California DEI Response to RFI

The Institute on Aging (IOA) would like to respond briefly, and somewhat incompletely to the Department's RFI -- mainly from the vantage point of a community-based provider of health care and supportive services for low income, frail older adults.

The IOA has, for many years, served as the provider in two Pace program sites, in San Francisco, under contract with On Lok. Virtually all the clients in the program are dually eligibile for MediCal and Medicare. The IOA has also, for many years, administered the MSSP program in San Francisco, and looks forward to continuing to do so. The IOA has also operated an Adult Day Health Center, one of the earliest of such programs in the State;

however. that program must close at the end of the month owing to the undertainties of

MediCal funding. These three programs sserve dually eligible clients who, for reasons of

frailty, would be considered *" nursing home eligible."* Our response to the RFI is, therefore, mainly focused on that group of dually eligible clients who have significant chronic illness

and disability with, in many instances, complicated associated problems of memory loss,

behavioral change, and various "geriatric syndromes" (falls,

incontinence,etc). These clients moreover, are frequently coping as well with difficult social support issues. Nonetheless,

with the help of PACE -- when they can enter its all-inclusive care program -- and outside PACE , with the help of the skilled care management services of MSSP, many of the clients are able to continue living successfully in the community, avoiding institutional care.

1. Whatever the enrollment model, it will be essential that dually eligible beneficiaries have

the benefit of *easy access to high quality primary care sservices* to assure coordination and

continuity of care. Excellent primary care, perferably involving an interdisciplinary health

team, should be a central requirement in any of the models of care for the dually eligible.

For those with significant frailty ("*nursing home eligible*") no program provides geriatric care

that is so comprehensive and well coordinated at the PACE program. Its central core is high
quality primary care by an interdisciplinary health care team. The RFI itself eloquently
describes the many unique advantages of the PACE program. Whatever enrollment processes are selected by the Department in the pilot programs, they must be designed to
make the Pace program well known to those eligible - and provide
ample opportunity to join the program. Robust notification about the
program and appropriate "marketing" is necessary so that this valuable
community resource does not get overlooked or "lost in the shuffle" of health plans. If available in its area, the pilot programs should insure that the PACE program is utilized to the fullest extent possible..
And, whatever enrollment model is selected, the model should make full use of the skilled care management services of the MSSP for dually eligible frail seniors who are not in Pace, but receiving health care services from other
providers. Those providers usually do *not themselves* offer the all-important care management services that are required for overal
success of the care process. This remains an exceedingly important role for MSSP, and should be made readily available to eligible clients through appropriate contractual arrangements.
2. <u>All</u> of the services currently offered by PACE are essential to proper care and should be
included in an integrated model.
3. Many clients with mental health problems, especially those related to memory loss, but also individuals with behavioral issues, can be care for successfully in the PACE program
with proper staffing and staffing training. Our experience at the "Fillmore" Pace site in San Francisco has demonstrated this to be the case. The Department can assist the integration of
mental health issues into the overall constellation of problems cared for by PACE programs *by adapting its eligiblity rules for PACE to accomodate and encourage this* -- rather than directing the clients to segregated mental health programs "specialized" in such care, or to institutional care. PACE is still an underutilized resource for care of older adults with
chronic mental health issues - because, in part, the approval process (when reviewing "nursing home eligible") does not give adequate weight to mental health factors.

4. On Lok and CALPACE will respond to this RFI question more cogently. Suffice it to say that in the IOA's vie, the capitated MediCal/Medicare reimbursement arrangement for PACE has worked extremely well, has alligned incentives in a balanced way, and has allowed PACE to combine its skills in geriatric care and social support with conscientious and thoughtful use of resources. It remains an exceedingly important model of integrated and comprehensive care of older adults and should receive the Department's unqualified endorsement in development of the Pilot programs.

5. See #2. For many dually eligible clients who meet the necessary "nursing home eligible" standard but who do not obtain PACE services, experienced care-management is a key ingredient in successful community based care. The MSSP care management services should be made available, under contractual arrangements, in all the counties.

7. Questions we would ask of a potential contractor would include:
How would you make robust use of PACE program services, if they are available in your area? How would you make eligible clients aware of the program and encourage their enrollment?
Are you aware of the MSSP program and its special case-management and supportive services. How would you plan to utilize this valuable resource in the plans for your clients.

6. Related to the answer to 7 above, is the need for education and outreach about community-based services that are designed to help in the care of frail older adults who need easily accessible primary care, coordinated services , and care management. Valuable programs such as PACE and MSSP are all too often overlooked and underutilized because of failure to educate providers, beneficiaries and other stakeholders of their vital roles.

8. The Department should review the track record of potential contractors for commitment to services for the underserved and to standards of excellence in health care and

social support. The best index of cultural competency and sensitivity to the client population might be found in the staffing patterns of the agency. Is there good representation by
racial and ethnic minorities, women, LGBT at all levels of client care, including management
and governance?

9. I believe we have described the contribution we would hope to make in terms of PACE, MSSP and also the other non-Medical community- based services we offer for older and disabled adults. Eg. social models adult day health care; alzheimer's care services; fiduciary
services; elder abuse prevention.

10. Make sure that the pilot programs would make full use of PACE and MSSP

11. The Department's plan for "rigorous evaluation" will require the assistance of individuals
skilled in health services research, perhaps from one of the UC campuses.
One suggestion for what it may be worth: It might be valuable to select comparison groups
from counties outside the pilot program areas - *early in the implementatin process*, so as to
get comparative measures of health status, service utilization and perceived satisfaction with
health care in the pilot counties and non-pilot counties. The Department should provide the
budgetary support and data systems support that a rigorous evaluation would entail. An
advisory committee representing the various interested parties, should be chosen at an early
stage in the project, to give needed transparency and to allow opportunity for contrasting views on the pilot project to be expressed and explored.

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