SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER
DUAL ELIGIBLES TECHNICAL WORKGROUP
Meeting #1 – Tuesday, April 27, 2010
10:00am – 3:00pm
USC State Capitol Center, 1801 I Street, Sacramento

The meeting convened at 10 AM.

Attendance

Technical Workgroup members attending: April Alexander, Molina Healthcare; Maya Altman, Health Plan of San Mateo; Richard Chambers, California Association of Health Insuring Organizations (CalOptima); Bonnie Darwin, California Culture Change Commission; Sandi Fitzpatrick, California Commission on Aging; Brad Gilbert, Inland Empire Health Plan; Nancy Hayward, California Association of Health Facilities; Janet Heath, MSSP Site Directors' Association; Marilyn Holle, Disability Rights California; Michael Humphrey, Sonoma County IHSS Public Authority; Cynthia Jackson Kelartinian, Heritage Clinic, Pasadena; David Kieffer, SEIU; Marty Lynch, LifeLong Medical Care (on phone); Jackie McGrath, California Council of the Alzheimer's Association/Chronic Care Coalition; Cheryl Phillips, On Lok/PACE (on phone); Kevin Prindiville, National Senior Citizens Law Center; Dawn Myers Purkey, Woodland Healthcare/Yolo Adult Day Health Center; Timothy Schwab, SCAN Health Plan; Lisa Shugarman, The SCAN Foundation; Patricia Sussman, Contra Costa Health Plan; Sarah Takahama, California Association of Physician Groups; Suzanne Tavano, California Mental Health Directors Association; Ed Walsh, Area Agencies on Aging; Mary E. Whitehead, Scripps Health; Casey Young, AARP.

Others attending: David Maxwell-Jolly, Director, DHCS; Gregory Franklin, Director of Medi-Cal Operations; Melanie Bella, CHCS; Paul Miller, DHCS; Dean Scourtes, DHCS; Brian Hansen, DHCS; Eileen Carroll, DSS; Lora Connolly, CA Department of Aging; Giang Nguyen, CDMH; Carol Risley, CA Department of Developmental Services.

Public in Attendance: 10 individuals attended in person, and 50 people called in on the listen-only telephone line.

Welcome and Introductions

Bobbie Wunsch welcomed the group and thanked them for their participation. She thanked Lisa Shugarman and the SCAN Foundation for their support of the process, and the USC State Capitol Center for hosting the meeting.

Co-leads of the Duals Technical Workgroup (TWG), along with Bobbie Wunsch, are Brian Hansen, DHCS, Paul Miller, DHCS, and Alice Lind, CHCS.

Meetings of the Duals TWG are open to the public in three ways: members of the public can attend in person or on the listen-only phone line and a written summary will be distributed to the workgroup and posted on the duals webpage approximately one week after the meeting. Additional meetings will be held on:

- May 19, Sacramento Convention Center, Rooms 104-105
- June 3, Sacramento Convention Center, Rooms 104-105

The purpose of the Workgroup meetings is to help DHCS understand issues facing dual eligibles and the provider network that serve or could serve them. While the group's discussions inform the proceedings of the legislatively-mandated Stakeholder Advisory Committee (SAC), the group is advisory to DHCS.

Overview of the Purpose and Desired Outcomes of the Dual Eligibles TWG

David Maxwell-Jolly, Director, DHCS, welcomed the group and thanked members for their participation. He noted that it is the largest of the technical workgroups (TWGs), and that the complexity of the issue means that a number of other agencies are also involved.

David Maxwell-Jolly introduced a document entitled *Persons with Dual Medi-Cal and Medicare Eligibility* (available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Persons_with_Dual_Medi_427accepted_changes.pdf). The paper represents an initial effort to identify the opportunities for integrating services for duals. Dually eligible individuals represent a large and high-need group. The population is similar in some ways to the Seniors and Persons with Disabilities (SPD) group, many of whom will eventually gain Medicare eligibility and become dual-eligibles themselves, with the key difference that the duals group is predominantly elderly.

Currently, these clients are predominantly served in fee-for-service (FFS) Medi-Cal, with attendant disorganization. Some clients can do a good job of navigating the systems, but many have trouble accessing services. DHCS believes that providing an organized infrastructure can provide significant benefits for beneficiaries relative to FFS.

Medicare and Medicaid have siloed funding streams with different rules, spheres of influence, controls, and payment rules, and the intersection of the two can be burdensome and painful to maneuver for providers and beneficiaries alike. In addition, while cost-saving steps on the Medi-Cal side that might result in hospital savings, these are lost to the state since they can't be retained across Medicare.

Another bifurcation is between Medicare's focus on acute care and Medicaid's focus on long-term care. Because of that division, beneficiaries who move from one treatment location to another, or from an institution to home, sometimes move from one payment mechanism, care management structure, and set of controls to another. In DHCS's view, this is inefficient and leads to a loss of resources. Yet another dichotomy is between physical and behavioral health care. The BHI TWG has devoted significant time to discussing how to bridge that gap, but the specific impact on duals requires attention.

DHCS's existing work with the SCAN Foundation and CHCS provides a foundation for this Workgroup. The goal is to build on the knowledge base represented by the papers, stakeholder interviews, and public discussions. DHCS has opened discussions with CMS: they are very interested in better coordination and the new HCR law ratifies that interest.

David Maxwell-Jolly emphasized that DHCS has not decided on a course of action. They do not anticipate that the full strategy will be in place by the end of the current waiver period on August 31. He noted that dual-eligibles are already integrated into some organized Med-Cal systems of care, as in the special needs plans (SNPs) in some County-Organized Health Systems (COHS). He said that DHCS would like to use those as a model for experimenting with greater integration.

DHCS understands that Medicare represents a key revenue source for many providers, and in many cases is favored over Medi-Cal. These revenues are critical for the hospitals that are the State's key partners in Medi-Cal, and there is no intention to threaten that. DHCS also is realistic about the challenges to funding for home- and community-based services (HCBS) and the lack of additional state General Fund resources.

DHCS' goals for the workgroup are to review the options for integration that have been presented already, discuss additional ideas that are raised, and come up with practical recommendations about which options are feasible and how they could be accomplished. David Maxwell-Jolly emphasized that he hopes to come up with something the state can do: the next best step to push the envelope on integration, that is feasible in the context of the waiver and that can provide a good foundation for future improvements.

Marty Lynch, LifeLong Medical Care, said he appreciated the opportunity, after many years of discussion, to move the needle on this issue. Dual-eligibles' ability to find what they need is severely impaired by having HCBS, behavioral health, and medical care all in different places. He cautioned that any changes to Medicare engender a great deal of fear, and that the process should be sensitive to that.

Brad Gilbert, IEHP, noted that in addition to SNPs in COHS, there are local initiatives (LIs) and commercial plans that also have both Medi-Cal and SNP. David Maxwell-Jolly said that this was on point, and that the Workgroup should discuss this issue if there is a feeling that DHCS' focus on COHS is too narrow.

David Kieffer, SEIU, said that the Workgroup should look to Medicare providers for their expertise. Kaiser has the largest SNP in the state, with 60,000 duals, and that expertise should be included. David Maxwell-Jolly agreed, and said he hoped to get input from them over the next few meetings.

Lisa Shugarman, SCAN Foundation, asked whether the state's goals were integration of services, funds, or both. David Maxwell-Jolly responded that if you don't integrate both, you run the risk of losing resources that have been dedicated to the population. One advantage of global budgeting/global responsibility models is that you don't risk losing your savings in the next budget round. DHCS fundamentally believes that things work best when budget and organizational responsibility are unified.

Marilyn Holle, Disability Rights California, asked whether California could get a Medicare waiver alongside the Section 1115 waiver in order to capture savings in hospital care as a result of HCBS. David Maxwell-Jolly replied that that would be the goal under any structure. The most aggressive option under discussion would be unification of Medicaid and Medicare finances at the state level, with a capitation to the state from Medicare: this would allow California to hold onto any savings. Around the country, various states have formulas

for sharing Medicaid and Medicare savings that aren't as global, and these are also options. He said that CMS is very interested in structures that allow for shared savings.

Bonnie Darwin, CCCC, asked to what extent it would be possible to phase in any changes, to avoid moving large groups of people at once as in Medicare Part D. David Maxwell-Jolly said a phased implementation would be a requirement.

Suzanne Tavano, CMHDA, said that issues of substance use confound all the outcomes across medical and behavioral health care, and should be factored in. David Maxwell-Jolly said that this issue has been discussed in the BHI TWG, with a focus on the state's very low investment in SA treatment in the existing Medicaid program. Bobbie Wunsch noted that behavioral health issues will be on the agenda at the second meeting.

Casey Young, AARP, said he appreciated the focus on HCBS and the caution that it may not be possible to get everything done at once, but noted that depending on the budget outcomes, there may be an argument for being more aggressive in moving forward.

Tim Schwab, SCAN Health Plan, noted that one difference between Medi-Cal and Medicare is that Medicare encompasses behavioral health issues as an acute care benefit, in contrast to Medi-Cal. Thus, integrating the two programs means incorporating behavioral health to a significant extent. On the Medicare side, providers have learned that it's not possible to carve out behavioral health and still care for the population.

Cynthia Jackson Kelartinian, Heritage Clinic, said that it is essential to figure out where dementia care fits. Currently, it is always handed off – neither mental health nor physical health want it, and it constitutes an extraordinary expense. Behavioral health for this population is often best delivered within the HCBS array. She cautioned that since behavioral health benefits in Medicare are so different from in Medi-Cal, pulling the two together is a very complex issue.

Jackie McGrath, Alzheimer's Association, said that testimony at an April 26 budget hearing suggested that specifics about federal health care reform (HCR) implementation might not be available by August. Flexibility is needed given this uncertainty. She requested that more information be provided to the group as it becomes available.

DHCS Draft Concept for Improving Care for Duals

Greg Franklin, DHCS Waiver Project Director, discussed the status of the waiver concept and the draft paper on duals. His presentation is available at http://www.dhcs.ca.gov/Documents/Duals%20Proposal%20Overview%204-21%20gf1.pdf.

He announced that all four of the other technical workgroups will complete their meetings by the end of April. DHCS intends to issue a draft implementation plan in the first week of May, and to discuss it at the Stakeholder Advisory Committee (SAC) meeting on May 13. This portion of the implementation plan addressing dual-eligibles will not be completed for that version of the implementation plan.

DHCS has been meeting by phone on a bi-weekly basis with CMS, and keeping them informed of the state's progress on the waiver. DHCS' goal is a new comprehensive waiver by September 1, 2010.

Kevin Prindiville, NSCLC, asked to what extent the waiver is a unique opportunity, and which goals might be achieved outside the waiver process, and said that understanding these opportunities and limitations would be helpful. Greg Franklin said that the concept paper released in December 2009 remains the best guide to the state's plans: DHCS is interested in moving these high-needs populations into better care arrangements. On a broad scale, the state is trying to be efficient with a historically expensive population, and these changes may be best accomplished through demonstration projects. The stakeholder process is an opportunity to understand what's realistic and where the barriers are.

Lora Connolly, California Department of Aging, asked about changes at CMS that would bring Medicaid and Medicare together. Greg Franklin said that he understands that the agency is moving in that direction. Lora asked whether DHCS was receiving any direction from CMS about what would be allowable in a waiver, given HCR. Greg Franklin replied that CMS' is clearly interested in how any waiver proposals align with HCR.

Data Presentation

Bobbie Wunsch introduced Melanie Bella, CHCS, and Dean Scourtes, DHCS, to present state and national data. She asked Workgroup members to think about additional data that would be helpful to the process.

National Data

Melanie Bella, CHCS, recognized the SCAN Foundation for supporting CHCS' work with DHCS on this issue, and noted that the data are from multiple sources: the Urban Institute (for the Kaiser Commission on Medicaid and the Uninsured) and the Hilltop Institute (using MedPAC data). Thus, the data have certain limitations, including representing different years (2003 and 2005). She noted specifically that the 2003 data predates the implementation of Medicare Part D. Her presentation is available at http://www.dhcs.ca.gov/Documents/Dual%20Eligibles%20National%20Data%20Snapshot.pdf.

Marty Lynch, LifeLong Medical Care, asked whether there was an age breakdown (under 65/over 65) for the disease prevalence information (slide 15), and Cheryl Phillips asked whether psychiatric diagnoses included dementia, which CMS' data show can predict up to 40% in increased costs for another diagnosis. Melanie Bella said that the age information could be made available, and that the psychiatric diagnosis and dementia in particular require additional investigation. She said that diagnosis data is taken from the Chronic Illness and Disability Payment System (CDPS), a risk adjustment system, and that the category of psychiatric diagnoses is a roll-up that could include dementia, but that it is certainly underrepresented. In addition, she noted that the diagnoses tend to be representative of seniors, and on the mental health side many SMI diagnoses, including schizophrenia, are not included. *Jackie McGrath, Alzheimer's Association,* said that recent research shows that fewer than 20% of people with dementia had it noted in their medical record, and that pulling out dementia diagnoses may therefore be of limited utility.

Tim Schwab, SCAN Health Plan, noted a discrepancy in the magnitude of difference between duals and Medicare-only beneficiaries in their utilization versus their increased expenses. Melanie Bella did not have an explanation but said it was worth further investigation.

Mike Humphrey, Sonoma IHSS, asked where the 120,000 individuals who are in fully integrated Medicaid/Medicare arrangements are located, and what is known about their experience. Melanie Bella said that many are in the 3 states with the original Medicaid/Medicare demonstration projects: Wisconsin, Massachusetts, and Minnesota. New Mexico has since developed a program, and there are smaller efforts such as California's SCAN Health Plan. Melanie said that there is not as much research into these arrangements as there could be. There were few studies of the early states, and while there is data about consumer and provider satisfaction, there is little on clinical outcomes (although that data is getting stronger). The Medicare Payment Advisory Commission (MedPAC) has engaged Mathematica to do case studies of these integrated models, and has funded linkage of Medicare and Medicaid data (see presentation from April 2010 meeting available online at http://www.medpac.gov/transcripts/duals%20april%202010.pdf. State level data exists but is not yet available to the public.

Jackie McGrath, Alzheimer's Association, asked whether the 120,000 included individuals enrolled in PACE models. Melanie said it counted only SNPs, and thus not PACE enrollees: they number approximately 20,000 in 30 states.

California Data

Dean Scourtes, Research and Analytical Studies Section, DHCS, presented slides summarizing a 60-page paper on dual eligibles in California. The full report is available at http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal%27s%20Dual%20Eligible%20Population.pdf, and the slides presentation is at http://www.dhcs.ca.gov/Documents/Dual%20Eligibles%20Summary%20California%20Data.pdf.

Tim Schwab, SCAN Health Plan, asked whether the capitated programs (PACE, SCAN, Kaiser) were included in the cost analysis. Dean Scourtes replied that they were included in the overall analysis: capitated programs in the capitation category, and carve-outs with FFS payments. However, the samples were limited to people enrolled in FFS for 12 continuous months, so people in capitated programs were not part of those analyses.

Bonnie Darwin, CCCC, asked whether there was any way to project what the federal government is spending on the Medicare side. Dean Scourtes said that one would have to look to the literature; it is not possible to do a 1:1 match of the data.

Casey Young, AARP, said that that information is fundamental to the duals project. Much of the money goes to nursing facilities, for example, and the state has to have a plan in that area. He asked whether DHCS had drilled down to analyze where exactly in the FFS system people are receiving care. Dean Scourtes answered that the paper drills down to the vendor code level, so it is possible to differentiate private offices from FQHCs, for example. The data show more physicians than clinics, but counties vary tremendously in their

reliance on clinics. *Cheryl Phillips, PACE,* noted that physician services are billed to Medicare for duals, and private physicians are more willing to take Medicare than Medi-Cal. Dean Scourtes said that the question of service location is a good area for follow-up.

Eileen Carroll, CA DSS, asked whether people in IHSS who are under 65 would all be dually eligible. Dean Scourtes said that some would be, and clarified that the analysis includes all costs that they received from DSS for duals. *Michael Humphrey, Sonoma County IHSS,* said that this was an important question, and clarified that many people in IHSS are Medi-Cal only.

Summary

Melanie Bella, CHCS, summarized the national and state data presentations. She said that integration can improve care and outcomes by:

- Looking for areas of high overlap between Medicaid and Medicare, duplications, avoidable utilization, gaps in care, etc.
    - Inpatient hospital: avoidable hospitalizations for institutionalized and community-based duals
    - Home health: overlaps, proxies to show utilization driven by "cost shifting"
    - SNF AND NF: overlaps, opportunities for cost shifting
    - Pharmacy: utilization and spending broken out by institutionalized vs. non-institutionalized, polypharmacy, contra-indications
- Coordinating (Medicare) hospital discharge planning with (Medicaid) community-based supports and services
- Improving transitions between institutional and community settings, such as hospital and home, hospital and nursing facility, nursing facility and home

Melanie Bella said that one way of addressing integration could be to look at subsets of the population: people whose needs are LTC-driven and who are institutionalized; people whose needs are LTC-driven and who are in the community; and people whose needs are acute-care driven. She also said that CMS is interested in putting resources into a better understanding of the two programs.

David Kieffer, SEIU, cited the SEIU model for nursing home rebalancing, and said that the study finds that there could be as much as $6-7 million in annual savings if discharge planning and transitions between care settings could be improved.

Ed Walsh, Area Agencies on Aging, said that his agency has a care coordinator resident at the hospital to provide a bridge service from there to LTC or other settings, and that this service has made a big difference. They are also working on the Coleman transition care model, which tracks transitions according to specific chronic disease diagnoses.

Mary Whitehead, Scripps Health, noted that many in the duals population are driven into institutions in order to receive care. In some cases, they are not able to discharge people to a lower level of care because of the reimbursement rates. Often, the high utilization on the institutional side is due to a lack of other options. There are a number of effective case management models, but they are not always used to their potential.

Marty Lynch, LifeLong Medical Care, said he was struck by how much of the cost is in LTC. Negotiating some shared savings with Medicare is essential for the state, as is shifting the balance from institutional care to HCBS.

Lora Connolly, CA Department of Aging, said that missing from the state's presentation are the "what-if's" – what could be done for the same amount of money? She said she would be interested in hearing more detailed information about models in other states, even if outcome data is not available.

Carol Risley, CA DDS, asked how this discussion fits with the reality of severe budget cuts to HCBS in particular. She said she understands the concept of using the same dollars differently, but that if the HCBS service system is so diminished, realistically there is nothing to shift people to.

Suzanne Tavano, CMHDA, said that hospital care is a dilemma: many dually-eligible consumers are enrolled in Medi-Cal managed care plans, and when they need inpatient hospitalization, while the plans manage the medical component they are essentially just along for the ride for the hospital care. The mix of managed and unmanaged care is extremely inefficient.

Key Themes from Interviews and Meetings with Stakeholders

Melanie Bella provided an overview of CHCS work to date on California duals. The first phase, supported by the SCAN Foundation, resulted in the creation of the options document, available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/CHCS%20Options%20for%20Integrating%20Dual%20Eligible%20Care.pdf, that was presented at the March 30 webinar on March 30. Subsequent interviews with many members of the Workgroup and two community dialogue meetings are summarized in *Options for Integrated Care for Duals in Medi-Cal: Themes from Interviews with Key Informants and Community Dialogues,* available at http://www.dhcs.ca.gov/Documents/CA%20Dual%20Options%20Interviews.042110.pdf.

The options document was nationally-focused, and was not intended to describe options for the California specifically. Thus, the focus of the interviews was not on favored or disfavored options as presented in the paper, but rather on what the subjects hoped to see in an integrated system and what supports are necessary to get there. Themes from the interviews include the following:

Overall:

- California needs a system that puts the individual at the center and makes it easier for providers to deliver the right care, at the right time, in the right place. Such a system doesn't currently exist, and nobody is responsible for ensuring that this coordination happens.
- One size does not fit all: California needs local flexibility.

- Infrastructure varies significantly from location to location, and it's critical to leverage the strengths that exist.
- Many interview subjects said that California must pay attention to the balance of medical and non-medical services. Both are needed, and non-medical services require particular focus.
- Integration of dual eligibles is an enormous undertaking. It must be approached carefully, with ongoing stakeholder involvement.

Strengths of the California system include:

- Community-based long-term supports and services (MSSP, IHSS, ADHC) –They exist and are rich resources
- Strong public safety net -- Provides strong partnerships
- Managed care – Many plans (particularly COHS) already serve complex populations
- Integrated programs – PACE, SCAN Health Plan

Weaknesses of the California system:

- Fragmentation – No accountability, disconnect between acute care and LTC
- Provider shortages – Mental health and geriatric specialty care in particular

Core elements to be included in an integrated system:

- Comprehensive assessment to determine needs, including screening for cognitive impairment/dementia;
- Personalized (person-centered) plan of care, including a flexible range of benefits;
- Multidisciplinary care team that puts the individual beneficiary at the center;
- Involvement of the family caregiver, including an assessment of needs and competency;
- Comprehensive provider network, including strong primary care base;
- Strong home- and community-based service options, including personal care services;
- Adequate consumer protections, including ombudsperson;
- Robust data-sharing and communications system; and
- Aligned financial incentives
- (Those elements added as a result of interviews and community meetings are bolded on page 5 of the *Themes* paper.)

Supports required to create an integrated system:

- Performance measurement – This is related to similar discussions in the SPD TWG, but the measures must be appropriate for dual populations both under and over 65
- Standards – Statewide standards are needed, regardless of the structure of the delivery system, and must be consistent across all regions and models. These must include networks standards and provider standards.
- Balance of medical and non-medical services
- Navigating Medicare and Medicaid is a nightmare and must be fixed: there are models in some areas that provide guidance
- Care management opportunities – especially around transitions and medical management – are important

Comments from interviewees on the options presented in the initial paper:

- There was significant variation in opinion among respondents
- Accountability – No consensus on where it should be located (state, county, health plan).
- Variability in opinion on public and private partners – Concerns that the state may use Medicare to plug the state's budget hole, and that counties might do the same, given the chance. Concerns about the state's role were alleviated somewhat by the idea of a quasi-governmental entity that would be protected from budget pressures
- Concerns that changes in the Medicare market could create volatility for SNPs (rate reductions)
- Role for state in readiness reviews

Small Group Discussion: Matrix of Core Elements

Bobbie Wunsch, PHCG, introduced the structure of the small group discussions. Each of four small groups was asked to answer two questions about each of nine core elements:

1) In which programs and delivery systems does this core element already exist? How might this core element be improved or strengthened to serve dual eligibles?
2) Which core elements are missing in current programs and delivery systems? For the core elements that are missing currently, is there experience that offers insight into the barriers to implementation and possible solutions we can pose for successful implementation?

Notes from small group discussions are included at the end of this summary in a chart format.

When the full group reconvened, Bobbie Wunsch thanked the facilitators of each group and asked a member of each to discuss a single core element that their group felt was missing in the current system.

Group 1: April Alexander, Maya Altman, Lora Connolly, Bonnie Darwin, Marilyn Holle, Cynthia Jackson Kelartinian, Casey Young

Casey Young said that the group had a lively conversation about what is lacking. The biggest gap is a comprehensive care plan: there are many such plans – the doctor has one, the psychologist has one, IHSS may have one, but none is comprehensive. However, much of the group's discussion focused on existing infrastructure (MSSP, Linkages, SNPs) that they believe can be built upon. How can California take these things that do work and grow them to scale? *Marilyn Holle, DRC,* added that the group discussed the multiple assessments that a dually-eligible individual receives, and how much money could be saved if the same information wasn't collected over and over.

Group 2: Richard Chambers, Sandi Fitzpatrick, Nancy Hayward, Janet Heath, Michael Humphrey, Giang Nguyen Lisa Shugarman

Janet Heath said that in discussing family caregivers, her group realized that hospice may provide a strong model for how to run family support and training programs. Assessment of caregiver competency typically isn't done at discharge, so when individual gets home the level of needed care often isn't available. Janet said that some MSSP and IHSS programs run programs to train or support caregivers, so models do exist.

Group 3: Brad Gilbert, David Kieffer, Kevin Prindiville, Dawn Myers Purkey, Carol Risley Tim Schwab, Suzanne Tavano

Brad Gilbert said that his group was unanimous about the disorganization and fragmentation of the current system. They agreed that services are available in many areas – Regional Centers, ADHC, etc. -- but that there is a need for a central multidisciplinary team to assess people's needs and leverage and access these services. Related to that idea, data must be available to all providers. There are privacy concerns to be worked out, but at minimum the care team must know where the person is accessing services. The group had consensus (but was not unanimous) that financial incentives must be aligned: the more fragmented the finances, the more cost-shifting will occur. *Suzanne Tavano, CMHDA,* added that if Medicare really were to come under managed care, it would be important to maximize the Medicare benefit in the way that California did when Medi-Cal managed care began.

Group 4: Eileen Carroll, Jackie McGrath, Pat Sussman, Sarah Takahama, Ed Walsh, Mary E. Whitehead

Pat Sussman said that their group focused on aligning financial incentives. There are a number of promising models in California and elsewhere. Full integration of services is necessary in order to avoid silos; carve-outs will not work. Flexibility, control, and a focus on quality are essential, as is a lock-in period to ensure continuity of care.

Ed Walsh added that the group discussed the need to establish care coordination across the entire continuum. This requires a clinical, comprehensive, bio/psychosocial assessment. Such an assessment would be tremendously useful at hospital admission, to drive hospital care as well as discharge planning. *Cheryl Phillips, PACE,* cautioned that assessments have to be updated regularly, or they risk becoming dangerous shortcuts. Ed Walsh said that, done right, everyone owns the assessment and wants to keep it alive and real.

Tim Schwab, SCAN Health Plan, said that another thing his group found missing was a focus on quality, which deserves its own discussion. *Jackie McGrath, Alzheimer's Association,* said that her group discussed that as well. Consumers worry that any integration is only about managing access, so collecting data on both fiscal efficiencies and quality outcomes is essential.

Kevin Prindiville, *NSCLC,* said that his group discussed the need for additional core elements within consumer protections, to include enrollment, network protections, and accountability, so that there are clear standards to be met and accountability to meet them. *Bobbie Wunsch, PHCG,* said that the SPD workgroup had engaged in detailed discussion of consumer protections at their March 11, 2010 meeting. (A summary of the meeting is available at
http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/SPD_TWG_Summary

3_3-11-10_FINAL.pdf, and materials presented at that meeting related to consumer protections are on the SPD TWG web page at http://www.dhcs.ca.gov/provgovpart/Pages/TechnicalWorkgroupSPDs.aspx.)

Jackie McGrath, Alzheimer's Association, suggested that another core element to be added would be the integration of physical and behavioral health. As long as mental health care is carved out, there is limited ability to manage the whole person's care.

Next Meeting and Feedback on Today's Meeting

Bobbie Wunsch, PHCG, said that the draft agendas for upcoming meetings include discussion of behavioral health and HCBS at meeting 2, and discussion of the feasibility of various options for organizing services at meeting 3, but asked each Workgroup member what they would like to discuss over the course of the next meetings.

Brad Gilbert, IEHP, said that option 4 in the CHCS paper, with the state as fiscal intermediary for Medicare, offers a variety of options: SNP, managed care, FFS. He said that if more detail is available on how other states have implemented such an option, it would be useful. For example, if a member chose to be in a SNP, could the state mandate that the Medi-Cal piece is rolled into managed care? The prospect is high-risk and high-reward, so knowing more about details of implementation is important.

Marilyn Holle, DRC, said that she has historically been concerned about any Medi-Cal caps, but might feel differently about a more flexible Medicare cap. She asked whether the waiver could be used to increase flexibility: for example, in the case of post-transplant patients who need expensive medications, could the plan be used to pay for these drugs while the individual is waiting to enter the high-risk pool? Could funds be used to buy community supports such as housing? She said she would also like to discuss strategies for rural areas.

Nancy Hayward, California Association of Health Facilities, asked for discussion on where nursing facilities, which care for custodial patients in the Medicaid arena and provide post-acute care under Medicare, fit into the discussion. She said that data on length-of-stay in LTC for duals would be useful.

Dawn Myers Purkey, Woodland Healthcare/Yolo Adult Day Health Center, said she would add discussion on facilitating local collaborations.

Kevin Prindiville, NSCLC, suggested that the group work through the broad principles in the context of specific models, in order to identify which models actually meet the standards. *Lora Connolly* echoed this suggestion, and mentioned Minnesota's model in particular; *Tim Schwab, SCAN Health Plan,* said outcome data would be particularly useful. He also suggested discussing development of capitation rates for this population. *Cheryl Phillips* also called for outcome data.

Suzanne Tavano, CMHDA, suggested discussion of care integration in the context of behavioral health, and aligning incentives so that people can get services in different places depending on their needs and wants. *Giang Nguyen, CDMH,* agreed that mental health financing should be on the agenda.

Jackie McGrath, Alzheimer's Association, said a state-commissioned study on LTC financing would be relevant for this group,

Jackie McGrath, Alzheimer's Association also asked for any available details on HCR implementation. Many Workgroup members echoed this call. Michael Humphrey recommended a SCAN Foundation brief on key elements in HCR, available at http://www.thescanfoundation.org/sites/default/files/TSF%20Policy%20Brief%20No.%202%20Mar%20%202010%20-%20Side-by-Side_0.pdf, and suggested discussion of how California can take advantage of some of the incentives and initiative that the federal law makes available.

Sarah Takahama, CAPG, suggested additional discussion of rural issues and models that might work in these areas (ASOs and virtual medical homes).

Carol Risley, CA DDS, noted that some systems already have many of these components and these programs should be preserved. She also suggested that the issue of duals should be addressed from a social integrative model perspective – medical and behavioral health care are important, but not the only issues. Housing, social services, and community supports are critical, and waivers are specifically designed to get away from a medical-only model.

Michael Humphrey, Sonoma County IHSS, suggested discussion of HCBS, and said he was interested in more specific discussion about how HCBS is currently being integrated in the California plans that are doing so.

Maya Altman, HPSM, said that her plan has been talking to SEIU about how to integrate IHSS in the health plan, and she would be happy to discuss that. She also was interested in options under federal HCR.

Cynthia Jackson Kelartinian, Heritage Clinic, said she would like to discuss strategies for providing services in a manner that postpones custodial care as long as possible, including evaluations of the upfront costs and longer savings from such services.

Casey Young, AARP, said he wanted more detailed discussion of financing. What savings does DHCS believe they can achieve from moving this population into organized systems? How does the current financing structure promote nursing homes over HCBS? A presentation on LTC financing would be helpful. *Richard Chambers, CalOptima,* suggested discussion of the role of LTC facilities in integrated care.

Bonnie Darwin, CCCC, said she would be interested in hearing from health plans about what they've been able to do under the current structure and what they haven't been able to do without integrated financing.

Mary Whitehead, Scripps Health, asked for discussion on how to integrate FQHCs.

Ed Walsh, Area Agencies on Aging, said he was interested in comprehensive chronic disease management, and in models weighted toward the social versus the medical side. Comparative outcome data would be helpful.

Janet Heath, MSSP, suggested discussion of the workforce, and workforce shortages.

Bobbie Wunsch, PHCG, said that the Workgroup leads would develop the agendas based on this discussion, and that some members might be contacted for assistance. All Workgroup members are encouraged to attend the upcoming meetings in person.

The meeting was adjourned at 3:10 pm.

3) In which programs and delivery systems does this core element already exist? How might this core element be improved or strengthened to serve dual eligibles?

4) Which core elements are missing in current programs and delivery systems? For the core elements that are missing currently, is there experience that offers insight into the barriers to implementation and possible solutions we can pose for successful implementation?

For each core element below, use the questions above to discuss to what degree each core element is largely in place or missing. Based on this assessment, provide comment about how to improve this element or build it from the ground up.

Core Element **1. Comprehensive assessment to determine needs, including screening for cognitive impairment dementia**	Largely in place? (Y/N)	Largely missing? (Y/N)
Comments about how to strengthen/improve this element • San Mateo – pilot to test uniform assessment tool for aging and adult services (AIDS case management, IHSS, MSSP, APS). Using it in NFs – identifying people who have been overlooked and finding unmet BH needs. Can look across systems at clients. Closest thing to a single comprehensive assessment, but still not there. San Mateo organized services under one roof. (Group 2) • Assessment should occur before person enters system • Need core elements of assessment –e.g, CHCS/CHCF elements. • Need a blend of social and medical , and should be risk-adjusted. • San Mateo may have a good start for a unified assessment. PACE assessment also a model, as is the CareMore SNP in the LA area (Group 4)		Yes, except reg. (Gp. 1)
Comments on barriers and possible solutions for successful implementation • Technological exchange missing • Difficult to implement single assessment statewide, and mixed opinions on usefulness of such a tool. • Currently: individual assessments within each system (comprehensive for that system). Silo assessments are not comprehensive across systems. (Group 1) • Dementia not included in criteria for specialty mental health. • Barrier to dementia screening and assessment is that it's a "life-altering diagnosis" (i.e., physicians are reluctant to label a person with dementia because it is such devastating news). Commonly used tools are no good (but clock-face is a good tool.) • Barrier to San Mateo comprehensive assessment – no substitution for IHSS assessment (state policy). • Should at least use common elements, same language across assessments for different services. For example, could use a modular approach so that service provider could select the appropriate modules and skip the ones that are not needed. • Vision to move common assessment approach into hospitals and NFs to allow health plan to start care planning. • Goal to share information in real time (currently a barrier)		

• Ideally would be used by all counties, since clients move across counties. Ultimately, state has to impose a standard. (Group 2) • Enrollment broker, phone assessment and claims data don't adequately capture complexity of duals. • Poor coordination among MSSP, IHSS, ADHC, MH – all do assessments. • Cost built into capitation rates or other rates. • Data coordination • Agreement on the assessment (need everyone to get the comprehensive assessment, rather than targeted sub-assessments focused on specific groups) (Group 4)		

Core Element **2. Personalized (person-centered) plan of care, including a flexible range of benefits**	Largely in place? (Y/N)	Largely missing? (Y/N)
Comments about how to strengthen/improve this element • This is done in SNPs because managed care requires it but likely done in each system separately – not across systems. • SNP may not be assessing needs paid by Medi-Cal. • Need to bring client into planning. • San Mateo does have integrated care plan but this is not common in all SNPs. (Group 1) • Must span social and medical settings, particularly for chronic care. (Group 4)		
Comments on barriers and possible solutions for successful implementation • Plan of care cannot be person-centered unless funding is more flexible. • Currently, care is planned by what is paid for – not what person needs. (Group 1)		

Core Element **3. Multidisciplinary care team that puts the individual beneficiary at the center.**	Largely in place? (Y/N)	Largely missing? (Y/N)
Comments about how to strengthen/improve this element • Should add "and family caregiver" to this element. • Some programs do put individuals at the center, as follows (Group 2): • DD – coordinated care in place in facilities, coordinates vision, dental • PACE – physical colocation, providers see each other each day, anything that ties people together helps • CalOptima – has a multidisciplinary team for a subset. Challenge to integrate MDs due to the way their practices are organized, MSSP not co-located, IHSS totally separate • MSSP • IHSS	Yes (Gp 1) No (Gp 2)	Yes (Gp 2)
Comments on barriers and possible solutions for successful implementation • Lots of disconnects in HCBS and acute care • Within/between county and non-county based services is a challenge (APS to MSSP, e.g.) • Medi-Cal plans don't have good partnerships with IHSS • Transitions model good but needs funding to continue • Behavioral health: have liaison to MH in one county, but in others just have to beat down doors • Orange County – Contracted with PacifiCare for specialty MH but will be bringing it back in house in July; at that point will be able to reinvest savings • Workforce development very important (Group 2)		

Core Element **4. Involvement of the family caregiver, including an assessment of needs and competency**	Largely in place? (Y/N)	Largely missing? (Y/N)
Comments about how to strengthen/improve this element • Massachusetts has models of training to look at. (Group 1) • Hospice does a good job of family support. • Redwood Caregiver Resource Centers (8 throughout state) – but funding is being cut • Assessment of competency not done especially at discharge to residential settings • Janet Heath has small program (serves 25 people) to assess caregiver psychosocial aspect (e.g., can they handle wound care). In a review of suspicious deaths, of 35 who died of sepsis most had care at home. • IHSS Sonoma did 15-30 classes for caregivers but not since last October. (Group 2)		Yes (Gp 1) Yes (Gp 2)
Comments on barriers and possible solutions for successful implementation • Funding a barrier to caregiver assessment and training. • Acute care facilities driven by length of stay and discharge prematurely – transitional care a possible solution to readmits. • Discharge planning not handled well. • Look for national models – HCR has grants. (Group 2)		

Core Element **5. Comprehensive provider network, including strong primary care base**	Largely in place? (Y/N)	Largely missing? (Y/N)
Comments about how to strengthen/improve this element • Some health plans are strong – COHS, Kaiser. Integration of LTC with medical is what needs to be strengthened. • VA system has comprehensive provider network, funding and information systems aligned, have MH and an array of services available. • FQHCS generally can take Medicare, but FQHC can't bill MH/physical health on the same day, and disabled/elderly may prefer *not* to access clinic settings. (Group 2)		
Comments on barriers and possible solutions for successful implementation • How funding is organized can either increase or decrease coordination. • Organization of information • Breaking down silos leads to relationship-building and solutions; need to put MOUs and agreements in place. (Group 2)		

Core Element **6. Strong home- and community-based service options, including personal care services**	Largely in place? (Y/N)	Largely missing? (Y/N)
Comments about how to strengthen/improve this element • Strong for subsets of population (DDS has an entitlement) but quality of service availability diminishes with generic services. • Look at DDS as a model • Strong services (IHSS, ADHC) but not accessible in rural areas, and many cultural barriers. MSSP is available. IHSS' strength is that it's consumer directed and can be built on. (Group 3)	Yes, more on the Medi-Cal side (Gp 3)	
Comments on barriers and possible solutions for successful implementation • Access issues a barrier, esp. for low-income "near-duals" • People don't always know their options • Centralized case management element that would assist in access to services is missing • Mental health clients may not know about the available options and how to access them. • IHSS is turning more medical than social. • If your door to the system is your PCP, access may be limited compared to hospital or clinic doors. Solution: an advocate or ombudsman for everyone accessing services. • Electronic medical records help all team members understand patient needs. • Barriers: knowledge and referral, care manager to develop individualized care plan, cultural barriers (Group 3)		Yes (Gp 3)

Core Element **7. Adequate consumer protections, including ombudsperson**	Largely in place? (Y/N)	Largely missing? (Y/N)
Comments about how to strengthen/improve this element • There are bits and pieces of protections, limited in scope • Create FFS Medi-Cal ombudsman • Better protections under managed care • Not just mechanism of protections, but protections themselves (Group 3)		Yes (Gp 3)
Comments on barriers and possible solutions for successful implementation • No Medi-Cal FFS ombudsman • Adequate programs should be effective • One door entry to include ombudsperson, advocacy, protections, knowledge of other entities and their functions. • Need to standardize consumer protections, and include enrollment and disenrollment options • Option of a third party • Inadequate consumer protections re: quality (Group 3)		

Core Element **8. Robust data-sharing and communications system**	Largely in place? (Y/N)	Largely missing? (Y/N)
Comments about how to strengthen/improve this element • Integrate public service database that is patient-centric • If people are afraid their data will be shared, they may not want to use services (Group 3)		Yes (Gp 3)
Comments on barriers and possible solutions for successful implementation • Currently can't share data with other providers. Solution: an integrated data system. • Most data comes later in the form of claims • Give care coordinator access to relevant data • In managed care, data is available for capitated pieces • Bottom line: not robust, fragmented system, true health information exchange would help for medical data • Data helps plan for the future of the health plan (predictive modeling) (Group 3)		

Core Element **9. Aligned financial assessment**	Largely in place? (Y/N)	Largely missing? (Y/N)
Comments about how to strengthen/improve this element • Consolidate into single entity, e.g., county, that is public, accountable. • COHS well-positioned to consolidate funding. (CalOptima gets all funding but it's not blended for LTC.) (Group 2) • Centralized accountability • Full integration – some states have integrated LTC and HCBS dollars (Group 4)	No (Gp 4)	
Comments on barriers and possible solutions for successful implementation • Need incentives to make this work – if savings occur, they must be reinvested in the system. Currently, if health plans reduce acute care, their rates are cut by the state the next year. • Rural counties could work like Partnership (also see MN rural models) – there are ways to link counties and build a common infrastructure for bill-paying, etc. • PACE e.g. taking $5M to start up – need to look at who has funds. (Group 2) • Financing needs to be aligned, dollars need to be put together. • State should have several options to do this (Group 3) • More flexibility and control with Medicare dollars • Need flexibility in benefits -- hospital can't discharge to SNF due to tube feeding, e.g. • Need a lock-in period to make capitation incentives work and for continuity of care • Solution could be managed care, but how to align managed care incentive so as to emphasize savings from quality and access, and not utilization reductions? • Know there are models out there to explore. (Group 4)		
Other Notes • Blend financing, standards development, Medicare choice waiver or passive enrollment/opt out are key areas to accomplish (Group 1) • Missing element: Eliminate carve-out of BH and Rx – blend funding and benefits (Group 4)		