The dual eligible population would best be served by a program when the enrollment process allows changes no more than once a year. Limiting change to once a year prevents plans from encouraging or discouraging participation based on needed services, but allows ample time for participants to follow a course of treatment and personally measure perceived program benefit. . Enrollment to the program would be unrestricted to all eligible persons and participating providers will not have the option of restricting potential participants. A single enrollment submission, (as opposed to separate enrollment for the federal and state governments) for a participant would also be desirable by decreasing the labor requirements and increasing efficiency, (thereby reducing administrative costs) of enrollment.

Long term Medicaid support services would include payment for and coordination of alternative skilled nursing accommodations. The contracting providers will be granted waivers in order to subsidize assisted living or RCFE living accommodations. Total care including medical, behavioral health counseling, DME, chore workers, meals, transportation, case management, nutrition counseling and any type of expenditure deemed necessary to enhance the quality of life and decrease cost of care for the participant.

Behavioral health services should be integrated into any healthcare delivery model as a seamless component of the program, fully integrating this currently disparate method of care. Full integration as part of a primary care clinic model reduces the stigma of seeking treatment for behavioral health illnesses and also will help reduce the negative physical outcomes of participants by reducing or eliminating the aggravation of anxiety or stress. *

Any potential contractors for participation in the dual eligible pilot program would need to demonstrate the ability to capture data and provide analytical analysis based on outcomes. Potential contractors for the pilot program should be required to demonstrate previous Medicaid population experience. Theoretically historical experience with this target group will have provided any potential contractor with the skills to care for a population with above average needs coupled with a low reimbursement structure.

Success of the pilots should demonstrate a trend in cost savings, measurable difference in the slowing of the deterioration of ADL's for the participant population based on a comparable control group.

Financial arrangements should include cost saving incentives to be shared by CMS, DHCS and the contractor. All cost savings must be supported by increased quality measures.

- In evaluating the costs for integrated primary care, there are two competing trends to be considered. One is the trend toward lower medical cost in the presence of psychosocial intervention (Budman, Demby & Feldstein, 1984; Cummings, Dorken, Pallack
- & Henke, 1990; Jones & Vischi, 1979; Katon, 1995, Mumford, Schlesinger & Glass, 1981; Mumford, Schlesinger, Glass, Patrick & Cuerdon, 1984). The other is the trend toward wider utilization of mental health services when they are available

in the primary care site. The literature on medical cost savings, especially in the presence of targeted, focused mental health services, is compelling. Cummings and his collaborators studied the Hawaii Medicaid Project and found that when therapy was targeted toward the highest utilizers of medical care and focused on specific problem resolution, medical costs were reduced for all groups in the first year after the beginning of treatment, even when the cost of the mental health treatment was included. The cost reductions were 38% for Medicaid patients who were not chronically ill, 18% for Medicaid patients who were chronically ill, 35% for "employed" patients (their term for patients on group health insurance through an employer) who were not chronically ill, 31% for employed patients who were chronically ill, and 15% for Medicaid patients who had substance abuse diagnoses. http://www.integratedprimarycare.com/cost%20effectiveness.htm