

Blue Shield of California Foundation
Key Points & Major Take-Aways of Medi-Cal Waiver Meetings
Oakland – July 23, 2009
Sacramento – July 28, 2009
Los Angeles – July 29, 2009

Organizations Represented

- ARC
- AARP
- AIDS Project LA
- Alzheimer’s Association
- Alzheimer’s Coalition
- California Children’s Hospital Association
- California Commission on Aging
- California Foundation on Independent Living Centers
- Cedars Sinai Medical Center
- Children’s Hospital Orange County
- CMSP
- Contra Costa Health Plan
- Disabilities Rights Education and Defense Fund
- Greater Los Angeles Agency on Deafness (GLAD)
- Independent Living Resource Center, San Francisco
- LA Care
- LifeLong Medical Care
- Lighthouse for the Blind
- National Health Law Program
- On Lok
- Packard Children’s Hospital
- Rancho Los Amigos
- San Mateo County Behavioral Health
- Santa Barbara, Ventura and San Luis Obispo Centers for Independent Living
- Senior Services Coalition of Alameda County
- Through the Looking Glass
- United Cerebral Palsy
- Westside Center for Independent Living

Purpose

Surface in-depth perspectives from engaged leaders on systems of care for Medi-Cal beneficiaries who are seniors and persons with disabilities and their advocates to inform decisions about California’s new Section 1115 Medi-Cal waiver to replace waiver expiring in August 2010.

Key Points/Major Take Aways

Medical Home

- Medical home concept generally appears to be acceptable to all, but participants wanted a better understanding of how “medical home” would be defined.
- Identify, test and evaluate models for medical homes for seniors and people with disabilities.
 - Models should be driven by principles and be evidence-based.
 - Develop knowledge base among advocates and State regarding models for medical homes.

- Enhanced medical home model needs stakeholder involvement and guidelines that are clearly articulated.
- Possible guiding principles for a medical home:
 - Medical home should be designed around unique needs of patients.
 - The system must be universal, not county specific, but have flexibility to implement system outcomes on a local basis.
 - There must be care coordination.
 - Rates must be reasonable and reflect the time and access needs of people with mobility, communication and cognitive needs.
 - Providers need to know the clinical needs of the target population served by that medical home
 - Pay special attention to rural areas.
 - Protect local safety net provider(s).
 - Quality improvement measures should be specific to people with disabilities, with clear performance measures and ongoing evaluation, and must be different for adults and children. Refer back to the CHCF standards.
 - Use evidence-based models.
 - Separate adults and children in designing the system for people with disabilities.
 - Encourage flexible use of funding.
 - Ensure that any medical home serving people with disabilities be accessible to the group it is qualified to serve.
 - Care model must be preventive and include primary, secondary and tertiary prevention.
 - Care model must understand the person in the context of their community (family, social and work life).
 - Patient and family education, empowerment and responsibility must be promoted.

Accountability

- Mandate inclusion of consumers and caregivers along with providers and community agencies to inform the process and create solutions.
- System needs trust between State and advocates and needs to recognize people's individual needs.
- Comprehensiveness is essential: care coordination must include community supports. This came up in all three stakeholder groups.
- Hold providers within a medical home accountable to provide services across the spectrum of disabilities for the patients they serve.
- Build in requirement to include expertise of needs of people with disabilities.
- There must be a system to ensure physical, communication and program accessible services and facilities.

Managed Care Issues

- Managed care should be voluntary for people with disabilities, including children who are in the ABD category.

- Change the name “managed care” because it feels like reducing services. Health maintenance measured by true health outcomes would be attractive to people.
- Transportation is essential and would attract people to managed care.
- There is not a one-size-fits-all managed care system that would meet people’s individual needs. Therefore, the system needs flexible approaches for different types of patient groups: those with mental health needs, chronic illness, or mobility and sensory disabilities.

Social Health Model/Medical Necessity

- Change the definition of “medical necessity”. Identify preventive services for seniors and people with disabilities that are would be better classified as “medically necessary”. For some people, there must be the flexibility to take advantage of what the individual needs to achieve a more expanded definition of health or “living necessity” or functioning.
- Change institutional bias of the state from bias for nursing homes: promote home and community services.
- Consider making home and community-based services the core of the waiver.
- Provider must facilitate linkages to other community services.