP workforce as a critical issue in system reform. For example, public health nurses are highly paid and in short supply, but current scope of practice and waiver rules require them to conduct MSSP enrollee assessments. Convening participants suggested exploring reforms which would allow registered nurses and/or social workers to perform this task. In addition, social workers bear the responsibility of both managing their caseloads and time-consuming clerical and administrative tasks. In every instance, the intent was to ensure that clients would receive services from the appropriately trained staff, and to supplement clerical or support staff for just those administrative duties for which they are trained. There are several ways that MSSP could diversify the workforce, and tailor that workforce to the acuity of clients:

- **Assessment:** Use a two-tier assessment system, using a social worker or registered nurse to perform an initial assessment, which could trigger follow-up from a registered or public health nurse as necessary.
- **Administration:** Streamline the paperwork burden and demands in the system, as well as expand the use of clerical workers or volunteers to manage administrative tasks in order to free up more time for case managers to actually provide services.
- **Care Management:** Scope of practice issues can pose a special challenge in MSSP. Several speakers identified the complex care management roles MSSP staff perform:
  - Assigning RNs to clients with predominately medical needs, and social workers to manage clients with predominately social and support service needs.
  - Providing clients with multiple medical conditions with a case manager with general expertise in medical issues to help coordinate among their many doctors, or help identify when clients may need to see a particular specialist.
  - Ensuring case managers are able to help clients navigate the 48 different available Medicare Part D plans, and the Social Security Administration.
- **Follow-up:** Initiate check-up calls by staff trained to triage and identify clients who need follow-up from case managers or medical professionals. This could focus the highest-trained nurses and case managers on the highest acuity clients.

#### Information Technology (IT)

As with many aspects of our health care system, most MSSP programs do not leverage the efficiencies of IT. As beneficial as incorporating a statewide IT infrastructure into MSSP processes could be, the initial start-up costs may pose a significant barrier given the state's current budget



constraints. Despite that challenge, convening participants were nearly unanimous in their interest in the possibilities presented by IT.

- **Track Client Needs:** Health IT is being developed, which complements care management, reminding clients and their providers about medical needs, including information about prescription drug interactions and refills. Medication mismanagement was identified by convening participants as a problem for many MSSP clients, suggesting that a well-designed IT system could help prevent some of those problems. In addition, the system could be designed to help manage cases in a variety of ways, including reminding case workers when the mandatory six-month Medi-Cal reassessment is due.
- **Streamlining Daily Administrative Tasks:** Electronic client records could reduce redundancy in the system, particularly as MSSP and other agencies with overlapping clientele often collect the same information. This could also prevent against misplaced paper records. Meeting participants also agreed on the need for less paperwork and documentation to be required of seniors, which is a particularly acute problem for those seniors receiving services from multiple programs. With or without the use of improved IT, the application should be more streamlined for consumers.
- **Information Technology in Action:**
  - San Mateo is currently working with a software development company to create and refine a uniform assessment tool to efficiently document clients, and help screen them for MSSP as well as other relevant county services. The county is optimistic about the process, and has devoted time and resources to develop a tool that meets its needs. The current version of the assessment system is time-intensive, and while work continues budget challenges may keep it from being implemented in the near term.
  - Kathy Leitch, Assistant Secretary for the Washington State Department of Social and Health Services, described her state's lap-top system for assessing clients. (See Appendix III for a copy of Leitch's presentation and Appendix IV for a full case study of the Washington State long term care system reforms.) The system employs an initial assessment which may trigger additional nurse assessments based on the acuity of a client. This system is also used to collect data on cost and quality.

#### **4. Tracking Data to Drive Improvements**

To improve MSSP, it is critical that policymakers and frontline staff alike have better information, which will require significant increases in cost and quality measurement across the local programs. The most recent waiver reauthorization includes new quality indicators and outcome measures, which will serve to address this area.

#### **Understanding the System and Population**

Local MSSP programs could benefit from better data regarding what is happening in the local population of potentially eligible seniors. For example, if certain populations are found to be using the emergency room for the same conditions for which they have received inpatient services, they are likely candidates for higher levels of care management. Some local programs have used this to tailor their outreach and assessment processes, and to partner with local hospitals to forestall repeat emergency room and inpatient admissions.



## **Improving Services**

Measuring and reporting quality data often helps providers improve the quality of care they provide. By tracking local MSSP innovation efforts it is possible to share information to help local, state and federal leaders better understand what has been successful, and to drive improvements for the whole system.

## **Tracking Costs**

The MSSP waiver's budget neutrality requirements require MSSP to closely track the full costs for all clients to ensure that the total per client cost (including all services as well as the capitation-basis cost of MSSP care coordination) is not greater than the cost of a skilled nursing facility. Budget cuts have reduced the amount of funding available for MSSP to serve clients. However, better cost data could be used in the future around deciding fair and rational payments within the MSSP system.

## **Conclusion**

The MSSP program is one of California's premiere care management programs serving the state's frailest older adults, and it is an important resource within the state's entire long-term care and HCBS system.

The convening discussion shows California's long-term care system clearly faces difficult political and budgetary challenges. Despite this, it is also clear that stakeholders have many ideas about how the system can be reformed to better serve California's seniors. Stakeholders clearly must continue this discussion in order to work through these challenges.

There are many steps California could take to begin work on improving care coordination within the categories outlined above. The state should also consider including some of these reforms in the new program waiver. Based on the convening, the top priorities included efforts to:

- Begin moving toward interagency coordination at the system and local level.
- Improve enrollment processes, including:
  - Have MSSP functional assessments serve as the assessment to determine a client's eligibility for IHSS services. This would reduce duplication and use of IHSS social workers' time in reassessing MSSP clients.
  - Use a triaging system during enrollment and follow-up to target higher acuity clients, and graduate older adults no longer requiring this level of care out of the program.
- Reorganize the MSSP staffing model to use resources more efficiently and flexibly to leverage the skills and specializations of different types of staff.
- Begin planning for the development of information technology tools, including coordinating electronic medical records and program data through a statewide system.
- Brainstorm ways to more efficiently collect quality improvement data required by the waiver, and use this data to improve the delivery of MSSP services to clients.

## **Acknowledgements**

The SCAN Foundation funded Harbage Consulting to coordinate this convening and draft this report. Harbage Consulting would like to thank all the convening participants and speakers, as well as those participants and speakers who provided valuable input on this paper.

## **About The SCAN Foundation**

### **Mission**

The SCAN Foundation's mission is to advance the development of a sustainable continuum of quality care for seniors. A sustainable continuum of care improves outcomes, reduces the number and duration of acute care episodes, supports client involvement in decision making, encourages independence and reduces overall costs. The SCAN Foundation will achieve this mission by encouraging public policy reform to integrate the financing of acute and long-term care, raise awareness about the need for long-term care reform and work with others to promote the development of coordinated, comprehensive and patient-centric care.

### **Vision**

The SCAN Foundation's vision is a society where seniors receive medical treatment and human services that are integrated in the setting most appropriate to their needs and with the greatest likelihood of a healthy, independent life.

### **Principles**

- Seniors are able to choose how and where they live, have a high quality of life, live with dignity and be valued by their community
- In order to provide a continuum of acute and chronic care that serves the needs of seniors, healthcare financing should be integrated and service delivery coordinated
- Those who suffer from chronic illnesses should receive an integrated suite of social, preventive and health maintenance services
- High-quality and affordable long-term care should be available to all seniors
- Meeting the long-term care needs of seniors requires the development of a suitably sized workforce of specially trained caregivers and professionals

### **Foundation Strategies**

- To advocate for a cost-effective array of benefits for seniors that improves their quality of life as well as health, and helps them live independently
- To support, evaluate and extend innovative service models that encourage independent living for seniors
- To support health-services research aimed at evaluating and improving the continuum of care for seniors and senior-centered decision making
- To address the need for an educated and trained workforce to meet the long-term care needs of seniors

- To identify, recognize and encourage best practices and leaders in senior-centered long-term care
- To become a trusted source of information on senior healthcare needs
- To raise public awareness about the healthcare needs of our aging population
- To inform and influence policymakers about issues that support The SCAN Foundation mission

### **About Harbage Consulting, LLC**

Harbage Consulting LLC is an independent firm specializing in national and California health policy. Harbage Consulting's clients are primarily not-for-profit organizations and foundations. The firm has a national research practice on health reform concepts and the public financing of health care. Its work also focuses on coalition-building to find solutions to the pressing challenges facing health care systems in America.

**Peter Harbage**, president, has more than a decade of experience working to improve health policy at the federal, state and local level. He has worked at senior levels in both the federal government and the state of California. He currently teaches a course in health policy for the University of Southern California's School of Policy, Planning and Development, and is a senior fellow at the Center for American Progress.

**Hilary Haycock** is a director at Harbage Consulting LLC. Hilary has held senior communications positions, both in private industry and with SEIU, dealing extensively with health care issues. She is currently a graduate student studying health policy at Georgetown University and holds an undergraduate degree with high honors from the University of California at Berkeley.

**Ingrid Aguirre Happoldt** is an independent policy consultant, currently working on projects with Harbage Consulting and Blue Shield of California Foundation. In addition to policy research and project management, she helps foundations develop strategic opportunities to inform the policy process. Prior to becoming a consultant, she was a Program Officer with the California HealthCare Foundation (CHCF), an independent philanthropy committed to improving the way health care is delivered and financed in California.

## Appendix I. “Beyond the MSSP Waiver: The Future of Care Coordination in California” Convening Agenda

Monday, December 8, 2008—Sheraton Grand Hotel in Sacramento

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- 9:30–9:35 A.M. Meeting Overview**  
Ingrid Aguirre Happoldt, Consultant to Harbage Consulting LLC
- 9:35–9:45 A.M. Welcome and Introductions**  
Bruce Chernof, M.D., CEO, The SCAN Foundation  
Lynn Daucher, Director, California Department of Aging
- 9:45–10:00 A.M. The Importance of Addressing Long-Term Care Issues in California**  
Kimberly Belshé, Secretary, California Health and Human Services Agency
- 10:00–10:10 A.M. Overview of MSSP Program and Update on the Waiver Process**  
Paula Butler, Chief, Multipurpose Senior Services Program Branch,  
California Department of Aging
- 10:10–11:10 A.M. Roundtable: Care Coordination in California—  
Innovations and Challenges**
- Denise Likar, Director of Programs, Independence at Home,  
part of SCAN Health Plan
- Vicky Noegbauer, Coordinated Care Programs Manager,  
Riverside County Office on Aging
- Chris Rodriguez, Protective and Supportive Services Programs,  
San Mateo County
- Moderator:** Diane Kaljian, Adult and Aging Services Director, Sonoma  
County Human Services Department
- Three MSSP program leaders will jumpstart a facilitated group discussion  
on innovations and challenges within the current program by sharing their  
program experiences. Questions will be posed to both the commentators  
and the group as a whole. The goal is a thoughtful dialogue on the current  
state of MSSP and how coordinated care can be strengthened.*
- 11:10–11:50 A.M. Lessons and Learning from the State of Washington**  
Kathy Leitch, Assistant Secretary, Aging and Disability Services  
Administration, Washington State Department of Social and Health Services
- Following key insights on developments of Washington’s programs, Kathy  
Leitch will also comment on issues raised in the previous roundtable.*
- 11:50–12:05 P.M. Break**

**12:05–1:00 P.M.**

**Lunch Speakers**

Janet Heath, President, MSSP Site Association  
The Importance of MSSP

Steven Lutzky, National Long-Term Care Expert and President of HCBS  
Improving Core Business Processes Supporting California's MSSP Program

**1:00–2:10 P.M.**

**Issue Brainstorming By Topic**

Peter Harbage, President, Harbage Consulting, LLC

*After Peter Harbage briefly explains the role of the breakout sessions, attendees will gather into small groups for 45 minutes to discuss one of three topics: 1) Achieving sustainability; 2) Improving the care management model; and 3) How to support the growing population needs using current resources. Each group will have a designated facilitator.*

**2:10–2:15 P.M.**

**Break**

**2:15–3:40 P.M.**

**Blueprint for the Future of Care Coordination**

Andrew Scharlach, Associate Dean and Kleiner Professor of Aging,  
University of California at Berkeley

After opening remarks, attendees will disperse into pre-assigned groups of 6–8 people. Each group will address all of the following:

**Key Challenges:** What are the top three challenges facing MSSP and care coordination in California?

**Key Opportunities:** What are the top three opportunities to improve MSSP and care coordination in California?

**Immediate Steps:** What are three immediate steps that California should prioritize to strengthen MSSP and care coordination in California?

*After a 45-minute session in small groups, Andrew Scharlach will moderate a discussion of the groups' findings and will summarize key themes from the day.*

**3:40–3:45 pm**

**Closing and Next Steps**

Peter Harbage, President, Harbage Consulting, LLC

## **Appendix II. Convening Attendees (listed alphabetically)**

**Ginni Bella**, Fiscal and Policy Analyst  
California Legislative Analyst's Office

**Paula Butler**, Branch Chief, MSSP  
California Department of Aging

**Secretary Kimberly Belshé**  
California Health & Human Services Agency

**Eileen Carroll**, Chief, Adult Programs Branch  
California Department of Social Services

**Bruce Chernof**, President & CEO  
The SCAN Foundation

**Jodi Cohn**, Research Director, GPI  
SCAN Health Plan

**Lora Connolly**, Chief Deputy Director  
California Department of Aging

**JoAnn Damron-Rodriguez**  
UCLA School of Public Affairs  
Department of Social Welfare

**Lynn Daucher**, Director  
California Department of Aging

**Gary Fontenot**, Section Manager  
Sonoma County/Adult & Aging Division,  
Human Services Department

**Elissa Gershon**, Staff Attorney II  
Disability Rights California

**Ingrid Aguirre Happoldt**, Special Consultant  
Harbage Consulting

**Peter Harbage**, President  
Harbage Consulting

**Janet Heath**, President  
State MSSP Site Association  
MSSP/Linkages Site Director  
UC Davis Medical Center in Sacramento

**Mark Helmar**, Chief, Long-Term Care Division  
California Department of Health Care Services

**Arlene Hostetter**, Director  
Care Management Services  
CSU, Chico Research Foundation

**Myesha Jackson**, Policy Consultant  
Office of the Senate President Pro Tem

**Megan Juring**, Assistant Secretary  
Aging & Long-Term Care  
California Health & Human Services Agency

**Diane Kaljian**, Director  
Sonoma County/Adult & Aging Division,  
Human Services Department

**Cindy Kauffman**, Vice President  
Institute on Aging

**Kathleen Kelly**, Executive Director  
Family Caregiver Alliance

**Derrell Kelch**, Executive Director  
California Association of Area Agencies on Aging

**Eileen Koons**, Director of Govt. Programs  
Huntington Hospital Senior Care Network

**Kathy Leitch**, Assistant Secretary  
Aging and Disability Services Administration  
Washington State Department of Social and Health Services

**Denise Likar**, Director of Programs  
Independence at Home  
SCAN Health Plan



**Eva Lopez**, Deputy Director  
California Department of Social Services

**Steven Lutzky**, President  
HCBS Strategies

**Jackie McGrath**, State Public Policy Director  
Alzheimer's Association

**Lydia Missaelides**, Executive Director  
California Association for Adult Day Services

**Rene Mollow**, Associate Director, Health Policy  
California Department of Health Care Services

**Wendy Moore**, Deputy Director  
Aging & Comm. Svcs.  
San Joaquin Co. Human Services Agency

**Vikki Neugebauer**, Coordinated Care Programs Manager  
Riverside County Office on Aging

**Erin OKeefe Levi**, Partner  
Lehman Kelly Sadler OKeefe

**Cheryl Phillips**, Chief Medical Officer  
On Lok Lifeways (PACE)

**Susan Poor**  
Susan Poor Consulting

**Chris Rodriguez**, Health Services Manager II  
San Mateo County Aging and Adult Services

**Elizabeth Rottger**, Olmstead Advisory Committee Member  
AAA Representative

**Allison Ruff**, Chief Consultant  
Assembly Committee on Aging and Long-Term Care

**Melissa San Miguel**  
California Department of Health Care Services

**Andrew Scharlach**, PhD, Professor of Aging  
UC, Berkeley

**Timothy Schwab**, Chief Medical/Informatics Officer  
SCAN Health Plan

**René Seidel**, Vice President Programs and Operations  
The SCAN Foundation

**Sandra Shewry**, Director  
Department of Health Care Services

**June Simmons**, President & CEO  
Partners in Care Foundation

**John Wagner**, Director  
California Department of Social Services

**Han Wang**, Finance Budget Analyst  
California Department of Finance

**Monika White**, EVP  
External Affairs/Program Innovation  
WISE & Healthy Aging

**Kate Wilber**, Professor  
University of Southern California

**Sheldon Zinberg**, CEO  
Nifty after Fifty

**Anwar Zoueihid**, Project Director  
Partners in Care Foundation

**Appendix III. “Beyond the MSSP Waiver: The Future of Care Coordination in California” Convening Presentations (attachments)**

1. Paula Butler, Branch Chief, MSSP, California Department of Aging
2. Kathy Leitch, Assistant Secretary at the Aging and Disability Services Administration at the Washington State Department of Social and Health Services
3. Steven Lutzky, President, HCBS Strategies
4. Andrew Scharlach, PhD, Professor of Aging at UC Berkeley

# **The Multipurpose Senior Services Program (MSSP)**

*The California Department of Aging*



# The Multipurpose Senior Services Program (MSSSP)



The California Department of  
Aging



## MSSP – The History

- 1915 (c) Home and Community-Based Waiver:
  - Children's (18 and under);
  - Disabled;
  - Aged (65+)







# Waiver Capacity

- @ 16,000 individuals a year
- 11,789 “Slots”





## The “Program”

- Assessment “Team”
- Care Plan
- Resources



# Program Issues, or. . .the good, the bad and the ugly. . .

- Funding
- Site Closures
- Flexibilities



## The Current Waiver Process

- The current 5-year waiver expires June 30, 2009.
- The waiver renewal process begins 18-months prior to renewal.
- The MSSP Waiver Workgroup



■ In Conclusion. . .

# **Rebalancing the Long-Term Care System**

**Kathy Leitch**

*Assistant Secretary*

*Washington State Department of Social and Health Services  
Aging and Disability Services Administration*

## A View from Washington State



# Rebalancing the Long-Term Care System

*Presented by:*

**Kathy Leitch**  
Assistant Secretary  
Washington State Department of Social and Health Services  
Aging and Disability Services Administration

*Presented to:*

**Multipurpose Senior Services Program Conference**  
Sacramento, California  
December 8, 2008



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Services Administration



## A View from Washington State

# Aging and Disability Services Administration

- One administrative organization - Aging, Long Term Care (LTC) and Developmental Disabilities programs
- ADSA's values receive strong statewide support to help seniors/adults with disabilities to stay healthy and independent in their communities
- Washington is recognized as a state with a balanced, efficient LTC system



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Services Administration

## A View from Washington State

# The Lewin Group Analysis

- Washington is one of only four states that met three measures of LTC progress
- 1995-2005:
  - Total LTC spending +5% (per person age 65+)
  - HCBS spending +32%
  - Nursing facility spending -37%
- National average: 40 per 1,000 in nursing facility (age 65+)
- Washington's average: 17 per 1,000 in nursing facility (age 65+)



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## A View from Washington State

# AARP State LTC Reform 2008 Report

- Home and Community Based Services spending in FY 2006:
  - Washington allocates 54%
  - National average 24%
- Nursing facility spending in FY 2006:
  - Washington allocates 46%
  - National average 75%



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## A View from Washington State

# ADSA's 2007-2009 Biennial Budget

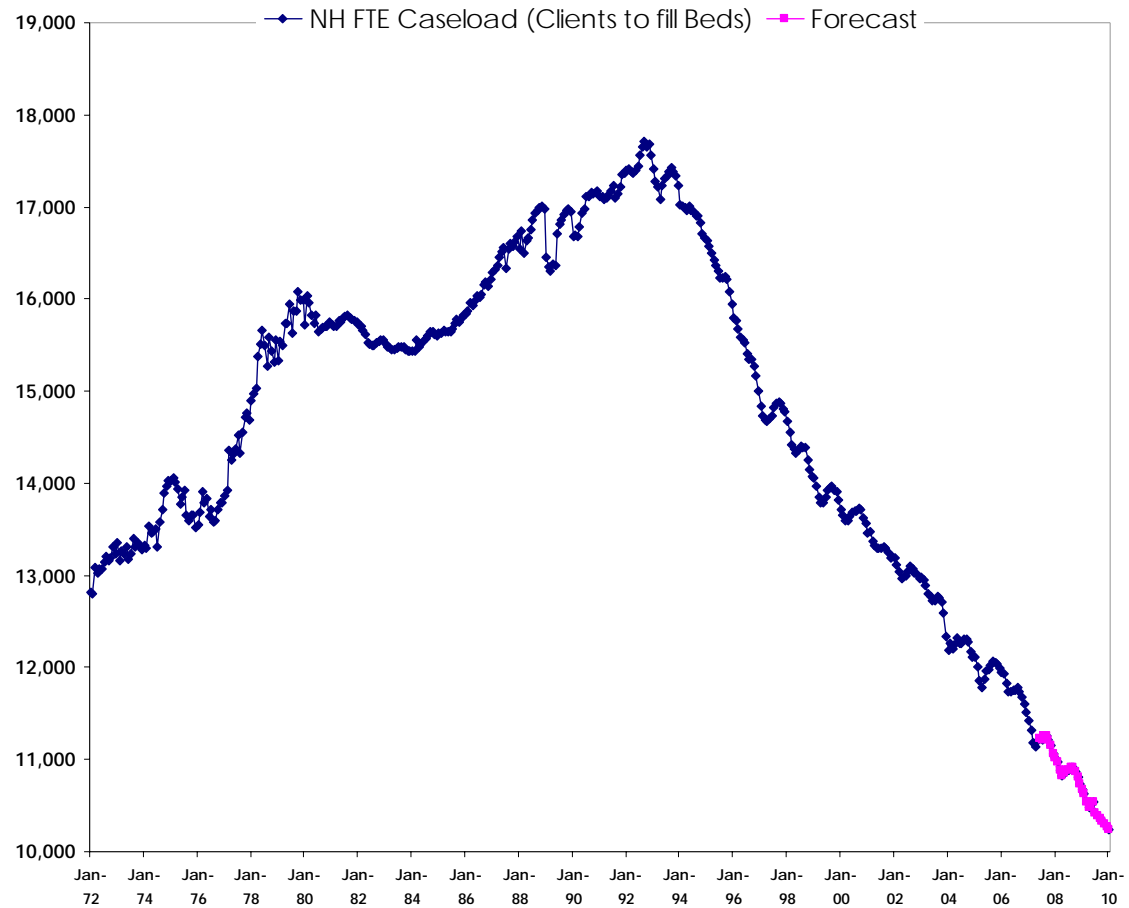
- LTC expenses - \$3 billion
- In-home – 49%
- Residential care – 12%
- Nursing facilities – 39%



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# A View from Washington State

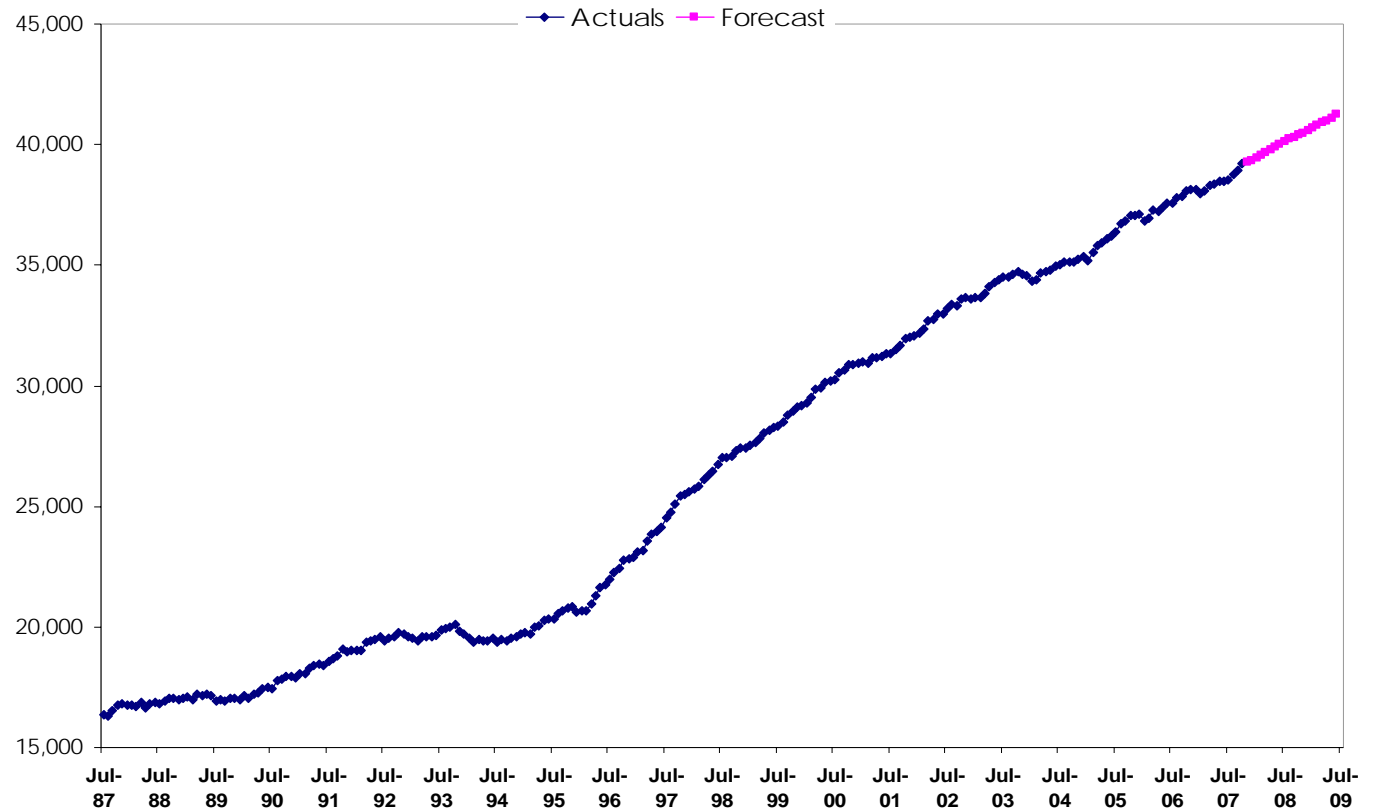
## Nursing Home Medicaid FTE Caseload Trend January 1972 - January 2010



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# A View from Washington State

## Home and Community Long Term Care Caseload Trend July 1987 - June 2009

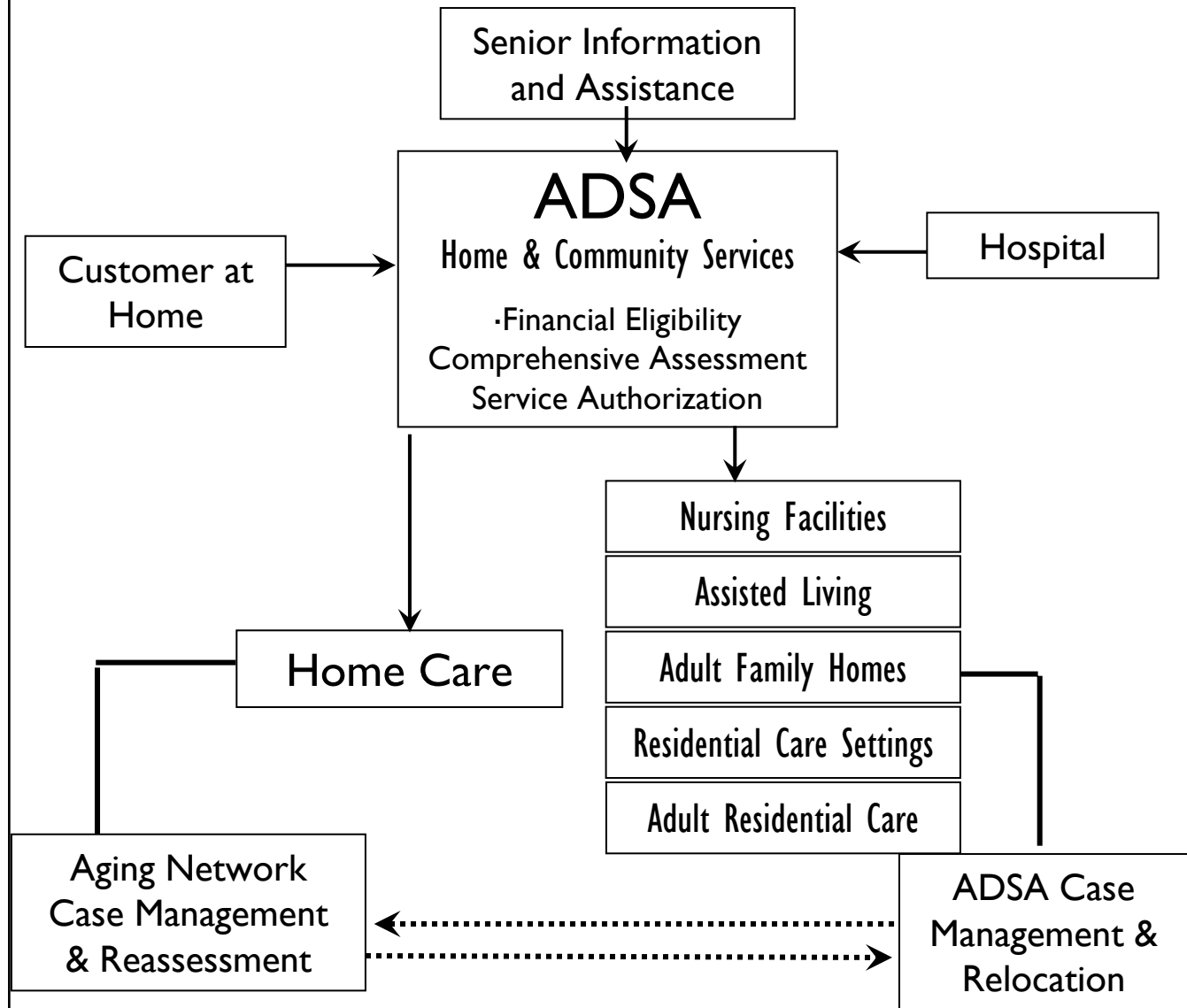


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SOURCES: Actuals from MMIS, SSPS; Forecast from Caseload Forecast Council Budget Forecast

# HCS Service Delivery System

A View from  
Washington  
State





## A View from Washington State

# HCS Statewide Network of Local Offices

- Financial eligibility for Medicaid long term care benefits
- Client needs assessment and LTC service authorization
- Case management for Medicaid clients in residential care settings
- Nursing services for vulnerable adults
- Adult Protective Services: investigation of abuse, abandonment, neglect and self-neglect, and the provision of protective services



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## A View from Washington State

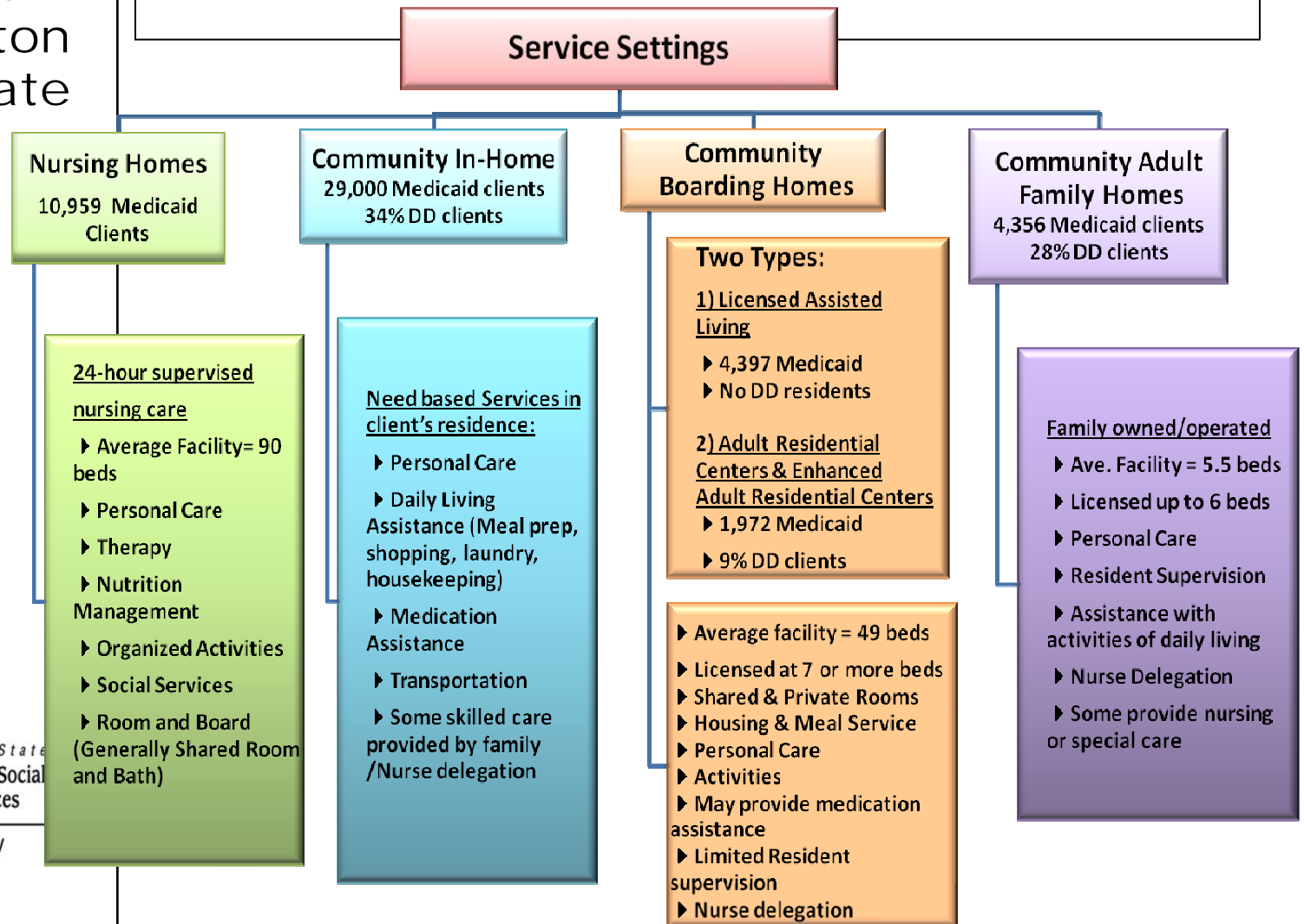
# Area Agencies on Aging (AAAs)

ADSA contracts with 13 local AAAs to provide:

- Specialized Senior Information & Assistance programs
- Case management for home care clients
- Nursing services for vulnerable adults
- Other community services: family caregiver support, nutrition, transportation, home modification, and legal services
- Training for in-home caregivers

# Long Term Care (LTC)

A View from  
Washington  
State



Washington State  
Department of Social  
& Health Services

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Services Administration

## A View from Washington State

# Key Elements of a Care Management Model

A uniform, comprehensive assessment that assesses:

- Personal care/household assistance needs
- Treatments/therapies
- Medication management
- Seizures
- Skin care
- Preventative care
- Risk of falls
- Pain management
- Cognitive capacity
- Depression
- Problem behaviors
- Suicide risk
- Substance abuse
- Communication
- Family supports
- Consumer goals



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## A View from Washington State

### Key Elements (cont.)

A client benefit that is consistently determined from the assessment:

- Washington uses a 17-level acuity-based tiered rate structure in residential settings (daily rate for care)
- Number of hours per month are authorized for in-home care based on 17-levels of care



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## A View from Washington State

### Key Elements (cont.)

- Trained, qualified social workers with on-call nursing expertise available
- Case managers in Washington are required to have bachelor's or master's degree and related experience
- All publicly funded recipients of home and community-based services have an assigned case manager
- Case managers present in nursing homes - actively work toward discharge or diversion
- Case managers available to hospitals for authorization of home and community-based services
- Other needs



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## A View from Washington State

# Importance of Triggered Referrals

- Certain elements in the assessment act as “triggers”, requiring action by the case manager and/or on-staff RNs related to medical issues, including skin integrity, that affect care planning
- Other assessment items trigger required protocols for appropriate referrals to community resources for:
  - depression
  - pain
  - suicidal ideation
  - alcohol/substance abuse



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## A View from Washington State

# Using Data for Decision-making

- Washington's assessment is automated and applied to each recipient of home and community based services
- Virtually all data fields can be queried and compared to payment data
- Example of use: Aggregation of age data and comparison of ADL scores across settings

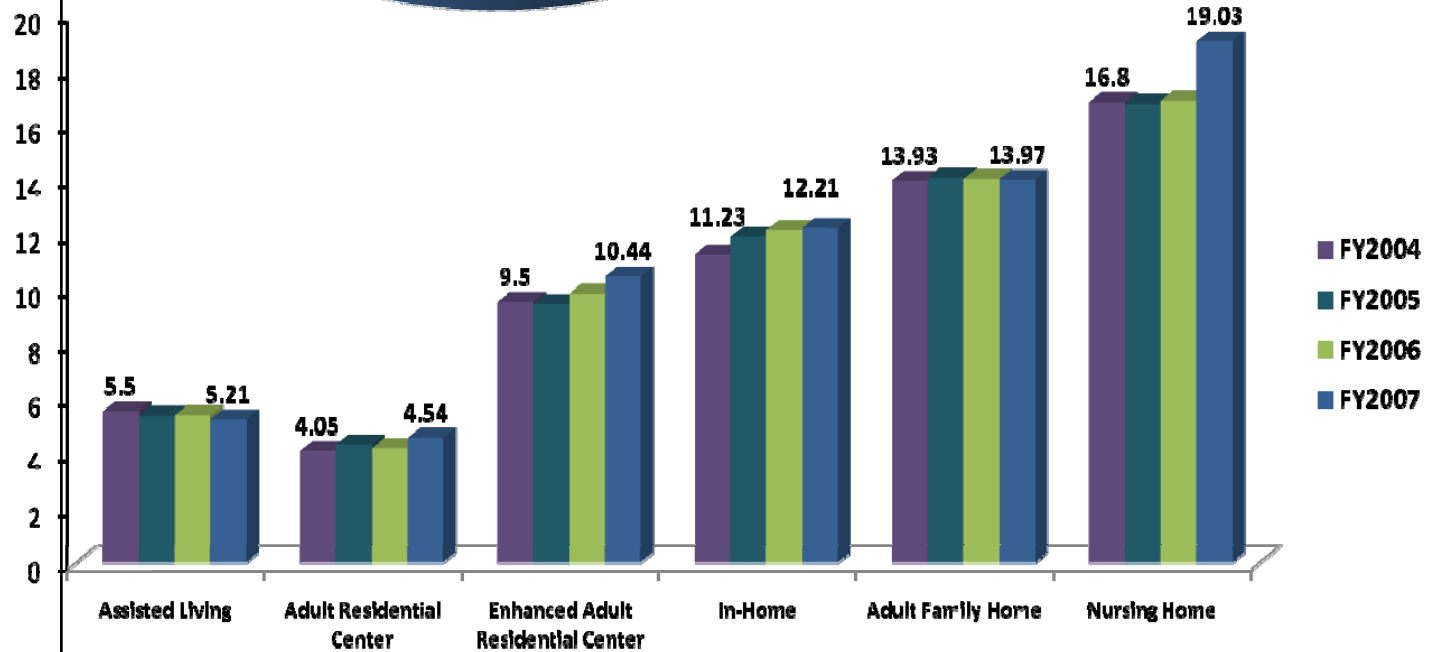
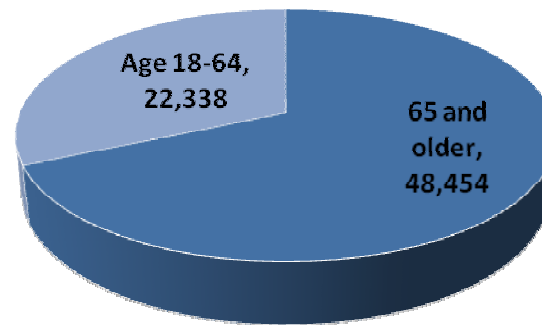


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# LTC Trends in Client Characteristics

A View from  
Washington  
State



Average Score: Activities of Daily Living (ADL)



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## A View from Washington State

# Move Toward More Effective Chronic Care Management

- In a multi-year pilot program, ADSA had success in linking CARE assessment data with health care utilization data to identify the most expensive Medicaid clients
- These clients were either enrolled in the pilot to improve management of chronic conditions or into the control group



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## A View from Washington State

# Findings from a Study of the Pilot Program

- Of five areas of health measured:
  - **Overall Health Rating**
  - **Pain Impact**
  - **Patient Activation Measure**
  - **Quality of Life Scale**
  - **Overall Self-Sufficiency**

the results consistently pointed to better self-reported health outcomes in the treatment group than the comparison group
- A statistically significant lower risk of death among clients who participated in the treatment group
- Nearly half of the enrolled clients achieved improvements in their health condition, living environment, or access to treatment
- For every dollar invested in the case management intervention, three dollars were returned in medical care cost savings



**ADSA** Aging & Disability  
Services Administration

## A View from Washington State

## References

Aging and Disability Services Administration  
[www.adsa.dshs.wa.gov](http://www.adsa.dshs.wa.gov)

AARP “A Balancing Act: State Long-Term Care Reform”  
[www.aarp.org/research/longtermcare/programfunding/2008\\_10\\_ltc.html](http://www.aarp.org/research/longtermcare/programfunding/2008_10_ltc.html)

The Lewin Group  
“Can Home and Community Based Services be Expanded without Busting the Budget”  
<http://www.nasua.org/ppt/Balancing%20Long%20Term%20Care.ppt#256>



**ADSA** Aging & Disability  
Services Administration

# **Improving Core Business Processes Supporting CA's MSSP Program**

Steven Lutzky, Ph.D.  
*Assistant Secretary  
HCBS Strategies*

# Improving Core Business Processes Supporting CA's MSSSP Program

HCBS STRATEGIES INC.

Steven Lutzky, Ph.D.

Presented at: Beyond the MSSSP Waiver: The Future of Care Coordination in California  
December 8, 2008



# HCBS Strategies

- Founded in May, 2004 by Steven Lutzky, Ph.D., with headquarters in Baltimore
- Dr. Lutzky has over a decade of experience as a consultant
  - Division Director at CMS
  - Headed up all Medicaid funded LTC for DC



# Major Clients

- State
  - Alaska Department of Health and Social Services
  - Illinois Department of Healthcare and Family Services
  - Illinois Department on Aging
  - Minnesota Department of Human Services
  - Maryland Department of Aging
  - DC Department of Mental Health
- Federal
  - Administration on Aging
  - Centers for Medicare and Medicaid Services

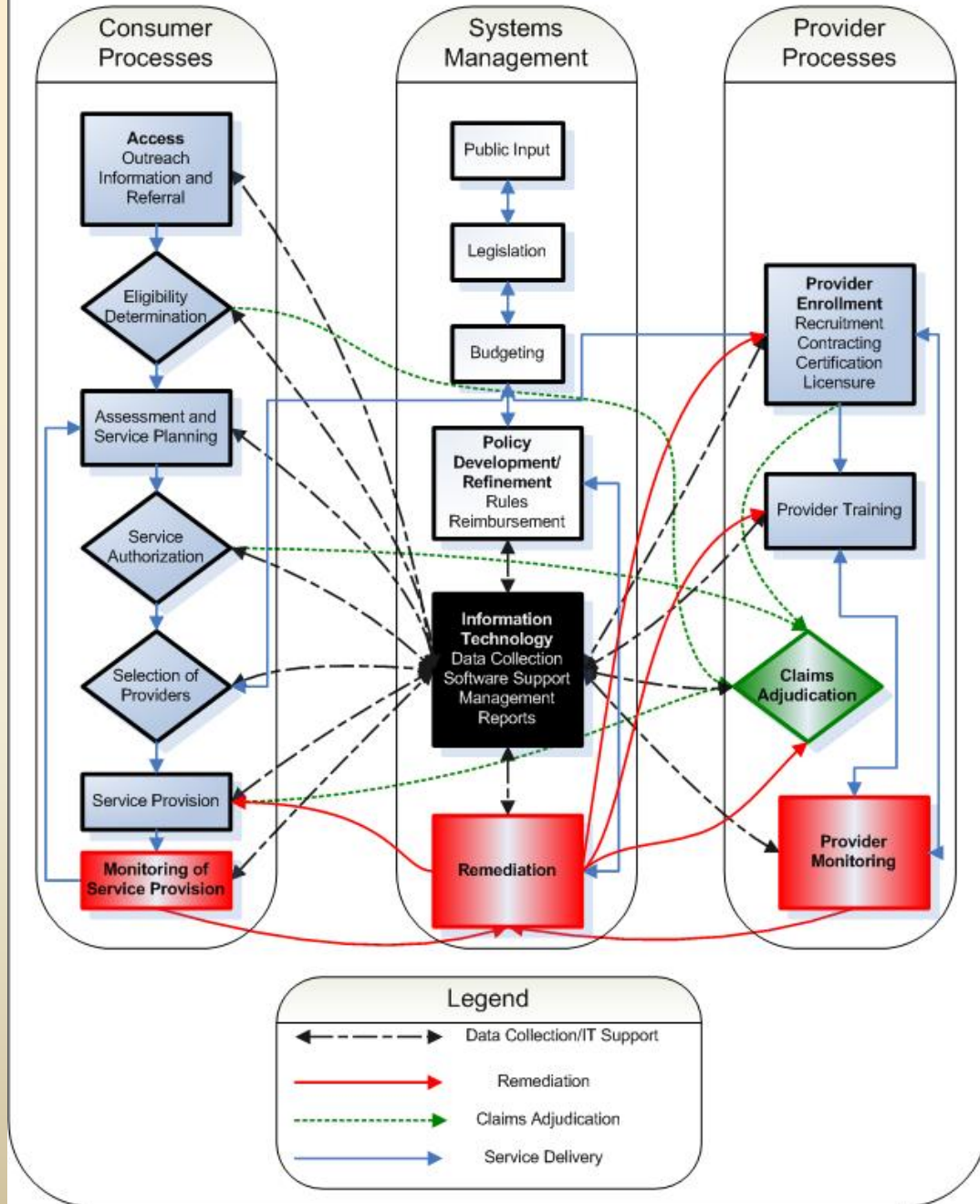


# Understanding HCBS as a Delivery System

- Providing HCBS involves several inter-related business processes
- These processes are inter-related
  - Changes in one will impact others
  - If you don't understand the system as a whole, you can get some bad results



# EXHIBIT 1: KEY HCBS BUSINESS PROCESSES



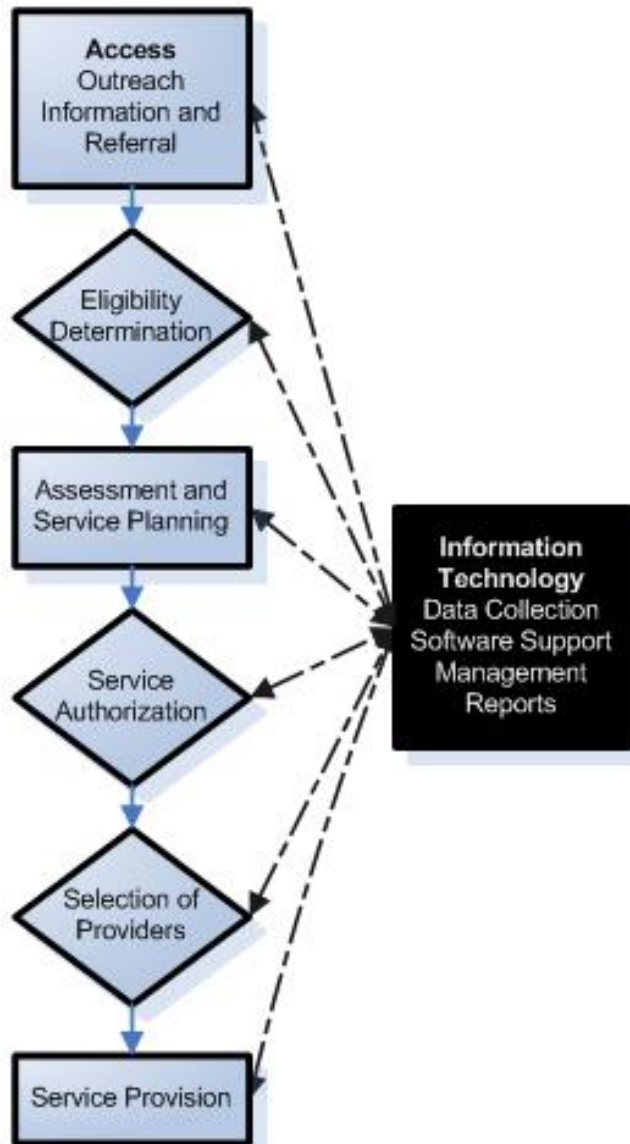
# Major Strength of MSSP

- **Network of agencies that are integrated into communities**
- **Have built capacity to manage budgets and risk**

# Overview of Major Challenges

- **Over-reliance on arcane rules and multiple forms**
- **Lack of performance based outcomes**
- **Lack of core infrastructure**
- **Free-for-all on the budget**

### Exhibit 2: Key Consumer Processes



# Access/Eligibility Determination

- Targeting/triaging
  - Differs by sites
  - No standard for identifying high-risk
  - Minimizes ability to divert
- Lack of integration of eligibility determinations (esp. with IHSS)
  - Bureaucratic hassle
  - Inability to assign to the most appropriate service array (e.g., IHSS only, both, etc.)
- No systemic databases
  - Common I & R system
  - Tracking unmet needs

# Assessment & Service Planning

- Need for better standardized tools
  - Unified assessment – one tool to rule
  - Consider InterRAI
- Electronic collection of data & software to support key business functions – part of MMIS
  - ❖ Enhanced match
  - ❖ Meeting CMS assurances
- Inability to tailor amount of care management to client

# Provider Selection & Service Authorization

## ➤ Selection of Providers

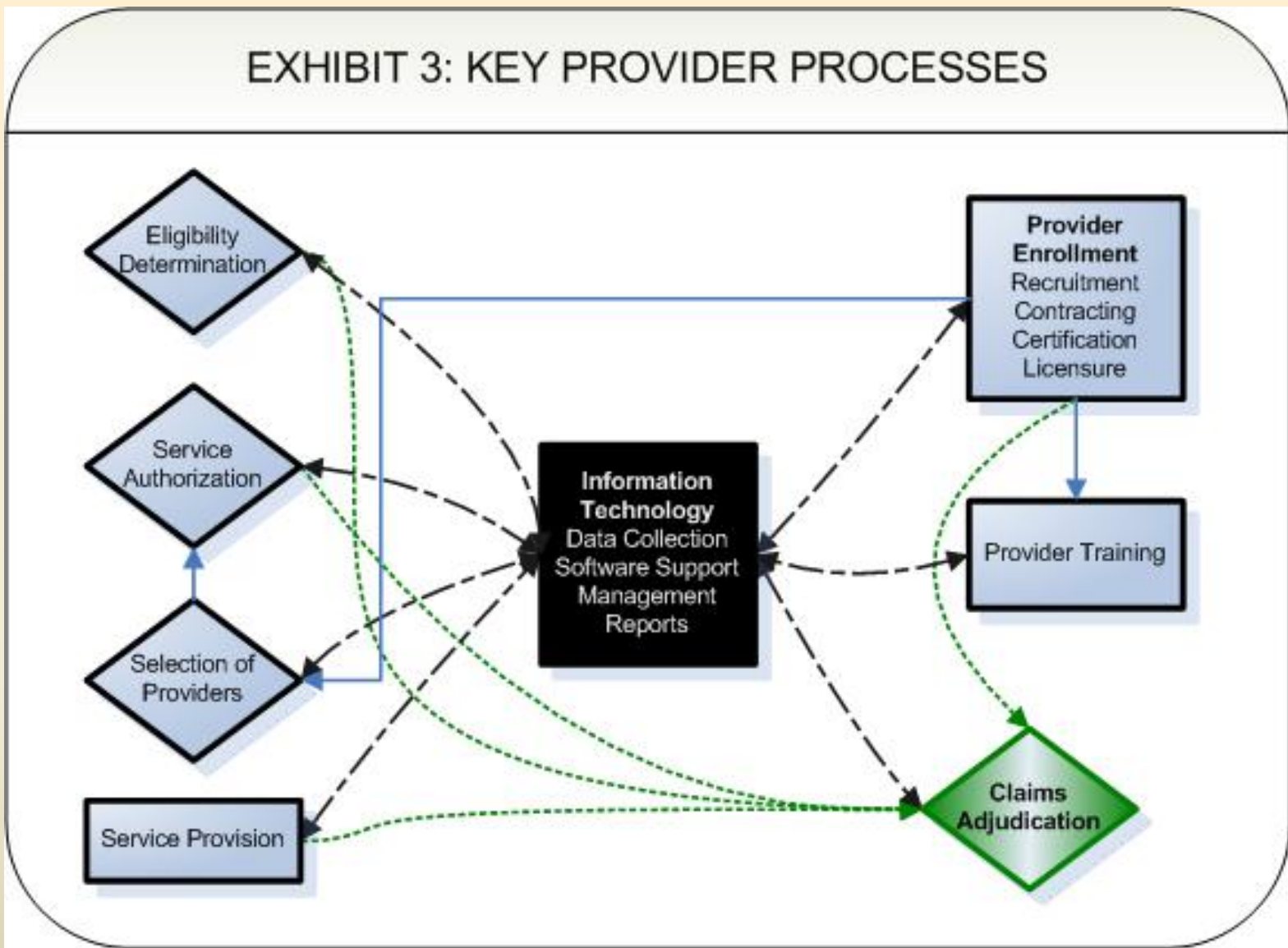
- limited information about providers, especially quality
- Choices made by word of mouth or guess
- Market forces not allowed to work
- State sponsored database including opportunity for consumer rating

## ➤ Service authorization

- Silo of MSSP from other services (esp. IHSS)
- Lack of guidance/benchmarks for establishing individual budgets



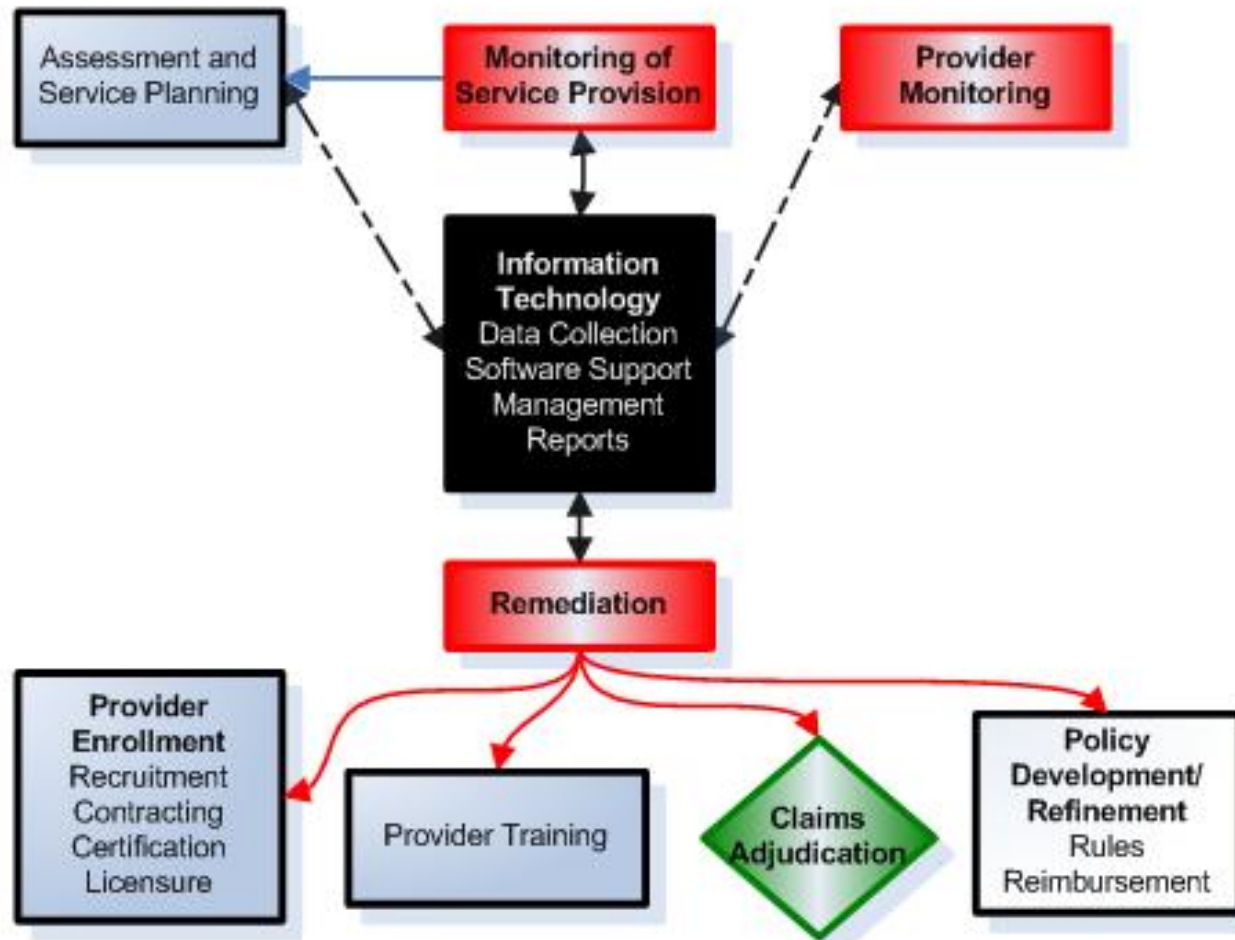
### EXHIBIT 3: KEY PROVIDER PROCESSES



# Provider Issues

- Provider enrollment
  - Inability to identify weaknesses
  - All willing provider concerns
- Setting rates that correspond to costs
  - Left up to individual sites/level of expertise varies
  - Audit concerns
- Training
  - Limited Requirements
  - Limited Capacity
  - Limited tracking ability

EXHIBIT 4: QUALITY MANAGEMENT PROCESSES



# Quality Management

- Lack of Standardized Performance Indicators Corresponding to CMS Assurances
- Limited capacity to determine:
  - Authorized services billed
  - Billed services actually provided
  - Provided services met needs and preferences

# Need Resources to Develop Infrastructure

- First develop a coherent plan
  - Must involve people on the frontlines: Care managers, providers, consumers
- Investment to build infrastructure
- Build mechanisms for state and individuals sites to manage cost and quality

# **Blueprint for the Future of Care Coordination**

Andrew E. Scharlach, Ph.D.

*Assistant Secretary*

*Center for the Advanced Study of Aging Services*

*University of California at Berkeley*

# Blueprint for the Future of Care Coordination

Andrew E. Scharlach, Ph.D.

Center for the Advanced Study of Aging Services  
University of California at Berkeley  
<http://cssr.berkeley.edu/aging/>

December 8, 2008



# *Presentation Outline:*



- Definitions and Types of CM (WHAT?)
- Goals of CM (WHY?)
- Roles & Core Tasks (HOW?)
- Principles, Values, and Standards (QUALITY)
- Models



# Policy Context

- California Long-Range Strategic Plan on Aging (SB 910)
- California Integrated Elder Care and Involvement Act of 2002 (SB 953)
- Aging Agenda for the 21<sup>st</sup> Century (Assemblywoman Patty Berg)
- Olmstead Plan
- California Community CHOICES

If you have seen one  
case management program,  
you have seen...

***One case management program.***

# Definitions of “Case Management”

“services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services.”

(Health Care Financing Administration, 2001)

“...coordinating services for vulnerable clients.”

(National Chronic Care Consortium, 2000)

# Definitions of “Case Management” (cont’d)

“...an intervention using a human service professional to arrange and monitor an optimum package of Long-Term Care services.”

(Applebaum & Austin, 1990)

“...the process of tailoring services to individual needs.”

(David Challis, 1999)

# Definitions of “Case Management” (cont’d)

“a component of the community care system. Its purpose is *to make the system work more efficiently* in order to assure that individuals receive assistance that is responsive to their needs.”

(NCOA, 1994)

# Goals of Case Management

1. Client System Goals
2. Administrative System Goals
3. Service Delivery System Goals

# CLIENT-SYSTEM GOALS

- Examples:
  - ✓ Increased functional capacity
  - ✓ Increased quality of life
  - ✓ Ability to remain in most desirable environment

# ADMINISTRATIVE-SYSTEM GOALS

- Examples:
  - ✓ Reduced costs
  - ✓ Reduced utilization of expensive services or treatment
  - ✓ Increased utilization of less expensive services (HCBS)



# SERVICE DELIVERY SYSTEM GOALS

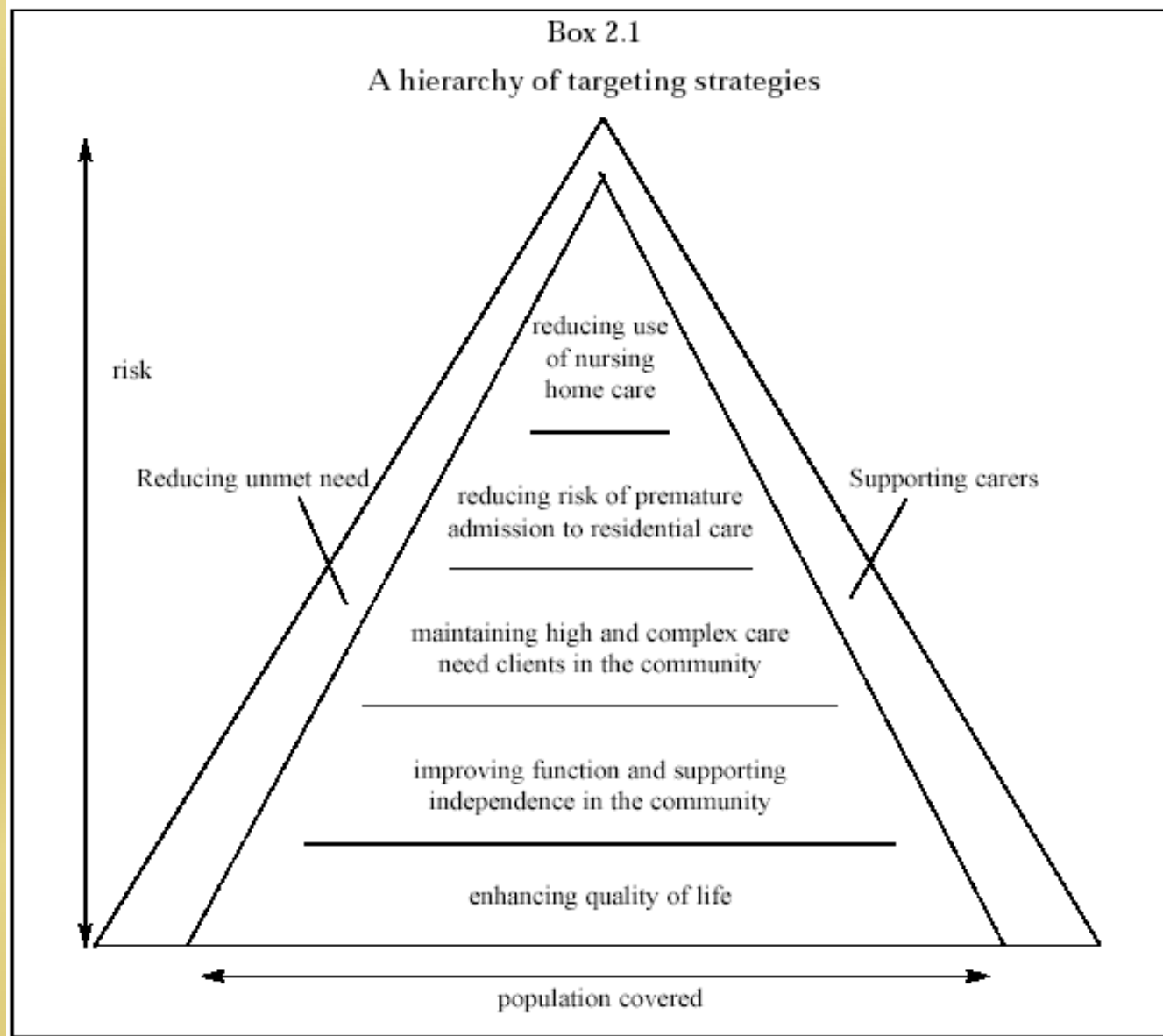
- Examples:
  - Increased efficiency
  - Increased accessibility
  - Increased consumer direction

# Outcome Patterns

- Service Utilization
  - Decrease in Institutionalization
  - Decrease in Acute Care
  - Increase in Home and Community-Based Services
- Functional Capacity
- Family Functioning
  - Decrease in Caregiver Strain
- Quality of Life
  - Increase in Social/Psychological Well-Being
  - Increase in Satisfaction with Services
  - Decrease in Unmet Need
- Cost
  - Overall cost can increase or decrease

# **Program Characteristics for Successful Outcomes**

- Small Caseload
- Specific Targeting Criteria
- Case Manager Training
- Case Manager Authority
- Case Management Intensity



A. Howe & L. Gray. Targeting in the Home and Community Care Program.  
July, 1999

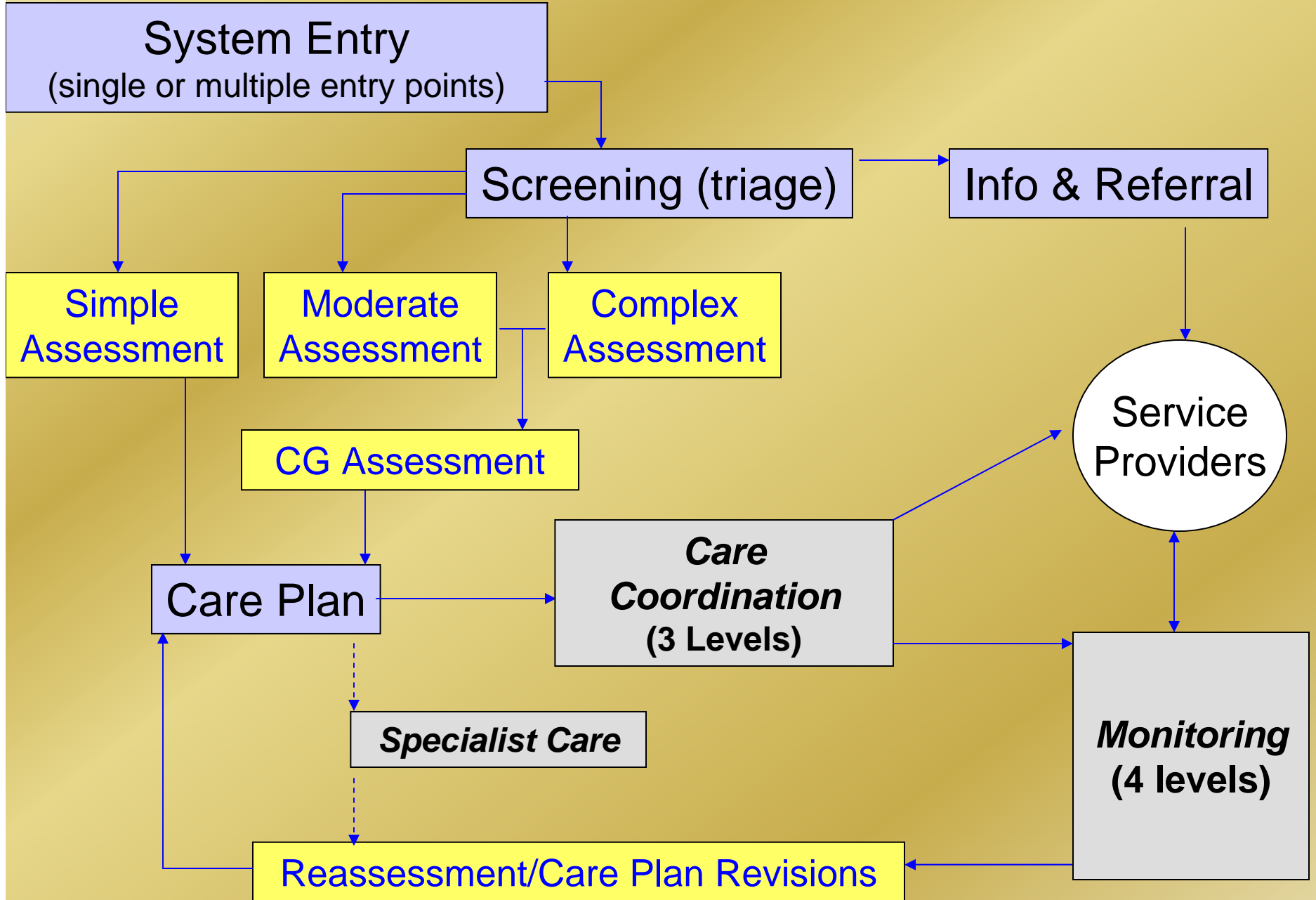
# Home and Community Care Targeting Model (Australia)

- I&R only (>80%)  
(Services from individual providers, no CM)
- Care Coordination (10-15%)  
(Assessment, care plan, service package)
- Intensive CM (2%)  
(Comprehensive assessment, care plan, service package, counseling, monitoring)

## Levels of Care Management Intensity

1. “Directory Assistance”: I&R
2. “Service Advisor”: enhanced I&R
3. “Care Consultant”: care planning, linkage, brokerage
4. “Care Coordinator”: service coordination and follow-up
5. “Intensive Care Management”: direct interventions with client +/- or service providers

# Differentiated Model Flowchart



The best way to predict the future  
is to invent it.

Peter Drucker



**THANK YOU!**

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## **Appendix IV. Washington State Case Study**

Among the many national experts who came to the convening to help share ideas with California MSSP practitioners was Kathy Leitch, the Assistant Secretary for the Washington State Department of Social and Health Services. Washington State has been pioneering efforts to integrate long-term care systems to better serve the people who rely on those services. This section is a short summary of the changes Washington State has made, and potential lessons for California.

### **Impetus for Change**

In the 1980s, Washington State was facing a huge budget crisis, and sought to reorganize its programs to address consumer needs and reform the nursing home budget. The state launched a pilot program to study nursing homes, including a study of Oregon's approach to the issue. Ultimately, Washington decided to reform the system to help those in the long-term care better understand their options, and to try to direct individuals towards the most appropriate option—thus diverting individuals who did not need the intensive care away from nursing home settings.

### **Change: System-Wide Plan**

One of the first steps in reform was to improve the integration and coordination among the state agencies which served the long-term care population. This involved not just programmatic changes to bring together services provided by different departments and agencies, but also to develop buy-in to a shared vision. This included working with the Secretary of Health, who was primarily focused on children's issues, as well as reaching out to the relevant legislative staff and bringing them onto the team.

Washington State has also taken a bigger picture approach to coordinating program eligibility assessments. Before nursing home applications are granted, applicants are assessed to determine whether they may be eligible for in-home, community-based care instead. This includes an educational component so that individuals understand all the options available to them in the community. Individuals now pay out of pocket for the services that best suit them, although there is also a financial eligibility component to the program.

Case managers are assigned to nursing homes to help follow up with clients to ensure they are reassigned, diverted or discharged as is appropriate, offering a continuity of client acuity assessment to help ensure individuals are receiving the right level of care. The number of nursing home clients has actually increased, despite the focus on diversion, which Leitch believes shows that people are being directed to the right care setting.

### **Change: Investing in Infrastructure Efficiencies**

Washington has developed a two-step assessment process that leverages both workforce and information technology efficiencies. Non-nursing staff have been given the responsibility of completing the initial client assessment. Those individuals identified as needing additional assessments will separate nurse-administered assessments. The process can be quite extensive in order to adequately capture the complex multiple issues that clients face, and which the program needs to understand early on. Laptops and an information technology system ensure that even if multiple staff members perform the assessment, all the information is

captured just once and does not need to be reentered. As mentioned previously in this paper, California should consider this approach in thinking about a new, uniform and statewide assessment system.

### **Change: Measuring Program Outcomes**

Washington's client assessment data has proven to be a rich source of information. The data is used not only to refer clients to all the programs and services for which they are eligible, it is also used to help policymakers and Legislators understand who is getting cared for, how many hours of home care are being provided, and that there is consistency in the types of services clients are receiving.

### **Metrics**

Today, Washington has a higher budgetary allocation than the national average for their long-term care services—the 2007–2009 budget was \$3 billion. There are now 24,800 participants in their waiver program, and 15,000 in the Medicaid personal care program which is most similar to the MSSP program. This includes not just seniors, but all adults over the age of 18 in need of long-term care. They have increased funding to in-home, community-based care, and while 87 percent of Washington's nursing home beds are occupied, they are monitoring the situation to divert more resources to community-based care if the demand rises.



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