Preparing for the transition to long-term care integration in San Francisco – and determining what is required to improve the provision of long-term services and supports for Medi-Cal eligible older adults and adults with disabilities

By the Long Term Care Integration Design Group
For the Department of Aging and Adult Services

October 2013
Examples of Older Adults & Adults with Disabilities on Medi-Cal
who will be provided long term services and supports, along with primary and acute care,
through managed care plans under LTCI in San Francisco

Vignette #1: Maria Sanchez
Maria Sanchez is a 36 year old Latino woman who suffered a traumatic brain injury. Her father was her caregiver until he
died, and then Maria was cared for by her extended family. It was noticed by a community agency that Maria had poor personal
hygiene and poor medical follow-up. Her family took her off her housing lease and out of adult day health care (ADHC). Since
then, she has been living with a friend. The community agency learned her family redirected her SSI checks and there were
allegations of IHSS fraud. Maria spends her days wandering around public housing in the Mission district. The Adult
Protective Services (APS) Program of the Department of Aging and Adult Services did an assessment of Maria’s situation.
APS is getting her re-enrolled into ADHC, and connecting her with a rep payee to get her suspended benefits restarted and to
manage her money. Maria has been referred to Mission Creek Senior Community for housing and to the Linkages Program for
ongoing care planning.

Vignette #2: Harold Smith
Harold Smith is 54 year old Caucasian man who has been homeless, and suffers from alcohol and heroin abuse. He has had
many admissions to San Francisco General Hospital and Laguna Honda Hospital. Through the Diversion and Community
Integration Program (DCIP) partners, including the Community Living Fund (CLF), he was placed in a studio apartment.
The DCIP Rental Subsidy Program, managed by West Bay Housing, subsidizes his rent after he pays 50% of his SSI income.
West Bay has a housing retention specialist to address his housing issues. CLF furnished his apartment and ensured services, like
home-delivered meals, were in place at the time of hospital discharge. Harold has diabetes, mild cognitive impairment, and a
history of depression. He has an on-site case manager who helps him with service coordination and getting to medical providers.
He has money management for help with budgeting, and paying his share of rent and utility bills. He has IHSS for help with
bathing and personal care. Harold is often unable to coordinate his services, even with all the support from the case manager. He
misses appointments, is not always compliant with medications, and has poor judgment about his medical frailty.

Vignette #3: Edwin Chang
Edwin Chang is a 79 year old mono-lingual Chinese man with dementia. He is legally blind but is still capable of doing many
things for himself. After his wife went into a long term care facility, there were signs of self-neglect and weight loss. Edwin had
been calling 911 frequently, reporting that family members or others were stealing money from him. While hospitalized, it was
recommended that he be transferred to a skilled nursing facility, but he refused. Edwin returned home with wrap-around services.
The Multipurpose Senior Services Program (MSSP) is providing case management, ensuring that his medical and community
services needs are met. He is receiving homecare services through the IHSS Consortium. The IHSS staff matched him with a
Cantonese male IHSS home care provider, who works with him on his behavior and helps him to take responsibility for his
actions. As a result of these community services, Edwin is medically and socially stable and living in his own home.

Vignette #4: Beverly Jones
Beverly Jones is an 89 year old African American woman who lives alone and owns a condominium in the OMI neighborhood.
For years, she has attended a senior center daily for lunch, food distribution programs, healthy aging activities, and socialization.
She uses a cane and has limited vision. She started having issues with her teeth that caused problems in eating, resulting in
significant weight loss. Beverly started receiving case management services from Catholic Charities when she was planning to have
knee surgery and knew she needed additional help at home. The staff provided a deep house cleaning and a home safety
evaluation. They referred her to Legal Assistance to the Elderly for problems with her SSI payments. She now receives home care
services from the IHSS Program to help her with eating, dressing, and bathing, as well as shopping, food preparation, house
keeping, and managing her finances. Her initial connections to services worked well for Beverly. The senior center built a
relationship with her earlier in her life when she needed minimal support, and 20 years later an array of comprehensive services
help her remain at home and in the community.
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SECTION I. INTRODUCTION
EXECUTIVE SUMMARY

With the development and implementation of California’s Coordinated Care Initiative (CCI), the state has begun the process of integrating health care and supportive social services while looking to reduce escalating health care costs. The desired results are: (1) a coordinated health care delivery system; (2) better health outcomes for consumers; and (3) greater control on spending.

In preparation, in December 2011, San Francisco’s Long-Term Care Coordinating Council, in collaboration with the Department of Aging and Adult Services, appointed the Long Term Care Integration (LTCI) Design Group to: (1) explore the potential for LTCI in San Francisco; (2) determine what is required to improve the provision of long-term services and supports (LTSS) that will benefit older adults and adults with disabilities; and (3) develop an LTCI Strategic Plan that includes recommendations to guide improvements in the organization, availability, and financing of LTSS. Long-term care integration (LTCI) is defined as the integration of home and community-based long-term care services with the delivery of primary and acute care services, and institutional long-term care services, for older adults and adults with disabilities. Implementation of the LTCI Strategic Plan will result in improvements in the City’s overall system for delivering LTSS for the benefit of all older adults and adults with disabilities in San Francisco.

In addition, specific improvements being recommended for LTCI will integrate home and community-based LTSS with the delivery of primary and acute care services, and institutional long-term care services, for older adults and adults with disabilities who are enrolled in Medi-Cal. When implemented, CCI will require most Medi-Cal beneficiaries to enroll in managed care to receive all Medi-Cal benefits including community-based and institutional long-term services and supports. In San Francisco, members of this group will be manditorily enrolled in Medi-Cal Health Plans (either the San Francisco Health Plan or Anthem Blue Cross), which comprise the two Health Plans in San Francisco’s Two-Plan Model. Another option, if appropriate, will be the PACE Program operated by On Lok Lifeways. All three managed care plans in San Francisco (the San Francisco Health Plan, Anthem Blue Cross, and On Lok Lifeways), will be participating in implementing the LTCI recommendations.

When LTCI is implemented in San Francisco: (1) Community-Based Adult Services (CBAS); (2) In-Home Supportive Services (IHSS); (3) the Multipurpose Seniors Services Program (MSSP); and (4) Skilled Nursing Facility Services, at minimum, will become part of the Medi-Cal managed care service delivery system.

Following are the objectives and the recommendations from the LTCI Design Group to improve access and coordination of LTSS for older adults and adults with disabilities:

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1 CBAS was transitioned to managed care on October 1, 2012.  
2 SF Request for Proposal #495 – Long-Term Care Integration and Strategic Plan Development
OBJECTIVES:

Objective 1: Collaboration: Strengthened collaboration among county departments, including the Department of Aging and Adult Services (DAAS), Human Service Agency (HSA), and Department of Public Health (DPH), and among the three managed care plans (Health Plans), which include the San Francisco Health Plan, Anthem Blue Cross, and On Lok Lifeways.

Objective 2: Access: Improved access to long term services and supports (LTSS) for seniors and people with disabilities.

Objective 3: Information: Improved ways to obtain information for consumers and service providers.

Objective 4: Care Coordination: Enhanced coordination of services and efficiency.

Objective 5: Data: Linked data systems to improve efficiency and collaboration.

Objective 6: Quality: Improved quality of services provided for consumers.

Objective 7: Support: Expanded supports for family caregivers, independent providers, community caregivers and individuals who are socially isolated.

Objective 8: Services: Incorporated Long Term Services and Supports (LTSS), crucial in keeping older adults and adults with disabilities healthy and safe in the community, into San Francisco’s managed care system.

Objective 9: Direct Care Workforce: Enhanced workforce to meet current and projected service needs.

Objective 10: In-Home Supportive Services: Improved In-Home Supportive Services (IHSS) Program

Objective 11: Care for Alzheimer’s and Other Dementias: Improved resources for people with Alzheimer’s and other dementias served by Health Plans.

Objective 12: Communication: Clear, consistent messaging delivered to consumers, stakeholders and advocates through a robust communications plan regarding the recommendations to improve access to and coordination of LTSS.

Objective 13: Opportunities for Service Providers: Newly created opportunities for aging and disability service providers to collaborate in the development of integrated business models and plans for the delivery and financing of community-based LTSS.

RECOMMENDATIONS:

Recommendation 1.1: Establish an LTCI implementation body with staff support that brings together DAAS, DPH and the Health Plans on a regular basis to create a process to: (1) oversee the implementation of the recommendations included in this LTCI Strategic Plan; and (2) ensure a successful transition to long term care integration (LTCI) in San Francisco.
Recommendation 2.1: Create a “central door” model of access to LTSS with the DAAS Integrated Intake Unit (IIU) as that central door.

Recommendation 3.1: DAAS should design a public information campaign targeting consumers. This will include, among other things, print media and an online listing of all LTSS service providers for consumers, with descriptions of the services that they provide and the criteria for accessing those services. The online listing should be updated on a regular basis to ensure the information is accurate.

Recommendation 3.2: DAAS should design a public information campaign targeting service providers. This will include information about the array of LTSS services that are available for consumers in San Francisco, with a focus on “single service” providers that may not have knowledge of or access to the larger service continuum. As part of this campaign, educate service providers about the DAAS IIU as the central door, its value and use.

Recommendation 4.1: DAAS and DPH should initiate an inter-agency care coordination committee to further develop an asset mapping tool including: (1) categorizing various care coordination services in the city into intensity levels; and (2) determining procedures for maintenance of the mapping tool. Based on this information, the committee should evaluate the current case management system with the goal of overall system improvement.

Recommendation 4.2: DAAS and DPH should pursue re-launching the Case Management Connect (CMC) Project (formerly called the Electronic Rolodex), which allows case management programs at DPH and DAAS (both in the departments and at community agencies) to view all case management enrollments. The re-launched version of the CMC Project should: (1) have all data provided to electronically populate CMC; and (2) enable case managers to enroll clients once in their own case management program. Lead care coordinators for each enrolled client should be made evident. Information in the CMC Project should be viewable from the DPH tool and the DAAS case management module by sharing enrollment transactions electronically.

Recommendation 4.3: DAAS, DPH, and the Health Plans should initiate and support procedures for virtual case conferences. This is not intended to replace current case conference processes, but to facilitate alternatives and more efficient communication among DAAS, DPH, and the Health Plans, as well as across settings such as hospitals, SNFs, and the community.

Recommendation 5.1: DAAS, DPH, and the Health Plans should form an inter-agency committee to create a data sharing solution that allows DAAS, DPH, the Health Plans, and service providers in the community to view client-level LTSS usage data in a single data report.

Recommendation 5.2: Given the current direction of CMS regarding de-institutionalization, DAAS and DPH should examine the value provided by best practice program models, like the Diversion and Community Integration Program (DCIP) and the Community Living Fund (CLF), among others, that assist older adults and adults with disabilities to return to community living. The use of such models could be beneficial for transitions from all nursing homes in the City.
Recommendation 6.1: DAAS, DPH, and the Health Plans should assign staff members to monitor the state’s development of standards and measures that demonstrate quality care to consumers. This effort should actively track the Cal MediConnect State Quality Workgroup. Based on that work, similar quality standards and outcome measures for LTSS should be developed and implemented in programs managed by DAAS, DPH, and the Health Plans.

Recommendation 7.1: Develop strategies that expand supports for family caregivers, independent providers, community caregivers, and individuals who are socially isolated. Additionally, respite services need to be developed for caregivers, particularly those caring for someone with Alzheimer’s disease and other forms of dementia.

Recommendation 8.1: Incorporate crucial LTSS into the San Francisco LTSS managed care system.

Recommendation 8.2: DAAS, DPH, and service providers should continue to collaborate to develop and promote a city-wide program of Healthy Aging that enhances the work currently being done by DAAS, DPH, and service providers.

Recommendation 9.1: Ensure that the current and future generation of direct care workers are recruited, trained, and retained to improve the quality of care and quality of life for consumers. Both basic and specialized training should be provided, and best practice standards should be used.

Recommendation 9.2: Ensure that direct care workers are an integral part of the health care teams organized by Health Plans. Because these teams will be arranging services and support for older adults and adults with disabilities, the involvement of direct care workers is essential.

Recommendation 9.3: Strengthen training and career development for direct care workers

Recommendation 10.1: As the IHSS program moves into managed care, retain the Independent Provider and Contract modes of IHSS service delivery.

Recommendation 10.2: Involve IHSS consumers and workers in designing the new LTCI service delivery system and in the care planning process. At the heart of the IHSS program is the concept of consumer direction.

Recommendation 10.3: DAAS should take the lead to collaborate on IHSS integration into managed care. Collaboration will include input from IHSS stakeholders.

Recommendation 10.4: Continue to provide consumers with access to essential IHSS services, like emergency on-call and consumer peer mentoring, as the IHSS program is integrated into managed care.

Recommendation 10.5: Expand training and education for: (1) consumers with long-term health conditions who are caring for themselves; (2) their family members who are also caregivers; and (3) community caregivers.
Recommendation 11.1: Health Plans should receive dementia-specific training on best practices and care, and should ensure that caregivers and people with dementia have access to resources, education, and training on disease management.

Recommendation 11.2: Health Plans or their designees should assess, identify, and diagnose people with Alzheimer’s disease and other dementias, and make referrals to community resources as early as possible in the disease process.

Recommendation 12.1: The communications plan, developed by the LTCI Communications Subcommittee and included in this strategic plan, should guide communications with consumers, advocates, service providers, stakeholders, City departments, commissions, and elected officials about the scope of these LTCI recommendations to improve access to and coordination of LTSS.

Recommendation 13.1: Pursue federal and state opportunities for DAAS to work with aging and disability service provider organizations in the development of integrated business models and plans for the delivery and financing of community-based LTSS for purchase by Health Plans and other potential buyers.

CONCLUSION: California has established the Cal MediConnect Pilot Project, which focuses on individuals who are full benefit Medicare and Medi-Cal beneficiaries (“dual eligibles”). The three-year project will combine all health services (medical, behavioral health, home and community-based services, and long-term services and supports) into a single benefit package, which will be delivered through a coordinated system. A capitated payment model will be used to provide both Medicare and Medi-Cal benefits through the state’s existing network of Medi-Cal Health Plans. This pilot project will initially launch in 2014 with eight approved demonstration counties, listed below:

- Alameda
- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- San Mateo
- Santa Clara

Expansion from the original eight counties cannot begin without Legislative approval. The state’s goal is to expand to eight additional demonstration counties (which may include San Francisco), with full statewide implementation to begin after that. Since additional legislation is needed, the most likely timeframe for CCI expansion to San Francisco is 2016. Accordingly, time is available to prepare for this transition so that the City and County of San Francisco, the Health Plans, and older adults and adults with disabilities eligible for Medi-Cal – all are ready for this transition.
MESSAGE FROM LTCI DESIGN GROUP CO-CHAIRS

The Long Term Care Integration (LTCI) Design Group was formed in December 2011 at the direction of the San Francisco Long-Term Care Coordinating Council (LTCCC) and charged to: explore the potential for LTCI in San Francisco; determine what is required to improve the provision of long term services and supports (LTSS) that will benefit older adults and adults with disabilities; and develop a strategic plan with recommendations to guide improvements in the organization, delivery and financing of LTSS. Members of the LTCI Design Group, as well as its subcommittees and workgroups, were chosen to represent service providers, older adults and adults with disabilities, other stakeholders, and a variety of city departments that serve this large and growing population. A critical goal of this effort was to recognize and build upon San Francisco’s history of innovation in regard to providing LTSS for older adults and adults with disabilities.

Our first meeting took place in January 2012 and we concluded deliberations in February 2013. Early in our work, the LTCI Design Group was instructed to develop the recommendations to improve the provision of services for all older adults and adults with disabilities in San Francisco. In addition, specific improvements to be recommended would help to guide the integration of community-based LTSS with primary and acute care services, and institutional long term care services, specifically for older adults and adults with disabilities eligible for Medi-Cal.

On behalf of the LTCI Design Group, we are very pleased to present the Long-Term Care Integration (LTCI) Strategic Plan for San Francisco. This strategic plan includes 13 objectives and 25 recommendations that, when implemented, will move San Francisco forward in integrating LTSS for older adults and people with disabilities. Moving ahead with this strategic plan is particularly important in light of the implementation of California’s Coordinated Care Initiative (CCI) in eight demonstration counties beginning in 2014.

A key part of CCI is the Cal MediConnect Pilot Project, which focuses on those who are full benefit Medicare and Medi-Cal beneficiaries. The three-year pilot will combine all Medicare and Medi-Cal services (medical, behavioral health, and institutional and community-based long-term services and supports) into a single benefit packet delivered through approved managed care plans. California’s goal is to implement Cal MediConnect in more counties once the first demonstration counties are successful. Since San Francisco is not one of the initial demonstration counties, we have the opportunity to learn from their experience and use this strategic plan as a road map for a transition that will better serve vulnerable San Franciscans.

We are proud to have been a part of the LTCI strategic planning process and we look forward to seeing the implementation of the recommendations included in this report. It has been an honor and a pleasure to work with the LTCI Design Group in the development of the LTCI strategic plan. We want to thank all the LTCI Design Group members, as well as subcommittee and workgroup members, for their commitment to the process. We also want to express our appreciation to the San Francisco LTCCC and, in particular, the Department of Aging and Adult Services (DAAS) for leadership for this effort.

Eileen Kunz, Co-Chair
Director of Policy and Regulatory Affairs
On Lok

Tangerine Brigham, Co-Chair
Previous Deputy Director of Health
and Director of Healthy San Francisco
Department of Public Health
MESSAGE FROM DAAS EXECUTIVE DIRECTOR

It is with great pleasure that the Department of Aging and Adult Services (DAAS) joins the LTCI Design Group to present the Long Term Care Integration (LTCI) Strategic Plan for San Francisco. Implementation of the recommendations in this strategic plan will guide improvements in the delivery of long term services and supports for the benefit of all older adults and adults with disabilities living in San Francisco. Ultimately, these improvements will help to integrate the delivery of home and community-based long term services and supports (LTSS) with the delivery of primary and acute care services, and institutional long-term care services, for older adults and adults with disabilities enrolled in Medi-Cal.

This strategic plan and the recommendations within it are a result of extensive investigative work, an analysis of system successes and failures, and in-depth reviews of managed care and LTSS services, as well as discussions with consumers regarding their current experience and what they are looking for in a new model of care and support.

Not surprisingly, strong collaborations/partnerships have already developed. Working together with key partners on the LTCI strategic planning process over many months has resulted in a greater understanding of the parameters under which each of us is working, as well as of the things we hold in common. I believe these relationships with our key partners will be crucial to the successful implementation of the recommendations in this strategic plan, which will prepare San Francisco for the eventual transition to LTCI.

I want to thank San Francisco’s Long Term Care Coordinating Council for taking the lead in applying to The SCAN Foundation for the initial funding that supported the development of this strategic plan. The SCAN Foundation and another financial supporter, the Metta Fund, were crucial to the successful completion of our strategic planning process and the development of this LTCI Strategic Plan. We could not have gone forward without their support, so I want to express a special “thank you” to each of them. I also want to thank the LTCI Design Group and members of the Workgroups and Subcommittees, whose dedication and hard work is evident throughout this document.

I know the service delivery improvements that will result from the implementation of this LTCI Strategic Plan and its recommendations will make an important difference in the lives of older adults and adults with disabilities in San Francisco who need long term services and supports.

Thank you to everyone who worked on and supported this effort. Now to implementation.

Anne Hinton
Executive Director
Department of Aging and Adult Services
Preface

With the development and implementation of California’s Coordinated Care Initiative, the state has begun the process of integrating health care and supportive services while looking to reduce escalating health care costs. The desired results are: (1) a coordinated health care delivery system; (2) better health care outcomes for consumers; and (3) greater control of spending.

To address these issues, the Department of Aging and Adult Services (DAAS), in collaboration with the Department of Public Health (DPH) and the Long-Term Care Coordinating Council (LTCCC), empanelled a group of experts as a Long Term Care Integration (LTCI) Design Group, and contracted with a consultant (Chi Partners) to serve as LTCI strategic planner, in order to undertake an LTCI strategic planning process to:

- Explore the potential for integrating long-term services and supports and with primary and acute care services;
- Determine what is required to improve the provision of long-term services and supports that will benefit Medi-Cal eligible older adults and adults with disabilities; and
- Develop an LTCI strategic plan with recommendations to guide improvements in the organization, availability, and financing of long-term services and supports.

Implementation of the recommendations that resulted from this LTCI strategic planning process will enable San Francisco to be prepared for the transition to managed care for Medi-Cal eligible older adults and adults with disabilities who require long-term services and supports (LTSS).

LTCI Design Group Membership and Affiliations

- Tangerine Brigham – Deputy Director of Health, and Director of Healthy San Francisco, Department of Public Health, Co-Chair
- Eileen Kunz – Director of Policy and Regulatory Affairs, On Lok, Co-Chair
- Phil Arnold – Deputy Director, Finance & Administration, Human Services Agency
- Sean Atha – Director, Regional Field Operations, Anthem Blue Cross Health Plan
- Margaret Baran – Executive Director, IHSS Consortium
- Donna Calame – Executive Director, IHSS Public Authority
- Betty Fung – Director of Programs, Self Help for the Elderly
- Anne Hinton – Executive Director, Department of Aging and Adult Services (DAAS)
- Melissa Howard – Fiscal & Policy Analyst, Mayor’s Office of Public Policy and Finance
- Cindy Kauffman – Vice President, Institute on Aging
- Herb Levine – former Executive Director of ILRC and disability consumer advocate
- Rebecca Malberg – Director, Home Care Division, SEIU-UHW
- Nina Maruyama – Officer, Compliance and Regulatory Affairs, San Francisco Health Plan
- Susan Poor – Long Term Care Coordinating Council

2 SF Request for Proposal #495 – Long-Term Care Integration and Strategic Plan Development
**Scope of Services and Service Delivery Subcommittee**

- Patty Clement-Cihak – Director, SF Aging Services, Catholic Charities CYO, Co-Chair (for Scope of Services)
- Megan Elliott – IHSS Program Director, DAAS, Co-Chair (for Scope of Services)
- Shireen McSpadden – Deputy Director, DAAS, Co-Chair (for Service Delivery)
- Joanne Rolle – Director of Developmental Services, The Arc of San Francisco, Co-Chair, (for Service Delivery)
- Margaret Baran – Executive Director, IHSS Consortium, at large position
- Debbie Bos – Director, Network Education Representative, Anthem Blue Cross
- Linda Edelstein – Long-Term Care Operations Director, DAAS
- Amie Haltman-Carson – Coordinator, Medi-Cal In-Home Operations Services, Toolworks
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- Louise Hines – Advisory Council on Aging and Disability
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- Grace Li – Chief Operating Officer, On Lok
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- Rebecca Malberg – Director, Home Care Division, SEIU-UHW
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- Benson Nadell – LTC Ombudsman, Family Service Agency
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- Jennifer Sinnott – Social Services Supervisor, NCPHS Community Services
- Moli Steinert – Stepping Stone and Community-Based Adult Services

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- John Sedlander – Chief Financial Officer, Institute on Aging, Co-Chair
- Sean Atha – Director, Regional Field Operations, Anthem Blue Cross
- Patti Clement-Cihak – Director, San Francisco Aging Services, Catholic Charities CYO
- Sarah Crow – Senior Planner & Health Care Reform Coordinator, Human Services Agency
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- Martha Peterson – Finance and Planning, Human Services Agency
- Eric Schwimmer – SEIU-UHW
- Greg Wagner – Chief Financial Officer, Department of Public Health
- Sue Wong – Chief Financial Officer, On Lok
- Mike Wylie – City Services Auditor, Controller’s Office
Communications Subcommittee

- Marc Slavin – Government and Community Relations, Laguna Honda Hospital, Co-Chair
- Margaret Wilmer – Marketing and Outreach, On Lok, Co-Chair
- Herb Levine – Disability Consumer Advocate, Co-Chair
- Rick Appleby – Institute on Aging
- Sean Atha – Director, Regional Field Operations, Anthem Blue Cross
- Sybil Boutilier – Public Policy, Programs and Legislative Affairs, DAAS
- Mary Cabarles – Integrated Intake – Outreach, DAAS
- Sarah Chan – Director, Adult Day Services, Self Help for the Elderly
- Cathy Davis – BVHP Multipurpose Senior Services
- Bill Fricker – Consumer Peer Mentor Program, IHSS Public Authority
- Marie Jobling – Executive Director, Community Living Campaign
- Hene Kelly – Senior Action Network and Senior Consumer Advocate
- Sandy Mori – Long Term Care Coordinating Council
- Ken Stein – Mayor’s Office on Disability
- Marti Sullivan – Director of Development and Community Relations, The Arc San Francisco
- Gloria Jean Thornton – Senior Health Promotion Consultant, Anthem Blue Cross

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- Dustin Harper – MSSP, CLF, IHO Waiver, CCT Program, Institute on Aging, Chair
- Patty Clement-Cihak – Director, SF Aging Services, Catholic Charities CYO, Co-Chair
- Shireen McSpadden – Deputy Director, DAAS, Co-Chair
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SECTION II. BACKGROUND
PURPOSE OF LONG TERM CARE INTEGRATION (LTCI) STRATEGIC PLAN

The purpose of the LTCI Strategic Plan is to guide improvements in the organization, availability, and financing of long-term services and supports (LTSS) in San Francisco. The implementation of LTCI will make improvements in the City’s overall system for delivering LTSS for the benefit of all older adults and adults with disabilities in San Francisco. In addition, specific improvements being recommended for LTCI will integrate home and community-based LTSS with the delivery of primary and acute care services, and institutional long-term care services, for older adults and adults with disabilities enrolled in Medi-Cal.

Assuming that San Francisco becomes a Cal MedConnect demonstration county, those who are dually enrolled in Medicare and Medi-Cal will also be included. All three managed care plans in San Francisco (the San Francisco Health Plan, Anthem Blue Cross Health Plan, and On Lok Lifeways) will be participating in implementing the LTCI recommendations. When LTCI is eventually in effect in San Francisco: (1) Community-Based Adult Services (CBAS)⁴; (2) In-Home Supportive Services (IHSS); (3) Multipurpose Senior Services Program (MSSP); and (4) Skilled Nursing Facility Services (Medi-Cal funded), at minimum, will become part of the Medi-Cal managed care service delivery system.

LONG-TERM CARE

The Basics

WHAT IS LONG TERM CARE?

Long-term care is a variety of services that help to address the medical and non-medical needs of people who have a chronic illness or disability for an extended period of time. Long-term care helps meet health care needs and/or personal care needs. Most long-term care is to assist people with support services that help with activities of daily living like dressing, bathing, eating, and using the bathroom. Long-term care can be provided at home, in the community, in assisted living, or in nursing homes. Individuals may need long-term care at any age.

In 2012, about nine million men and women over the age of 65 needed long-term care. By 2020, 12 million older Americans will need long-term care. Most will be cared for at home; family and friends are the sole caregivers for 70 percent of the elderly. A study by the U.S. Department of Health and Human Services says that people who reach age 65 will likely have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home will stay there five years or more.⁴

Acronyms used throughout this report are found in APPENDIX A.

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³ Oversight of the CBAS program was transferred to SF Health Plan and Anthem Blue Cross on October 1, 2012.
⁴ http://www.medicare.gov/longtermcare/static/home.asp
**WHAT IS MEDICARE? WHAT IS MEDI-CAL?**

**The Medicare Program.** Medicare is the federal health insurance program for qualifying persons over age 65 and certain people with disabilities, and is overseen by the federal Centers for Medicare and Medicaid Services (CMS). Medicare pays for most physician and hospital care and pharmacy benefits for program beneficiaries. Medicare also covers certain mental health services, including outpatient, community–based treatment and most acute inpatient psychiatric admissions. Medicare beneficiaries generally pay for their benefits through cost–sharing arrangements such as premiums, deductibles, coinsurance, and co-payments.

**The Medi-Cal Program.** Medi-Cal is a federal–state health care program. Medi-Cal is the Medicaid Program in California. As a voluntary joint federal–state program, federal funds are available to the state for the provision of health care services for low–income families with children, and seniors and persons with disabilities (SPDs). California receives a 50 percent Federal Medical Assistance Percentage—meaning the federal government pays for half of most Medi-Cal costs.

Medi-Cal provides a wide range of health–related services, including hospital inpatient and outpatient care, doctor visits, prescription drugs, and durable medical equipment. Medi-Cal also provides substance abuse treatment services and an array of mental health services for beneficiaries with mild and serious mental illnesses. These benefits are largely provided at the county level through county–administered mental specialty plans and substance abuse programs.

In addition to health-related services, Medi-Cal provides a variety of LTSS that are commonly categorized into two types: (1) institutional care, such as skilled nursing facilities (SNFs), and (2) home and community-based services (HCBS) aimed at preventing unnecessary hospitalizations and SNF stays, and maintaining people in the community. Major Medi-Cal LTSS include:

- **In-Home Supportive Services (IHSS).** The IHSS program provides in-home care for people who cannot safely remain in their own homes without such assistance.
- **Community-Based Adult Services (CBAS).** The CBAS program is an outpatient, facility-based service program that provides services to participants by a multidisciplinary staff, including: professional nursing services; physical, occupational, and speech therapies; mental health services; therapeutic activities; social services; personal care; meals and nutritional counseling; and transportation to and from the participant’s residence.
- **Multipurpose Senior Services Program (MSSP).** The MSSP benefit provides both social and health care management services for Medi-Cal beneficiaries aged 65 or older who meet the eligibility criteria for a SNF.
- **Skilled Nursing Facilities (SNFs).** The SNFs provide nursing, rehabilitative, and medical care to facility residents. Generally, SNF residents receive their medical care and social services at the facility.
Paying for Medi-Cal and Medicare. Under federal law, Medi-Cal is the payer of last resort for health care. This means that all other third party sources of health coverage for Medi-Cal beneficiaries, including Medicare, must be exhausted prior to any Medi-Cal reimbursement for health care. Accordingly, Medicare pays for most physician, hospital, and prescription drug (pharmacy) benefits for dual eligibles, with Medi-Cal covering a smaller portion of these costs—known as “wraparound coverage.” However, Medi-Cal pays for some benefits that Medicare does not cover, such as extended stays in SNFs.

Medi-Cal and Medicare provide health care through two main systems: (1) fee-for-service (FFS) and (2) managed care. In a FFS system, a health care provider receives an individual payment for each medical service provided. In a managed care system, managed care plans receive a capitated rate in exchange for providing health care coverage to enrollees. For some Medi-Cal beneficiaries, enrollment in managed care is mandatory. However, for Medicare beneficiaries, enrollment in managed care is voluntary.

Most of the 1.2 million dual eligibles in California currently receive both their medical and LTSS benefits under FFS. Although more than half of the 700,000 Medi-Cal-only SPDs have been mandatorily enrolled in Medi-Cal managed care for their medical benefits, they also continue to receive most LTSS benefits under FFS.

Generally, Medi-Cal only SPDs, including those eligible for Medicare, are more expensive to serve than other Medi-Cal beneficiaries because of the higher prevalence of complex medical conditions and greater functional needs within this population. In 2011–12, SPDs represented 25 percent of enrollment but 60 percent of General Fund expenditures in the Medi-Cal Program. The high cost of SPDs may be exacerbated by the fragmentation of care under the current framework, in which Medi-Cal FFS, Medi-Cal Managed Care, and Medicare function in silos.

See APPENDIX B for Requirements for the Medi-Cal and Medicare Programs.

WHAT IS LONG-TERM CARE INTEGRATION (LTCI)?

LTCI is defined as the integration of home and community-based long-term care services with the delivery of primary and acute care services, and institutional long-term care services, for older adults and adults with disabilities, and may include:\(^5\):

- Consolidating preventative, primary, acute, long-term care, and home and community-based services, and possibly funding.
- Emphasizing home and community-based services to allow people to remain in the community.
- Allowance for more local control and flexibility.

\(^5\) http://www.sfhsa.org/3500.htm
• Elimination of administrative duplication and complexity.
• Enhanced assessment, care planning, and medical management.
• Establishing smooth transitions between levels of care.
• Improving service delivery and access to care.

As part of California’s 1115 waiver, seniors and people with disabilities who are eligible for only Medi-Cal are required to enroll in managed care for Medi-Cal primary and acute care services. However, long-term care services are not integrated into the managed care and still delivered in the fee-for-service system. The historic context for LTCI is described on page 23 and Appendix G.

Health Care Reform/Managed Care

WHAT IS MANAGED CARE?

Managed care is defined as “any arrangement for health care in which an organization, such as a health maintenance organization (HMO), another type of doctor-hospital network, or an insurance company, acts as intermediary between the person seeking care and the physician.” In other words, managed care is an approach to health care that increases accountability for streamlining services and delivering high-quality, yet cost-effective, patient care. Many managed care programs feature preventative medicine as an effective method of controlling costs.

Managed care plans generally require members to utilize approved providers within their own network. If they allow members to seek services from out-of-network providers, they often pay a smaller portion of the costs. Plans closely monitor member care and generally reimburse providers through a capitated payment system. Many plans also require pre-approval of certain services to help control costs and prevent unnecessary services.

MEDI-CAL MANAGED CARE

Medi-Cal Managed Care is administered by the California Department of Health Care Services, Medi-Cal Managed Care Division (MMCD), which provides high quality, accessible, and cost-effective health care through managed care delivery systems.

MMCD contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care. Managed care plans are a cost-effective use of health care resources that improve health care access and assure quality of care. Today, approximately 4.5 million Medi-Cal beneficiaries in 30 counties receive their health care through three models of managed care.

6 The American Heritage® Medical Dictionary Copyright © 2007, 2004 by Houghton Mifflin Company. Published by Houghton Mifflin Company. All rights reserved.
**MEDI-CAL MANAGED CARE MODELS**

In 1975, the Knox-Keene Health Care Services Plan Act was enacted, which authorized the State of California to license health maintenance organizations (HMOs) or prepaid Health Plans to enroll Medi-Cal beneficiaries. This licensing is known as Knox-Keene licensing after the name of the legislation.

Today, most Medi-Cal beneficiaries are enrolled in some form of managed care. The type of managed care program depends on the county in which they reside. There are three main Medi-Cal managed care models in California: the Two-Plan Model, County Organized Health Systems (COHS), and Geographic Managed Care. Each model is discussed below.

The remaining counties that do not offer some form of managed care operate a Fee-For-Service (FFS) model wherein health care providers are paid for each service they perform. As part of California's Coordinated Care Initiative, passed in July of 2012, all Medi-Cal beneficiaries, including dual eligible beneficiaries, are required to join a Medi-Cal managed care Health Plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.

**Two-Plan Model**

The Two-Plan Model serves Medi-Cal beneficiaries in the following 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Beneficiaries in these counties have the option to select either a county-developed “local Initiative” plan (public Health Plan) with Knox-Keene licensure or a commercial Knox-Keene licensed Health Plan.

**County Organized Health Systems**

County Organized Health Systems (COHS) serve beneficiaries through six Health Plans in 14 counties: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura, and Yolo (Lake County has a COHS proposal which is currently being considered). In these COHS counties, the California Department of Health Care Services (DHCS) contracts with a single public Health Plan created by the County Board of Supervisors, and all beneficiaries are served by the same managed care plan.

Beneficiaries in these counties are unable to seek services through traditional FFS Medi-Cal options unless authorized by the plan. A COHS must be an independent public entity that meets the same state requirements for Knox-Keene licensure, but this license is not required.

**Geographic Managed Care**

The Geographic Managed Care Model (GMC) operates in only two counties: Sacramento and San Diego. In these counties, DHCS contracts with several commercial Health Plans to provide services to beneficiaries. Because this model offers more options for beneficiaries, participating Health Plans have greater incentive to enhance delivery of care to their members.
PROS AND CONS FOR CONSUMERS

There are a number of advantages for consumers to participate in a managed care plan:

- No-cost/low-cost preventative care – managed care plans will often subsidize or pay entirely for programs and services aimed at preventing disease (i.e., yearly checkups, immunizations, gym memberships, well-baby care, etc.). This can save money in the long run if they don’t have to pay for costly illnesses.

- Lower premiums – managed care plans often charge lower premiums because they have a limited pool of health care providers to choose from.

- Pre-determined co-payments – members often know what they will be paying out-of-pocket for services because they are generally limited to a fixed amount laid out in their plan.

- Fewer unnecessary procedures – managed care plans offer doctors financial incentives to provide only necessary care, so they are less likely to order tests or procedures not needed.

- Limited paperwork – while health care providers often have more paperwork to deal with in managed care, plan members generally only need to show a membership card and pay a co-payment to receive services.

There are also a number of disadvantages for consumers to participate in a managed care plan:

- Limited selection of health care providers – to keep costs down, managed care plans generally have a list of providers (including specialists) members must select from for their health care needs. In many instances, members must select “in-network” providers in order for their care to be covered by the plan.

- Restricted coverage – members generally need to receive approval from their primary care providers to justify treatment based on what their plan covers.

- Prior approval needed – most managed care plans require referral from primary care providers in order for members to access specialists or specialty care.

- Possibility of under-treatment – as managed care plans offer incentives to limit unnecessary care, health care providers may withhold treatment to save on costs.

- Compromised privacy – some managed care plans use patient records to monitor the performance and efficiency of their health care providers, so the details of members’ medical history may be seen by people other than their health care provider.

7 National Senior Citizen’s Law Corps and other advocate organizations
CALIFORNIA’S EARLY WORK WITH AND CHALLENGES FROM MANAGED CARE

While legislation was enacted in the 1970s to allow Medi-Cal beneficiaries to be enrolled in managed care programs, it wasn’t until the early 1990s that California began to shift large numbers of Medi-Cal beneficiaries into managed care.

In 1982, Medicaid Reform legislation was enacted that allowed Medi-Cal to contract with COHSs. Santa Barbara and San Mateo were the first counties to have COHS plans in California. As stated above, there are currently six COHS plans that serve 14 counties.

In 1991, the state passed legislation to establish the California Managed Care Initiative which required mandatory enrollment into managed care for certain Medi-Cal aid codes. The passage of the Managed Care Initiative also resulted in additional managed care models as alternates to COHSs in the delivery of health care for California’s Medi-Cal beneficiaries. One of these alternate models was Geographic Managed Care (GMC), which grew out of the GMC Pilot Project initiated in 1994. The major model implemented during the time of Medi-Cal managed care expansion prompted by the Managed Care Initiative was the Two-Plan model.

Initially, seniors and persons with disabilities who were eligible for Medi-Cal benefits in the GMC and Two-Plan model counties could enroll voluntarily into the managed care plans or enroll in Medi-Cal FFS. In 2010, with approval of the 1115 Waiver, DHCS initiated mandatory enrollment into Medi-Cal managed care for this population. The transition started in June 2011.

HISTORIC CONTEXT FOR LTCI

It is important to note that the concept of LTCI and aligning Medicare and Medicaid is not new. On Lok and its PACE (Program of All Inclusive Care for the Elderly) national replication have been a “duals” program (capitated reimbursement for Medicare and Medicaid) for over 25 years. Nationally, PACE has 88 sites in 29 states and, though the total number of PACE enrollees is small, the impact of its work has been significant and was the precursor for Medicare’s work on the Cal MediConnect Program.

California also explored LTCI in the mid 1990s with the Long Term Care Integration Pilot Program. See APPENDIX H for an Explanation of California’s Long Term Care Integration (LTCI) Pilot Program (AB 1040 – 1995)

NATIONAL

In 2008, there were 9.2 million individuals eligible for both the Medicare and Medicaid programs. Medicare-Medicaid beneficiaries, “dual eligibles,” are among the most chronically ill and costly individuals in both the Medicare and Medicaid programs, with many having multiple chronic conditions and/or long-term care needs. More than half of Medicare-Medicaid beneficiaries have incomes below the poverty line compared with 8 percent of other Medicare beneficiaries. Forty-three percent of Medicare-Medicaid beneficiaries have at least one mental or cognitive impairment, while 60 percent have multiple chronic conditions. Nineteen percent live in institutional settings compared to only 3 percent of Medicare beneficiaries who are not also
eligible for Medicaid. This group must navigate two separate programs: Medicare for coverage of basic acute health care services and drugs, and Medicaid for coverage of long-term care supports and services, and help with Medicare premiums and cost-sharing.

Medicare-Medicaid beneficiaries account for a disproportionately large share of expenditures in both the Medicare and Medicaid programs: accounting for 16 percent of Medicare beneficiaries, yet 27 percent of Medicare spending in 2006. In Medicaid, they comprised only 15 percent of beneficiaries but represented 39 percent of Medicaid spending in 2007.

Medicare-Medicaid beneficiaries account for approximately $120 billion in federal and state spending – about twice as much as Medicaid spent on the 29 million children it covered. States alone spent over $50 billion in 2007 to support the uncovered health and long-term care costs of people enrolled in Medicare. The Medicaid spending on Medicare-Medicaid beneficiaries was $15,459 in 2007, over six times higher than the comparable cost of a non-disabled adult covered by Medicaid ($2,541). This spending mostly reflects the significant costs of a population with low income and high health care needs; however, there is opportunity for savings through improved care coordination, simplification, and the alignment of Medicare and Medicaid rules.

Patient Protection and Affordable Care Act (PPACA). In March of 2010, the PPACA was signed into law by President Barack Obama. Together with the Health Care and Education Reconciliation Act, it represents the most significant government expansion and regulatory overhaul of the U.S. health care system since the passage of Medicare and Medicaid in 1965.

PPACA is aimed at decreasing the number of uninsured Americans and reducing the overall costs of health care. It provides a number of mechanisms—including mandates, subsidies, and tax credits—to employers and individuals to increase the coverage rate. Additional reforms are aimed at improving health care outcomes and streamlining the delivery of health care.

PPACA created the new Federal Coordinated Health Care Office (the Medicare-Medicaid Coordination Office). The goal of this Office is to improve coordination between the federal government and states for Medicare-Medicaid beneficiaries in order to ensure full access to covered services in both programs and high quality care. The Office is moving forward on improving access, coordination, and cost of care with a focus in three major areas: Program Alignment, Data and Analytics, and Models and Demonstrations.

To date, the Medicare-Medicaid Coordination Office has selected 15 states to design new integrated care program models for people enrolled in Medicare and Medicaid (Duals). The 15 states are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.

CALIFORNIA

In California, about 1.9 million seniors and persons with disabilities (SPDs) are enrolled in Medi-Cal, the state-federal program providing medical care and long-term services and supports (LTSS)
to low-income persons. The majority of SPDs are also eligible for Medicare, the federal program that provides medical services to qualifying persons over age 65 and certain persons with disabilities. The SPDs who are eligible for both Medi-Cal and Medicare are known as “dual eligibles” and receive services paid by both programs.

**Proposed Coordinated Care Initiative (CCI).** As part of his 2012-13 budget, the Governor proposed the CCI to: (1) integrate Medi-Cal and Medicare benefits for dual eligibles and integrate LTSS into Medi-Cal Health Plans. The Legislature adopted a modified version of the Governor’s CCI proposal in Chapter 33, Statutes of 2012 (SB 1008, Committee on Budget and Fiscal Review) and Chapter 45, Statutes of 2012 (SB 1036, Committee on Budget and Fiscal Review). The CCI is described more fully on page 31.

Although the Governor originally proposed statewide expansion of CCI to all 58 counties in three years, Chapter 33 provides statutory authorization for up to eight demonstration counties and requires that expansion beyond the initial eight counties be contingent on statutory authority and a subsequent budget appropriation. Chapter 33 also increases the Legislature’s oversight of CCI by placing reporting, monitoring, and other requirements on the administration. Chapter 45 primarily makes changes to IHSS, including changes to counties’ share of cost for IHSS and a shift to statewide collective bargaining for IHSS provider wages and benefits—beginning with the eight demonstration counties. Chapter 45 also requires a stakeholder workgroup to develop a universal assessment tool for home and community-based services (HCBS).

**Examples of where LTCI has worked, why and how**

While programs that integrate care for dual eligibles vary by state and target population(s), core elements found in most fully integrated LTCI models include:

- 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 teams that put the individual beneficiary at the center;
- Involvement of family caregivers, including an assessment of needs and competency;
- Comprehensive provider networks, including a strong primary care base;
- Strong home and community-based service options, including personal care services;
- Adequate consumer protections, including an ombudsman;
- Robust data-sharing and communications system; and
- Aligned financial incentives.\(^8\)

Based on experiences in other states, there are three core strategies for designing programs for dual eligibles based on current state strengths and capacities:\(^9\)

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\(^8\) “Profiles of State Innovation: Roadmap for Improving Systems of Care for Dual Eligibles”, Center for Health Care Strategies, November 2010.

\(^9\) Ibid.
• States that have a strong managed care system for medical services, but lack a robust LTSS program, should consider building on their existing managed care system to serve dual eligibles. If the state has contracts with managed care organizations (MCOs) for Medicaid populations that include SPDs, it may want to prepare managed care plans, beneficiaries, and stakeholders for an integrated set of medical/LTSS benefits.

Depending on the state’s approach, all or some of the HCBS waiver services can be made available through the managed care plans, which have additional flexibility to leverage cost-savings on the medical care side for Medicaid-only beneficiaries. The Health Plans can use their existing systems of care management and assessment, but may need technical assistance from state agency staff to expand these systems to incorporate LTSS.

• States that have a strong system for LTSS, but lack a strong managed care system for medical services, should consider broadening their LTSS system to include managed medical services for dual eligibles.

• In some states, MCOs do not participate in the delivery system for Medicaid-only SPDs, so it would be a stretch for these states to build a managed care program from the ground up for this population. But even in states with managed care for the SPD population, the state may not be ready for integration. In that case, strong coordination systems can be put into place. States can start by sharing data or coordinating care with the MCOs and providers.

• States with both a strong medical care system and a strong LTSS program should consider bridging these systems to integrate services. A small number of states have the luxury of robust systems of managed medical care and LTSS for Medicaid-only SPDs, but have not integrated the two systems. In the absence of that last step, one approach is to create linkages between LTSS and the entities that manage the medical services.

The table on the next page from the Centers for Health Care Strategies (CHCS), dated September 2010, shows states that have some form of integrated care models for Duals. However, in four of those states, including California, the models are in the developmental stage.

More recently, CHCS has provided a policy brief, entitled: *Innovations in Integration: State Approaches to Improving Care for Medicare-Medi-Cal Enrollees*, dated, February 2013, which is found in APPENDIX N.
### States with Integrated Care Models for Duals*

<table>
<thead>
<tr>
<th>State</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZ</td>
<td>Medicaid aged (65+), blind and disabled beneficiaries who need a nursing home level of care. Includes dual eligibles.</td>
</tr>
<tr>
<td>CA</td>
<td>All dual eligibles.</td>
</tr>
<tr>
<td>CO</td>
<td>All dual eligibles.</td>
</tr>
<tr>
<td>MD</td>
<td>Duals and Medicaid-only beneficiaries needing LTC services.</td>
</tr>
<tr>
<td>MA</td>
<td>Dual eligibles and Medicaid-only beneficiaries age 65 and older.</td>
</tr>
<tr>
<td>MI</td>
<td>Dual eligibles and Medicaid-only beneficiaries with nursing home level of care.</td>
</tr>
<tr>
<td>MN</td>
<td>Dual eligibles and Medicaid-only beneficiaries age 65 and older.</td>
</tr>
<tr>
<td></td>
<td>Dual eligibles and Medicaid-only beneficiaries with physical disabilities, ages 18-65.</td>
</tr>
<tr>
<td></td>
<td>Dual eligibles and Medicaid-only beneficiaries with disabilities</td>
</tr>
<tr>
<td>NM</td>
<td>All dual eligibles; Medicaid-only beneficiaries who receive certain waiver services or reside in a nursing facility.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population</th>
<th>Special Needs Plan (SNP)</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medicare Acute</td>
</tr>
<tr>
<td>AZ</td>
<td>Currently contracts/not required to be SNPs</td>
<td>✓</td>
</tr>
<tr>
<td>CA</td>
<td>Contracts planned</td>
<td>IN DEVELOPMENT</td>
</tr>
<tr>
<td>CO</td>
<td>Contracts planned</td>
<td>IN DEVELOPMENT</td>
</tr>
<tr>
<td>MD</td>
<td>Currently contracts/ required to be SNPs</td>
<td>✓</td>
</tr>
<tr>
<td>MA</td>
<td>Currently contracts/ required to be SNPs</td>
<td>✓</td>
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<tr>
<td>MI</td>
<td>Currently contracts/ required to be SNPs</td>
<td>✓</td>
</tr>
<tr>
<td>NM</td>
<td>Currently contracts/ required to be SNPs</td>
<td>✓</td>
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</tbody>
</table>
The Social Security Act of the United States provides for a number of waivers, which enable individual states to test out new or existing ways to deliver and pay for health care services in Medicaid and the Children’s Health Insurance Program (CHIP). There are four primary types of waivers and demonstration projects:

- **Section 1115 Research & Demonstration Projects** – allows for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP. These waivers are generally used to allow states to institute demonstration projects and provide federal funding that would not normally be eligible under federal law. To avoid Congressional approval, these waivers must be budget neutral over the life of the waiver, meaning that they cannot cost the federal government more than it would normally pay under Medicaid in the absence of the waiver.

- **Section 1915(b) Managed Care Waivers** – provides for a waiver to offer services through managed care delivery systems or otherwise limit people’s choice of providers.

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1115 Waivers and the Coordinated Care Initiative

The Social Security Act of the United States provides for a number of waivers, which enable individual states to test out new or existing ways to deliver and pay for health care services in Medicaid and the Children’s Health Insurance Program (CHIP). There are four primary types of waivers and demonstration projects:\(^{10}\)

- **Section 1115 Research & Demonstration Projects** – allows for program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP. These waivers are generally used to allow states to institute demonstration projects and provide federal funding that would not normally be eligible under federal law. To avoid Congressional approval, these waivers must be budget neutral over the life of the waiver, meaning that they cannot cost the federal government more than it would normally pay under Medicaid in the absence of the waiver.

- **Section 1915(b) Managed Care Waivers** – provides for a waiver to offer services through managed care delivery systems or otherwise limit people’s choice of providers.

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\(^{10}\) [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html)
Section 1915(c) Home and Community-Based Services Waivers – allows states to provide long-term care services in home and community settings rather than institutional settings.

Concurrent Section 1915(b) and 1915(c) Waivers – allows states to simultaneously implement two types of waivers to provide a continuum of services to the elderly and people with disabilities, as long as all federal requirements for both programs are met.

California applied for and received from the federal government on November 2, 2010, a five-year, $10 billion Section 1115 waiver to develop a Medi-Cal reform demonstration in preparation for the federal health care reforms that go into effect in January of 2014. This waiver proposal is known as California’s “Bridge to Reform” and involves expanding coverage to include additional participants that will become eligible in January 2014 as well as developing models for better coordination and quality of care delivery for the state’s most vulnerable populations (low-income seniors and persons with disabilities).

California’s Coordinated Care Initiative

In January 2012, Governor Brown introduced the California Coordinated Care Initiative (CCI) intended to improve coordination of care delivery, health outcomes and patient satisfaction while, at the same time, achieving substantial savings by diverting care from health care institutions to the home and community. The initiative requires mandatory enrollment of all Medi-Cal beneficiaries, including those who also qualify for Medicare (known as dual eligibles), into managed care for their Medi-Cal benefits, which will include the following minimum long-term services and supports: In-Home Supportive Services (IHSS), Multipurpose Senior Service Program (MSSP), Community-Based Adult Services (CBAS) and skilled nursing care. In addition, the initiative allows for optional and passive enrollment into the Cal MediConnect Pilot Project*, which is integrated managed care that combines Medicare and Medi-Cal benefits.

*The Cal MediConnect Pilot Project is defined on page 31.

CCI was passed in the California Legislature (as SB 1008 and SB 1036) and signed by the Governor on June 27, 2012.

SB 1008 – Contains necessary statutory changes to achieve savings assumed in the 2012 Budget Act related to the DHCS.

- Establishes the Cal MediConnect Pilot Project with all its specific provisions and goals.
- Expands from four to eight initial counties as demonstration sites.
- Provides that implementation will begin no sooner than March 2012 and expand statewide within three years, contingent upon statutory authorization and subsequent budget appropriation.
- Defines LTSS to include IHSS, CBAS, MSSP, and skilled nursing facility services.
- Requires a memorandum of understanding (MOU) between Department of Health Care Services (DHCS) and the federal government.
- Requires dual beneficiaries to be enrolled into a demonstration site unless they choose to opt out of enrollment or are enrolled in a Program of All-inclusive Care for the Elderly (PACE) or AIDS Healthcare Foundation (AHF).
- Allows those who meet the requirements for PACE or AHF to select either of these managed care plans for their Medicare and Medi-Cal benefits if available in their county.

**SB 1036** – Makes statutory changes necessary to implement portions of the 2012-13 Budget as it relates to the Cal MediConnect Pilot Project and Long-Term Services and Supports Integration.
- Incorporates IHSS into the Cal MediConnect Pilot Project and preserves the IHSS consumer’s right to direct and control their care.
- Commences the demonstration project with an eight-county pilot.
- Integrates LTSS.
- Maintains key social model components of the IHSS program and refocuses health care delivery to include the social model as a primary component of coordinated care.
- Beginning not before March 1, 2013, and transitioning over 12 months, the IHSS program will become a Medi-Cal benefit available through Medi-Cal Health Plans in participating demonstration counties.
- Ensures that access to and payment for services for IHSS-eligible individuals will be maintained.
- Establishes 13-member state consumer advisory committee to include current or former providers and individuals representing organizations that advocate for seniors and persons with disabilities (SPDs).
- Establishes stakeholder workgroups to design a universal assessment tool and process to be used for all home and community-based services and sets up a reporting process for implementation and testing.
- Requires the California Department of Social Services to develop training curriculum for providers in consultation with DHCS and in collaboration with stakeholders.

**State Objectives**

The Cal MediConnect Pilot Project includes the following goals. These were approved by the State Legislature in 2010 as part of SB 1008 and further developed through stakeholder engagement:

1. Coordinate state and federal benefits and access to care across care settings, improve continuity of care, and use a person-centered approach.
2. Maximize the ability of dual-eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care.
3. Increase the availability and access to home and community-based alternatives.
4. Preserve and enhance the ability for consumers to self-direct their care and receive high quality care.
5. Optimize the use of Medicare, Medi-Cal, and other state/county resources.
CALIFORNIA’S CAL MEDICONNECT PILOT PROJECT

The Cal MediConnect Pilot Project focuses on individuals who are full benefit Medicare and Medi-Cal beneficiaries (“dual eligibles”). The three-year project will combine all health services (medical, behavioral health, home and community-based services, and long-term services and supports) into a single LTCI benefit package, which will be delivered through a coordinated system. A capitated payment model will be used to provide both Medicare and Medi-Cal benefits through the state’s existing network of Medi-Cal Health Plans.

Project participants will be given the option to choose one of the designated Health Plans or, if appropriate, PACE. Those who do not choose a plan will be passively enrolled in one of the designated plans in their county. Dual eligibles will be allowed to opt out for their Medicare services only, if they wish to do so. If they do not opt out, they will be automatically enrolled. For most of the counties (excluding San Mateo and Los Angeles), passive enrollment will be phased in over a 12-month period with the earliest start date being January 1, 2014.

TIMELINE FOR INITIAL DEMONSTRATION COUNTIES AND POSSIBLE EXPANSION

The Cal MediConnect Pilot Project is schedule to launch in eight approved demonstration counties in 2014. Below are the initial eight approved counties:

- Alameda
- Los Angeles
- Orange
- Riverside
- San Bernardino
- San Diego
- San Mateo
- Santa Clara

Expansion from the original eight counties cannot begin without Legislative approval. The state’s goal is to expand to eight additional demonstration counties (which may include San Francisco) with full statewide implementation will begin after that. Demonstration Health Plans need to achieve managed care accreditation by the National Committee for Quality Assurance, if they do not already have it, by the end of the third year of the project.

Additional Participants – In addition to the “dual eligibles” participating in the demonstration counties, beneficiaries with a Medi-Cal share of cost also may be included, during the months they qualify for share of cost, with the opportunity to opt out if they wish.
**Ineligible for Pilot Project** – The following dual-eligible beneficiaries will not be eligible to participate in the Pilot Project:

- Part-benefit dual eligibles and dual-eligible beneficiaries who also have other health coverage (not including Medicare Advantage plans or partial plans such as dental coverage);
- Beneficiaries under the age of 21;
- Beneficiaries who have end-stage renal disease (ESRD) prior to enrollment in the demonstration;
- Developmentally disabled beneficiaries receiving services through a regional center or state developmental center;
- Beneficiaries enrolled in 1915(c) Waiver programs (i.e., Nursing Facility/Acute Hospital Waiver Service, HIV/AIDS Waiver Services, Assisted Living Waiver Services, and In-Home Operations Waiver Services); and
- Beneficiaries who reside in zip codes within the participating counties that are currently from Medicare and Medi-Cal managed care contracts.

**Exempt from Passive Enrollment** – Several populations of dual eligibles have been exempted from passive enrollment in the Cal MediConnect Pilot Project. They include: PACE enrollees; AIDS Healthcare Foundation (AHF) enrollees; beneficiaries enrolled in Medicare Advantage (Part C) Health Plans not administered by or contracted with the demonstration Health Plans; and those enrolled in Medicare Advantage Dual – Special Needs Plans (D-SNP) not administered by or contracted with the demonstration Health Plans. In addition, dual-eligible Native Americans residing in the participating counties may enroll in the demonstration.

**SYNOPSIS OF WORK TO DATE**

The 16 Health Plans identified to participate in the initial phase of the Pilot Project are already part of the state’s Medi-Cal managed care network and have experience delivering Medicare services in managed care settings. Prior to project enrollment, each health plan will be assessed (readiness review) to verify that they meet operational requirements.

Stakeholder workgroups, convened by DHCS, are an important component for the Pilot Project and they are already underway to assist the state in securing feedback from both providers and beneficiaries, developing recommendations on how the delivery of care to beneficiaries can be improved, and preparing for the 2013 launch date.

Each group consists of members of DHCS with other state offices and external partners, and is co-chaired by a public stakeholder and a state agency representative. The purpose of these groups is to support the development and implementation of the Cal MediConnect Pilot Project.
There are seven stakeholder workgroups identified for the Pilot Project. They include:

- **Beneficiary Notification, Appeals and Protections** – makes recommendations on the enrollment process for the demonstration, including text and design principles for beneficiary notices; provides feedback on coordinated appeals and grievances procedures to ensure the process is coordinated but maintains beneficiary protections.

- **Provider Outreach and Engagement** – makes recommendations about provider participation in demonstration sites, particularly medical providers, and to identify strategies to expand managed care plan provider networks.

- **Long-term services and supports (LTSS) Integration** – makes recommendations on how to preserve and expand existing home and community-based services in an organized system of care within the demonstration, including recommendations for LTSS network adequacy standards and coordination of IHSS, MSSP, and nursing facilities with the goal of developing a patient-centered care model that ensures consumer protections.

- **IHSS Coordination and Integration** – develops contract requirements between Health Plans and county IHSS entities to ensure the readiness and functioning of the new integrated program also with the goal of developing a patient-centered care model that ensures consumer protections.

- **Mental Health and Substance Use Services Integration** – develops strategies to support the implementation of integrated mental health and substance use services as part of the demonstration project, including proposals to overcome policy and regulation barriers, recommendations for care coordination, performance and accountability measurement frameworks, and the structure for financing and incentives.

- **Fiscal and Rate Setting** – supports actuaries’ understanding of program components and capitation rates for managed care plans with the understanding that rate setting is a proprietary and confidential effort between plans, the state, and federal government.

- **Quality and Evaluation** – develops recommendations on quality and outcome measurements and design of the evaluation for the demonstration.

**MAJOR ISSUES AND CHALLENGES**

**Administrative and Operational Hurdles** – There is no single entity responsible to oversee the benefits and services or coordinate care provided for dual-eligible beneficiaries. Some of the care they receive is covered under Medicare, and some is covered under Medicaid. In addition, Medicare and Medicaid each operate under their own separate set of laws and regulations as two totally separate programs. This results in beneficiaries having to navigate separate rules regarding benefits and services, coverage standards, conditions of provider participation, provider payment, and deal with varying systems of administration.

**Access to Good Data** – Because Medicare and Medicaid operate under completely different policies and procedures and provide coverage for different health needs of the dual-eligible

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11 www.calduals.org/workgroup
population, each manages their own data on the covered services provided to each individual, and there is no linkage between the two systems to allow for easy access by the other. Therefore, each has only a limited picture of the dual-eligible population and is severely limited in their ability to effectively deal with the varying needs this population presents.

**Financial Misalignments between Medicare and Medicaid** – There is little or no financial incentive to integrate services for beneficiaries enrolled in both Medicare and Medicaid. On the Medicaid side, states have little incentive to improve coverage, build integrated delivery systems or utilize higher payment rates because potential savings would accrue primarily to Medicare, with no opportunity for Medicaid to share in those savings.

On the Medicare side, legal and financial incentives are directed to shifting costs, when possible, into Medicaid. Because Medicaid allows payment for services that avert deterioration and loss of functioning, it is possible to finance treatment and services that maintain patient status, thereby avoiding acute episodes that result in high Medicare hospitalizations and churning readmissions. If states used the broader authority recognized under federal Medicaid law to expand Medicare coverage for dual-eligible beneficiaries, it might be possible to avert significant acute care costs for Medicare (although, again, Medicaid would not receive any of these savings)\(^\text{12}\).

**Enrollment Issues** – Materials must easy to understand. There needs to be sufficient enrollment in the Health Plans to provide adequate outcomes data. In addition, Health Plans need adequate time to develop case plans and implement improvement strategies for beneficiaries. After spending a great deal of time navigating the current system, beneficiaries are hesitant to enroll in a managed care program in which they may need to find new providers. Therefore, unless enrollment in a managed care program is mandatory, they may not choose to enroll.

**Stakeholder Concern/Resistance** – Beneficiaries and advocates have struggled to navigate the current system and develop relationships with their providers. With a change in the system, they are concerned with whether or not they will lose the health care providers they have been working with who are familiar with their particular needs (doctors, pharmacies, hospitals, etc.). They are also concerned with whether or not their care will be covered. Continuity of care is a big concern. Will they be unable to access the care they need while changes in the system are being made? Will they have to learn new phone numbers, new appeals processes, etc.? They want to know they are going to get the services they need, when they need them, in a setting that is comfortable to them.

See **APPENDIX J** for Consumer Protections, Risks & Opportunities for LTSS under managed care.

**Network Adequacy (especially LTSS)** – LTSS operate largely in isolation, the exception being those local areas in which individual care managers have developed relationships to bridge the silos. LTSS are also disconnected from medical providers and Health Plans in many counties.

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In February 2013, the California State Legislative Analyst’s Office issued a report on the CCI. The following were the issues raised:

- The 2012–13 Budget Act assumed implementation of CCI would begin in March 2013. In his 2013–14 Budget, the Governor proposes to delay the start date of CCI implementation to September 1, 2013, resulting in lower 2013–14 savings than initially anticipated. The Governor also proposes a one-time enrollment of dual eligibles into managed care in San Mateo County, and a 16-month enrollment period for dual eligibles in Los Angeles County.

- The state is preparing for oversight and other activities related to CCI. However, key financing and operational aspects will be informed by the MOU between the federal Centers for Medicare and Medicaid Services (CMS) and the state, hereinafter referred to as the “demonstration (Cal MediConnect Pilot Project) MOU.” At present, the state and CMS continue to hold MOU discussions without having reached an official agreement.

- The lack of the demonstration MOU creates uncertainty about the timely and successful implementation of CCI. The MOU will establish the enrollment process for beneficiaries and the rate-setting framework for managed care plans—both crucial determinants of plans’ abilities to effectively manage care for beneficiaries. Further, we believe that under current law, the state’s failure to reach an MOU agreement with CMS, or to receive adequate indication of pending approval, by February 1, 2013, generally renders authorizing language for CCI inoperative on March 1, 2013.

- The CCI legislation authorizes managed care plans participating in the eight county Pilot Project to provide additional IHSS hours to beneficiaries as needed. However, these plans do not have the authority to reduce IHSS hours assessed by county social workers. We find this problematic because the plans, as risk-bearing organizations, should, as a general principle, have the authority to determine the level of utilization for services that are factored into their capitated rate payments.

- The Legislative Analyst’s Office recommends the Legislature amend the authorizing statute of CCI to clarify the legal status of the project to go forward. To address concerns about the integration of IHSS under managed care, we recommend the Legislature use CCI as an opportunity to test the full integration of IHSS as a managed care benefit with at least one demonstration plan in the third year. This would enable the Legislature to compare the advantages and trade-offs of two models of integrating IHSS under managed care: (1) in the first two years, a more restrained approach that relies on care coordination between demonstration plans and county welfare departments and (2) in the third year, a fully integrated approach among plans prepared for such a shift.

On March 27, 2013, the California Department of Health Care Services (DHCS) and CMS announced the launch of the three-year demonstration, Cal MediConnect, that will promote coordinated health care delivery for seniors and persons with disabilities eligible for Medicare &
Medi-Cal. This Pilot Project aims to create a seamless service delivery experience for dual-eligible beneficiaries with the goal of improved quality of care, better health outcomes, and a more efficient delivery system.

See APPENDIX L For A Summary Of The MOU Between California And CMS Re: The Cal MediConnect Pilot Project.

The May 2013 revision to the State budget separated the two components of California’s Coordinated Care Initiative (CCI): (1) the Duals Demonstration (aka Cal MediConnect); and (2) Medi-Cal Managed Long-Term Services and Supports (MLTSS). When the CCI was initially passed, both components were inter-related, meaning the State could not do one without the other. Now, it is possible the State may determine the Duals Demonstration is not viable, yet still move forward with MLTSS.

In MLTSS, Medi-Cal beneficiaries, including dual eligible beneficiaries, will be required to enroll in a Medi-Cal managed care plan to receive their Medi-Cal benefits, including LTSS (IHSS, MSSP, CBAS and nursing facility care) and Medicare wrap-around benefits.). This will create some exceptional challenges for the Health Plans. Cost savings from Medicare are to be used to pay for LTSS. If there is no Duals Demonstration in California, then there will be no Medicare savings, which means that there will be no additional funding to offset extra costs spent on LTSS.
SECTION III. SAN FRANCISCO
SAN FRANCISCO LTCI TARGET POPULATION AND DEMOGRAPHIC CHANGES

Background

Long-term services and supports (LTSS) in San Francisco are intended to serve all seniors and all adults with disabilities who need support to live independently in the community. Services are not created based on the ability to pay, but rather based on service needs of seniors and adults with disabilities (SPDs). That being said, there are mechanisms in place for those who do not have the resources to pay for these services (Medi-Cal) and other services (funded through the Older Americans Act) that are available for seniors regardless of their income.

While the “system” that has been created in San Francisco focuses funding on those who have limited financial resources, that same “system” supports all SPDs. Adult day health care centers, care coordination agencies, home-delivered meals and other crucial LTSS services can be purchased by those with means or accessed by those without means with funding from city, state, and federal agencies. A more organized long-term care system in San Francisco is meant to reach all SPDs.

Cal MediConnect Target Populations

While San Francisco is not yet part of the Cal MediConnect Pilot Project in California, it may be included in later years. This demonstration project seeks to serve most dual-eligible (Medi-Cal and Medicare) older adults and adults with disabilities, though there are some population groups that are carved out. The following chart describes those who are included and excluded from the Cal MediConnect Pilot Project and from LTSS via mandatory Medi-Cal managed care.
### State of California, Department of Health Care Services: Coordinated Care Initiative Participating Populations Chart

<table>
<thead>
<tr>
<th>Population</th>
<th>Cal MediConnect (WIC 14132.275)</th>
<th>Long-term services and supports (LTSS) via Mandatory Medi-Cal Managed Care(^1) (WIC 14182.16 &amp; 14186.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-Benefit dual eligible</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>Partial-benefit dual eligible</td>
<td>Excluded</td>
<td>Included</td>
</tr>
<tr>
<td>Medi-Cal-only seniors and persons with disabilities (SPDs)</td>
<td>Excluded</td>
<td>Include</td>
</tr>
<tr>
<td>Medi-Cal-only SPDs exempt from managed care due to approved Medical Exemption Request (MER)</td>
<td>Excluded</td>
<td>Included</td>
</tr>
<tr>
<td>Rural Zip Codes excluded from managed care</td>
<td>Excluded</td>
<td>Included</td>
</tr>
<tr>
<td>Other Health Coverage – Two-Plan/Geographic Managed Care (GMC) county</td>
<td>Excluded</td>
<td>Included</td>
</tr>
<tr>
<td>Other Health Coverage – County Organized Health System (COHS) county</td>
<td>Excluded</td>
<td>Included</td>
</tr>
<tr>
<td>Under age 21</td>
<td>Excluded</td>
<td>Included</td>
</tr>
<tr>
<td>1915(c) waiver beneficiaries (but not developmentally disabled or Multipurpose Senior Service Program (MSSP)</td>
<td>Excluded</td>
<td>Included(^{14})</td>
</tr>
<tr>
<td>Developmentally disabled beneficiaries receiving services through a DDS 1915(c) waiver, regional center, or state developmental center</td>
<td>Excluded</td>
<td>Included</td>
</tr>
<tr>
<td>ICF-DD Resident</td>
<td>Excluded</td>
<td>Excluded in Two-Plan/GMC County</td>
</tr>
<tr>
<td>End stage renal disease (ESRD) – previous diagnosis</td>
<td>Excluded(^{15})</td>
<td>Included</td>
</tr>
<tr>
<td>ESRD – subsequent diagnosis</td>
<td>Included</td>
<td>Included</td>
</tr>
</tbody>
</table>

\(^{13}\) Includes all dual eligible and Medi-Cal only SPDs unless otherwise noted.

\(^{14}\) Pending Clean-Up Trailer Bill Language.

\(^{15}\) Director may authorize voluntary enrollment in some counties.
<table>
<thead>
<tr>
<th>Population</th>
<th>Cal MediConnect (WIC 14132.275)</th>
<th>Long-term services and supports (LTSS) via Mandatory Medi-Cal Managed Care¹³ (WIC 14182.16 &amp; 14186.1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share of Cost – in skilled nursing facility, MSSP, or IHSS and continuously certified to meet share of cost</td>
<td>Included</td>
<td>Included</td>
</tr>
<tr>
<td>Share of Cost – in community and not continuously certified</td>
<td>Excluded</td>
<td>Included</td>
</tr>
<tr>
<td>Resident of veterans home of California</td>
<td>Excluded</td>
<td>Excluded</td>
</tr>
<tr>
<td>American Indian Medi-Cal beneficiaries¹⁶</td>
<td>Included, but may opt out any month</td>
<td>Included, but may opt out any month</td>
</tr>
<tr>
<td>Beneficiaries with HIV/AIDS</td>
<td>Included, but may opt out any month</td>
<td>Included, but may opt out any month</td>
</tr>
<tr>
<td>Program of All-Inclusive Care for the Elderly (PACE) and AIDS Healthcare Foundation enrollees</td>
<td>Exempt from passive enroll</td>
<td>Excluded</td>
</tr>
<tr>
<td>Medicare Advantage and Special Needs Plan beneficiaries</td>
<td>Exempt from passive enrollment in 2014¹⁷</td>
<td>Exempt in 2014</td>
</tr>
</tbody>
</table>

San Francisco’s Target Population

San Francisco’s *Living with Dignity Strategic Plan*, which guided improvements in the network of community-based LTSS for older adults and adults with disabilities from 2009 to 2013, also speaks to target populations with the following:

“The target population includes older adults and adults with disabilities of all income levels, including those have:

- Physical or mental disabilities,
- Developmental disabilities,
- Chronic illnesses, and
- HIV/AIDS.

¹⁶ Indian Medi-Cal beneficiaries can access services through Indian health programs and providers as provided by current law.

¹⁷ Enrollment in the Duals Demonstration will be reassessed in 2014, depending on federal re-authorization of the D-SNP model and the Department’s assessment of the demonstration plans.
Also, the target population includes those who are:

- Veterans,
- Younger adults with disabilities (18-24) aging out of systems focused on children,
- Residing in acute care settings or nursing facilities and are willing and able to return to community living,
- Aging in place in public housing,
- Aging in place in their own homes and apartments,
- Living in shelters,
- Living in assisted living facilities,
- Living in single room occupancy hotels, and
- Homeless.”

It is important to note that the Living with Dignity Strategic Plan specifically states “all income levels.” “All” adults with disabilities and seniors are part of the target population for LTCI in San Francisco, though not necessarily for the Cal MediConnect.

Finally, San Francisco’s Strategy for Excellence in Dementia Care (2010 - 2020) adds to the target population people with Alzheimer’s disease and other forms of dementia. While Alzheimer’s represents approximately 75% of all cases, there are many other forms of dementia including vascular dementia, Parkinson’s disease, Huntington’s disease, dementias associated with diabetes, thyroid disease, brain tumors, and AIDS, and finally, dementias related to alcohol or substance abuse. Older adults and adults with disabilities who have Alzheimer’s and other forms of dementia will be an additional category and part of the target population that will be served through Medi-Cal Managed Care Health Plans in San Francisco.

Size of the Cal MediConnect Population in San Francisco

The current total population of San Francisco County is 812,826, with 113,969 seniors (14 percent) being 65 years of age or older. 61,000 individuals are eligible for Medi-Cal in San Francisco. For those over age 65, one person out of every nine will have Alzheimer’s disease or some other form of dementia. Of those 85 and older, that number climbs to one out of every three. 12.3 percent of the population is below the poverty level, and 45.3 percent speak a language other than English at home.

“Aging in Place: Housing Assistance and Other Services for Seniors in San Francisco” further breaks down the older population: U.S. Census data indicated in 2000, San Francisco’s 136,369 seniors (18 percent) being 60 years of age or older made up a higher proportion of the city’s population than seniors did statewide or nationally (14 percent and 16.5 percent, respectively). However, the 2008 U.S. Mid-Census, the most recent estimate, reported that San Francisco’s senior population had grown to 161,580 or approximately 20 percent of the city’s population.

18 “Aging in Place: Housing Assistance and Other Services for Seniors in San Francisco”, SF Budget and Legislative Analyst Office, Updated February 2011.
The aging of the Baby Boom generation (adults born between 1946 and 1964) is likely to cause an increase in the future senior population in San Francisco. According to California Department of Finance projections, the number of seniors in San Francisco is projected to increase to 250,720 by 2030, an increase of 56.5 percent from the U.S. Census 2008 estimate of 160,169 seniors.

Households where the householders are seniors have significantly lower incomes than do the majority of other households in San Francisco in which the age of householder is between 25 and 64. The majority of San Francisco seniors (57 percent) are non-White, followed by 27 percent of seniors characterized as Asian/Pacific Islander.

San Francisco Dual-Eligibles

The SPD population, mandated to be enrolled into Medi-Cal Managed Care, includes Medi-Cal-only SPDs. This means they do not have Medicare. This is not the same population that is intended to become the LTCI target population, which is predominantly those referred to as “Duals” who have Medi-Cal and who are also in Medicare. The California DHCS estimate for dual beneficiaries for San Francisco County, those with Medi-Cal and Medicare, is provided below:

<table>
<thead>
<tr>
<th></th>
<th>Medicare Dual Eligible (22 – 64)</th>
<th>Medicare Dual Eligible (65 &amp; Up)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Francisco</td>
<td>10,102</td>
<td>34,890</td>
<td>44,992</td>
</tr>
</tbody>
</table>

The SPD population with Medi-Cal only, mandated to be enrolled, has already been transitioned into Medi-Cal managed care. Dual beneficiaries in San Francisco County remain as a population that may voluntarily enroll in Medi-Cal managed care.

In regard to estimated enrollments for the San Francisco Health Plan (San Francisco HP) and Anthem Blue Cross, if beneficiaries do not actively choose a health plan, such beneficiaries will be defaulted into a health plan. The current ratio of default assignments is 71% to San Francisco HP and 29% to Blue Cross. This ratio changes from year to year.

San Francisco LTCI Key Partners

Department of Aging and Adult Services

The mission of the Department of Aging and Adult Services (DAAS) is to assist older adults and adults with disabilities and their families to maximize self-sufficiency, safety, health, and independence so that they can remain living in the community for as long as possible and maintain the highest quality of life.
DAAS provides the following services:

- Adult Protective Services
- In-Home Supportive Services
- Office on the Aging
- Public Administrator
- Public Conservator
- Public Guardian
- Representative Payee Program
- County Veterans Service Office
- Long Term Care Operations:
  - Community Living Fund
  - Diversion and Community Integration Program
  - Transitional Care
- Integrated Intake & Screening Unit for Information, Referral & Assistance. Does intake for:
  - Adult Protective Services
  - Community Living Fund
  - Home-Delivered Meals
  - In-Home Supportive Services
  - Transitional Care

DEPARTMENT OF PUBLIC HEALTH

The mission of the Department of Public Health (DPH) is to protect and promote the health of all San Franciscans.

DPH provides the following services*:

- Community Behavioral Health Services
- Dental Services
- Disease Prevention
- Emergency Services
- Health at Home
- Housing and Urban Health
- Primary Care
  - Community-based primary care clinics and hospital-based primary care clinics
- Laguna Honda Hospital & Rehabilitation Center
- San Francisco General Hospital & Trauma Center

* DPH also provides jail health services; maternal, child and adolescent health services; and public health services - community health promotion, environmental health, public health emergency preparedness, disease prevention and control, and emergency medical services.

SAN FRANCISCO HEALTH PLAN

San Francisco Health Plan (San Francisco HP) is a managed care plan that offers several different programs to provide medical, dental, and vision care to members. Each program features unique benefits and has its own eligibility requirements (based on income, family size, residency, and sometimes age). All programs available through the San Francisco HP are for low income residents of San Francisco. The following programs offered by San Francisco HP are funded by the State of California:
• Medi-Cal (no-cost managed care coverage for individuals and families who are eligible – California’s Medicaid Program),
• Healthy Families (low-cost managed care coverage for children of families whose financial status makes them ineligible for Medi-Cal), and
• Healthy Kids.

San Francisco HP also partners with the Department of Public Health (DPH) to offer Healthy San Francisco. This is not an insurance plan. It is a the city’s health care safety net to encourage uninsured San Francisco residents to seek out primary and preventative care services. Each participant is provided with a primary physician to direct their care. While the program is designed to provide a greater focus on preventative services, specialty care, urgent and emergency services, laboratory services, hospitalization, etc., are also provided when necessary.

ANTHEM BLUE CROSS

Anthem Blue Cross, part of WellPoint, Inc., is one of the largest health insurance provider networks in California. Anthem works with the State of California to provide a number of health insurance programs including:
• Medi-Cal, Healthy Families, Access for Infants and Mothers (affordable pregnancy coverage for mid-income women),
• Major Risk Medical Insurance Program (a program to provide insurance coverage for those who are unable to secure independent coverage because of pre-existing conditions), and
• County Medical Service Program (a program that provides health coverage for low-income, indigent adults in 35 primarily rural counties in California).

In addition to these programs provided with funding by the state, Anthem Blue Cross offers a variety of private insurance programs for individuals and families of all income levels. These include both managed care programs and traditional, fee-for-service models of health coverage.

ON LOK LIFEWAYS (PACE)

On Lok Lifeways is a comprehensive Health Plan that provides various services for eligible seniors living in San Francisco, Fremont, Newark, Union City, and certain areas of Santa Clara County. On Lok pioneered the model of care known as the "Program of All-inclusive Care for the Elderly" or PACE, which allows seniors who are ill or disabled to live in their own home, whether home is a family residence, apartment, retirement village, or hotel room.”

The PACE program is designed for seniors 55 years and over who have been certified by the state to need nursing care and offers full medical care and support services to help these seniors remain in their homes and communities for as long as possible. On Lok Lifeways currently has

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19 http://www.onlok.org/HowPACEWorks.aspx
seven PACE day centers in San Francisco, two in Fremont, and one in San Jose. Each center includes a full health clinic and rehabilitation facilities. Also, each center offers a nutritious noon meal, social and recreational activities, and occasional group outings in the local area.

LONG-TERM CARE COORDINATING COUNCIL

The Long-Term Care Coordinating Council (LTCCC) was established in November 2004 to provide policy guidance to the Office of the Mayor on all issues related to the delivery of long term services and supports (LTSS). The LTCCC evaluates all issues related to improving service coordination and system interaction of community-based LTSS. The purpose of the LTCCC is to: “(1) advise, implement and monitor community-based long-term care planning in San Francisco and (2) facilitate the improved coordination of home, community-based and institutional services for older adults and adults with disabilities.”

The LTCCC is composed of 40 members representing: (1) services providers; (2) consumers and advocates representing older adults and adults with disabilities; and (3) City and County Departments. Thirty-two members are appointed by the Mayor of San Francisco from nonprofit service organizations, consumers and advocacy groups. The remaining eight members are representatives of seven San Francisco City and County Departments: Human Services, Aging and Adult Services, Public Health (two representatives), Mayor’s Office on Disability, Mayor’s Office of Housing, San Francisco Housing Authority, and the Municipal Railway.

COMMUNITY-BASED SERVICE PROVIDERS

See APPENDIX G for a Sample of community-based and county LTSS service providers.

See APPENDIX I for a description of Innovations in Programming in San Francisco.

- Community Living Fund
- Diversion and Community Integration Program
- IHSS Consortium
- IHSS Public Authority

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20 http://www.sfhsa.org/473.htm
SAN FRANCISCO LTCI INVESTIGATION

LTCI DESIGN GROUP AND SUBCOMMITTEES

The LTCI Design Group was the primary body charged with exploring the potential for long-term care integration (LTCI) in San Francisco. Members of the Design Group, as well as its Subcommittees and Workgroups, were chosen to be representative of service providers, consumers, stakeholders, and select San Francisco city departments involved in serving seniors and adults with disabilities.

The LTCI Design Group was given the following charge to:

- Explore the potential for LTCI in San Francisco;
- Determine what is required to improve the provision of long-term services and supports (LTSS) that will benefit older adults and adults with disabilities; and
- Develop a strategic plan with recommendations to guide improvements in the organization, availability, and financing of LTSS.

The recommendations included in this strategic plan are intended to guide improvements in the city’s overall system for delivering long-term services and supports for the benefit of all older adults and adults with disabilities in San Francisco. In addition, specific improvements being recommended for LTCI will integrate home and community-based long term services and supports with the delivery of primary and acute care services, and institutional long term care services, for older adults and adults with disabilities who are enrolled in Medi-Cal.

The LTCI Design Group met monthly throughout 2012 culminating with an all-day meeting in December of 2012 focused on crafting the final recommendations that would guide the writing of the strategic plan. While the monthly meetings focused predominately on the work of the subcommittees and work groups, a significant amount of time was spent providing background on long-term care and context for the work to be accomplished. As such, there were presentations and materials prepared on the following:

- Managed care from both a state and national perspective,
- Quality and performance measures as they relate to LTSS,
- Service-enriched housing options in San Francisco,
- Managed Care Health Plans: SF Health Plan, Anthem Blue Cross and On Lok Lifeways,
- San Francisco Department of Public Health,
- California Governor’s proposed budget (2013),
- California Coordinated Care Initiative & the Cal MediConnect Pilot Project,
- Dual Demonstrations in other states,
- Updates on progress in other counties – San Mateo and Alameda
- CBAS transition as it might relate to the transition of both IHSS and MSSP, and
- San Francisco’s new Transitional Care Program.
A series of town hall meetings was held from November 2012 to January 2013 throughout San Francisco attended by older adults and adults with disabilities in order to learn from them what works and does not work for accessing LTSS. In January of 2013, the LTCI Design Group took the feedback culled from subcommittees, workgroups, town hall meetings, and input from stakeholders and consumers and produced a draft set of recommendations. Those recommendations then went through a series of edits and the Design Group finalized and approved the recommendations at its February 2013 meeting. Those finalized LTCI recommendations are part of this strategic plan.

**Mission, Vision and Values**

**Mission**: The mission of the LTCI Design Group was to: (1) explore the potential for LTCI in San Francisco; (2) determine what is required to improve the provision of LTSS that will benefit older adults and adults with disabilities; and (3) develop a strategic plan that includes recommendations to guide improvements in the organization, availability and financing of LTSS.

**Vision**: While San Francisco is already a national model for the provision of LTSS for older adults and adults with disabilities, the recommendations of the LTCI Design Group, when implemented, will create a more integrated service delivery system, which will improve the quality of care and the quality of life for older adults and adults with disabilities.

**Values:**

1. **Consumer Driven**: Services and supports will be coordinated and delivered using a consumer driven approach based on an assessment of the unique needs and preferences of each person and their existing support systems. The presence of consumers will be included in all phases of planning, transition, and implementation. Consumers will have a voice throughout the process and help shape the design of both programs and services. Consumers are responsible for decisions involving their care with the advice of their health care providers. The consumer will determine the direction of his or her care and will have the choice of leading his or her care team.

2. **Most Integrated Setting**: Health Plans and other stakeholders should provide consumers with a range of support to make informed decisions about all available options. All services should be provided in the most integrated, least restrictive setting.

3. **Community Living**: Every effort will be made to assist older adults and persons with disabilities to remain integral members of their communities.

4. **Quality of Services and Cultural and Linguistic Sensitivity**: LTSS will be of the highest quality, be delivered in a manner that is culturally and linguistically appropriate, and seek to improve the beneficiaries’ health and quality of life.

5. **The Importance of Caregivers**: Services will support, augment, and acknowledge the vital role of both paid and unpaid family members and informal caregivers.
6. **A Well-Trained and Compensated Direct Care Workforce:** A well-trained direct care workforce compensated with a living wage is crucial to the success of quality health care delivery and to LTCI efforts in San Francisco.

7. **Equivalent LTSS Services:** Consumers with the same or similar needs and circumstances should receive comparable LTSS services.

8. **Responsive to Consumer Needs:** Health Plans and other service providers should be responsive to the changing needs and circumstances of consumers, allowing flexibility over time.

9. **Adequate Funding for LTSS Services:** Sufficient funding should be provided for LTSS. Toward this end, additional federal and state funding should be sought to support a comprehensive LTSS delivery system that will provide high quality services to all of those in need.

10. **Housing as a Health Care Resource:** The availability of service-enriched, affordable, accessible, and adaptable housing options is an essential component of the LTSS service delivery system. Housing must be seen as a health care resource, and as such, should be made available to managed care Health Plans in their efforts to serve their clients in the most integrated, least restrictive setting.

**LTCI Subcommittees**

**Services Subcommittee (Scope and Service Delivery)**

The purpose of the Scope of Services and Service Delivery Subcommittee was to look at existing long-term services and supports (LTSS), determine other needed services to be provided under long-term care integration (LTCI), and explore integration with the current delivery system. The Services Subcommittee divided its work into two areas: scope of services and service delivery. It was determined early on that the scope had to be defined first before service delivery could be analyzed.

**PART A - SCOPE OF SERVICES**

The Scope of Services exploration focused on which components of existing home and community-based services (HCBS) should be included under LTCI and, when and if managed care is implemented in San Francisco, which services included under LTCI will become part of the managed care system. This exploration included the following tasks:

1. Explore what components of existing HCBS should be included under LTCI.

2. Delineate what services are recommended to be provided under LTCI to eligible beneficiaries. The following initial list was used as the basis for that exploration, though the list was not considered to be all inclusive:
• Community-Based Adult Services (CBAS) - new ADHC model
• In-Home Supportive Services (IHSS)
• Multipurpose Senior Services Program (MSSP)
• Nutrition Services
• Community Behavioral Health Services
• Alzheimer’s Day Care Resource Centers
• Hospice Care
• Case Management
• Transportation Services
• Transitional Care – hospital to home
• Other services

3. Understand which services could be provided by Medi-Cal Managed Care plans under capitation.

4. Consider which services could be purchased by these managed care plans.

5. Explore which services could be coordinated with these managed care plans.

6. Develop draft recommendations for LTCI scope of services.

The outcome of this work is included as APPENDIX D: Crucial Services To Be Coordinated With, Purchased By, or Included in the LTSS Managed Care System.

PART B – SERVICE DELIVERY

The Service Delivery exploration included the following tasks:

1. Determine how to integrate the managed care medical service delivery system (primary & acute care) including the creation of medical homes, with San Francisco’s network of home and community-based services (health & social services).

2. Summarize the components of the proposed LTCI delivery system and how it will improve efficiency and enhance service quality. Capacity issues should be considered. Components may include:
   • Multiple initial contact locations
   • Single point of entry (central door of a no-wrong-door model of access)
   • Eligibility determination
   • Comprehensive intake and assessment
   • The role of medical homes
   • Improved availability of information
   • Community education and outreach
   • Access to an array of LTCI services
   • The use of case management (internal and external)
   • Consumer participation in care plan development
   • Coordination with other long-term care services
Continuous monitoring of consumer satisfaction and quality assurance
Training and education
For Providers
For Consumers
Workforce development

3. Explore how LTCI services can be organized to reflect a consumer perspective.

4. Explore role of Laguna Honda Hospital in the LTCI system.

5. Explore how the existing IHSS program will fit into the LTCI service delivery system.

6. Consider potential for development of supportive housing or assisted living for low-income residents such as Medi-Cal beneficiaries.

7. Determine how to integrate the current managed care medical service delivery system (primary and acute care), including the creation of medical homes, with the existing network of HCBS (health and social services).

8. Develop draft recommendations for the creation of the proposed LTCI service delivery system model.

This Subcommittee used actual cases (see APPENDIX C) to better understand where there were challenges in the system. The Subcommittee developed a list of crucial LTSS (see APPENDIX D) to be coordinated with, purchased by, or included in San Francisco’s LTSS managed care system. Finally, it created a SWOT analysis (see APPENDIX E) to determine what the strengths, weaknesses, opportunities, and threats (challenges) were in that system. The SWOT analysis and other work of this Subcommittee led the final recommendations in this strategy.

Case Management Workgroup

Under the auspices of the Scope of Services and Service Delivery Subcommittee, this Workgroup was charged to: (1) evaluate and craft a plan for the redesign of the care coordination process as it relates to services provided by - and coordinated with - managed care plans. The Subcommittee completed the following tasks:

- Inventory the current care coordination programs in San Francisco including care coordination provided by City Programs, San Francisco Health Plan, Anthem Blue Cross, and relevant providers throughout the city, including care coordinators in housing for seniors and adults with disabilities.

- Review all funding streams that provide care coordination in San Francisco.

- Review the regulatory requirements governing care coordination.

- Conduct a best-practices review of care coordination activities in other states.
• Conduct and complete a SWOT analysis (strengths, weakness, opportunities, threats/challenges) focused on care coordination throughout the city using stakeholders and consumers from the workgroup.

• Discuss the role and process for lead care coordinator and how that will be facilitated through a data system (Electronic Rolodex). The work on this is being coordinated with the Data Work Group.

• Create a preliminary set of recommendations to improve the care coordination process in San Francisco using stakeholders and consumers from the workgroup and submitted those to the LTCI Design Group.

Finance Subcommittee

The purpose of the Finance Subcommittee was to look at the current inventory of funds and resources that support services which may be provided by, contracted by, or coordinated with Health Plans, and explore realignment to create a seamless financing system. The Finance Subcommittee was charged with the following tasks:

• Explore the current per person costs for the services included in the LTSS menu;
• Determine the prevalence of use of each of service;
• Review the costs associated with a "typical" high-need consumer, an average consumer, and a low-need consumer; and
• Consider how funding streams could be used to better complement a seamless LTSS service delivery system in San Francisco.

The Finance Subcommittee completed the following:

1. Reviewed in detail the San Francisco Controller’s report, *Fiscal Analysis of Home and Community-Based Long-Term Care Services*, March 2010, and related reports, to determine relevance for allocating funds to community-based long-term care services that may be part of a managed care system under LTCI.
2. Reviewed draft recommendations from the Scope of Services and Service Delivery Subcommittee.
3. In collaboration with the San Francisco Controller’s Office, prepared an inventory of local, state, and federal funds, and private resources supporting long-term care in San Francisco.
4. In collaboration with the San Francisco Controller’s Office, considered how to use such local, state, and federal funds, and private resources to support LTCI services.
5. In collaboration with the San Francisco Controller’s Office, explored how to realign funding resources and reimbursement programs to create a seamless financing system that can shift services from one LTCI component to another as needed.
6. Developed draft recommendations for how financial resources should be used to support LTCI in San Francisco.
**Finance Subcommittee Challenge**

The Finance Subcommittee attempted to determine the costs associated with the vision of a seamless network of services and supports available to low-income seniors and disabled adults living in San Francisco. The Subcommittee framed its work in the expectation that Health Plans will be responsible for providing a set of these services within a managed care setting in the near future.

The Subcommittee addressed the following questions:

1. What are the current per person costs for the services included in the LTSS menu?
2. What is the prevalence of use of each of the services? What would the prevalence be if no funding caps were in place?
3. What are the LTSS costs associated with a "typical" high need consumer?

**Approach**

The Finance Subcommittee built a model to analyze the per client costs of services slated to be included in managed care as well as critical community-based services and supports that prevent institutionalizations for seniors and adults with disabilities.

The Subcommittee also sought to describe the need for these services among persons who are currently unable to access them. In some circumstances, the Subcommittee used wait list data to capture this information. In others, wait lists are not kept by providers or are thought to offer an inaccurate picture of the demand. In those cases, consumer survey data and other information included in the 2012 DAAS Needs Assessment\(^2\) provided estimates of the unmet need. Because some of these programs serve all seniors and adults with disabilities regardless of income, figures were adjusted to reflect the needs of the low-income population. In some cases, data were not available to describe the extent of the unmet need for some services.

\(^2\) Available at: [http://www.sfhsa.org/asset/ReportsDataResources/DAASNeedsAssessmentPartII.pdf](http://www.sfhsa.org/asset/ReportsDataResources/DAASNeedsAssessmentPartII.pdf)
Findings

The Subcommittee found the following estimates of costs associated with those services slated to be included in managed care for dual eligibles in the coming years:

<table>
<thead>
<tr>
<th>Long-Term Support Service</th>
<th>Annual cost per client</th>
<th>Current county share</th>
<th># of clients served annually</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHSS</td>
<td>$16,054</td>
<td>22.0%</td>
<td>21,611</td>
</tr>
<tr>
<td>CBAS/ADHC</td>
<td>$11,772</td>
<td>19.6%</td>
<td>1,473</td>
</tr>
<tr>
<td>MSSP</td>
<td>$3,411</td>
<td>0%</td>
<td>557</td>
</tr>
<tr>
<td>Nursing facilities</td>
<td>$83,918</td>
<td>0%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Of clients served in these programs, a high proportion are dually eligible for both Medi-Cal and Medicare. Approximately 85 percent of IHSS clients are dually eligible.24

The Subcommittee analyzed the costs associated with a number of social service supports that help to keep seniors and adults with disabilities out of institutions. The findings for the major categories of services are listed below.

<table>
<thead>
<tr>
<th>Long-Term Support Service</th>
<th>Annual cost per client</th>
<th>Current county share</th>
<th># of clients served annually</th>
<th>Estimated number of clients who demand service but cannot access it</th>
<th>Cost of unmet need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care Services</td>
<td>$157</td>
<td>0%</td>
<td>318</td>
<td>0</td>
<td>$0</td>
</tr>
<tr>
<td>Care Management</td>
<td>$2,804</td>
<td>70.4%</td>
<td>1,891</td>
<td>7,070</td>
<td>$11,867,576</td>
</tr>
<tr>
<td>Nutrition</td>
<td>$554</td>
<td>73.8%</td>
<td>8,448</td>
<td>840</td>
<td>$950,880</td>
</tr>
<tr>
<td>Caregiver Support</td>
<td>$337</td>
<td>14.9%</td>
<td>668</td>
<td>19,832</td>
<td>$13,696,475</td>
</tr>
</tbody>
</table>

Overall, the Subcommittee identified several areas of unmet need in the city. The largest areas of unmet need in terms of cost are case management, caregiver respite, and family caregiver support. The total costs associated with services for which there is demand but insufficient supply is estimated at $26.5 million per year.

In addition, there were three service areas where the Subcommittee could not complete its analysis of unmet need due to a lack of data. Health Plans already provide some transportation and medication management services, and the additional need in the community may be met by the current providers.

22 Only point-in-time numbers were available for IHSS.
23 There are 3,018 nursing facility beds in San Francisco.
24 Medi-Cal Background Paper for February 23, 2012 Hearing of the California State Senate Committee on Budget and Fiscal Review.
Using these figures, it is possible to get a general sense of the costs associated with different types of consumers at a point in time. For example, a frail consumer with high needs may require a high level of services through the Community Living Fund, 282 hours of IHSS, home-delivered meals, caregiver respite, and money management services in a given month, totaling $7,192, or $86,304 annually. A lower need consumer may have lower monthly costs incurred in the CLF program, 76 hours of IHSS, congregate meals and money management, totaling $1,714, or $20,568 annually.

Caveats and Notes

Several critical services were not included in the menu of services discussed here. Some such services, such as Adult Protective Services, are necessarily outside the scope of what a Health Plan could purchase for the benefit of a member. Others, like housing, may be essential to the well-being of a senior or person with disabilities, but may not be a resource feasibly provided by a health plan. Services provided and funded by the DPH are not included in this analysis.

Data Workgroup

Under the auspices of the Finance Subcommittee, this Workgroup was charged to: (1) examine how data is shared among providers and its use in impacting quality of care as well as cost; and (2) create a plan for three data systems, including:

- A resource directory for clients and service providers,
- An electronic rolodex to coordinate the work of case managers, and
- A detailed data system for service providers, Health Plans, and DAAS that tracks service usage and cost by client. This data system would be comprehensive, provide a process to share data with relevant providers, and allow Health Plans to do predictive modeling and provide cost comparison data (home & community based versus institutional).

The Data Workgroup completed the following:

1. Evaluated the current data systems in use for San Francisco with a focus on the DAAS and the Department of Public Health (DPH).
2. Evaluated the data systems being used or proposed by other Health Plans involved in the Cal MediConnect Pilot Project including those of three first demonstration counties: San Mateo, Alameda, and Santa Clara.
3. Completed analysis of HIPAA issues as they relate to sharing of data and how these issues might impact recommendations and the ability to share data among relevant providers.

4. Completed an informal analysis that focused on data systems.

5. Created a preliminary set of recommendations to improve sharing of data among service providers, including a recommendation to revitalize the Electronic Rolodex.

6. Completed a review* of uniform assessment tools from 12 states that have had tools (with inter-rater reliability) in place for over one year. That data was then compared with tools that are in use for In-Home Supportive Services (IHSS), Multi-Purpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and two health risk assessments currently in use for Alameda Alliance for Health.

*Nothing was done with this review as it was learned that the State is developing its own assessment tool.

Communications Subcommittee

The purpose of the Communications Subcommittee was to establish a process for communicating the ongoing work of the LTCI investigation and explore the best communication mechanisms to inform people across San Francisco about LTCI. The Communications Subcommittee was charged to complete the following tasks:

- Determine components of a communications plan for public information and community education to inform people – during the strategic planning process – about the potential for LTCI to benefit Medi-Cal eligible older adults and adults with disabilities who need LTSS;
- Explore the best communication mechanisms to reach racial, ethnic, and cultural communities;
- Consider types of media for sharing information, including newspapers, radio, television;
- Consider types of existing and new meetings, plus various community forums; and
- Develop a comprehensive communications plan as a basis for communicating with consumers, to be used upon completion of the LTCI Strategic Plan.

As the work began the initial charge evolved. The Subcommittee created a process to go out to consumers at town hall meetings, which were held at senior centers, senior housing sites, and other service locations, to:

- Explain that San Francisco is undertaking a LTCI strategic planning process; and
- Learn about their experiences – what works and what does not work – in accessing LTSS.

A simple one-page explanation was created of the pending move to Medi-Cal managed care and San Francisco’s current LTCI strategic planning process. The intention was to provide this explanation to service providers who, in turn, would distribute it to consumers. The
Subcommittee hosted four Town Hall meetings (to learn what is working and not working concerning the long term care service delivery system in San Francisco) at the following locations:

- 30th Street Senior Center
- Bayview Adult Day Health Center
- Jackie Chan Center
- Curry Senior Center

A community forum was also held at the regular meeting of the Mayor’s Office of Disability seeking feedback on what is working, and what is challenging about the long-term care system in San Francisco.

The intention of the Subcommittee is that further community forums following the publication of this plan in order to present the recommendations to a variety of audiences, get additional feedback, and learn if the recommendations are on the right track. It will be important to get consumer, service provider, advocate and stakeholder feedback on the recommendations as work to prepare for implementation begin.

The LTCI Strategic Plan will be presented to the Long-Term Care Coordinating Council, the Aging and Adult Services Commission, the Health Commission, the San Francisco Health Plan (San Francisco HP), Anthem Blue Cross, and On Lok, among others. Implementation of the recommendations included in this strategic plan, which will improve San Francisco’s service delivery model, will begin to occur in the fall of 2013.

**IHSS Workgroup**

DAAS convened a special IHSS Workgroup comprised of stakeholders, providers, and consumers to focus on how this process will unfold and what affect it will have on consumers and their families. Meetings with the California Department of Health Care Services have indicated that the State is open to creative solutions, is supportive of San Francisco’s work in this area, and will evaluate the outcome of this work as it prepares to transition IHSS into managed care in 2014.

Prior to any decision-making, consumers and providers (beyond those in the Workgroup) will be consulted and their feedback will be brought back to the Workgroup for discussion. The Workgroup will create an IHSS communication plan and work directly with the IHSS Program in DAAS, the IHSS Public Authority, the IHSS Consortium, SEIU, the San Francisco HP, and Anthem Blue Cross to communicate directly with all consumers and family members.

As DAAS is so intricately involved in the IHSS process, it will initially provide the interface between the Health Plans and IHSS program plus its contractors. Currently, DAAS has taken on a similar
relationship with the San Francisco HP and the CBAS program. DAAS has a contract with the San Francisco HP to ensure assessments for CBAS, and is working to find services and placements for those clients deemed ineligible for CBAS.

The primary outcome is to involve consumers and stakeholders in the process for IHSS integration into managed care and communicate to all consumers involved (clients, families and family caregivers) about how the process will transpire. It is important that this communication take place throughout the planning and integration process.
LTCI STRATEGIC PLAN OBJECTIVES AND RECOMMENDATIONS

The following objectives and recommendations are based on the explorations and findings of the LTCI Design Group, as well as its subcommittees and workgroups. These objectives and recommendations are designed to improve access to and coordination of long-term services and supports (LTSS) for older adults and adults with disabilities. Each recommendation includes suggestions for “lead responsibility” and “shared responsibility.”

OBJECTIVE 1: Collaboration: Strengthened collaboration among county departments, including the Department of Aging and Adult Services (DAAS), Human Service Agency (HSA), and Department of Public Health (DPH), and among the three managed care plans (Health Plans), which include the San Francisco Health Plan, Anthem Blue Cross, and On Lok Lifeways.

RECOMMENDATION 1.1: Establish an LTCI implementation body with staff support that brings together DAAS, DPH and the Health Plans on a regular basis to create a process to: (1) oversee the implementation of the recommendations included in this LTCI Strategic Plan; and (2) ensure a successful transition to long term care integration in San Francisco.

Success with LTCI will require exceptional collaboration among service providers throughout San Francisco. At the heart of this collaboration there will need to be a strong partnership involving DAAS, DPH, HSA, and the Health Plans.

Currently, there is no mechanism for coordination of leadership across departments and the Health Plans to oversee implementation of the recommendations included in this LTCI Strategic Plan. The establishment of an LTCI implementation body will provide the mechanism for the necessary coordination. It will also ensure that resources are used as efficiently and effectively as possible, and that seniors and adults with disabilities are receiving the best possible services.

The Long Term Care Coordinating Council, which includes DAAS, DPH, HSA, MOD, providers, advocates and consumers, should play an advisory role* on the LTCI implementation body.

In 2016 the Cal MediConnect Pilot Project may expand to additional counties (including San Francisco) and will require a close working relationship among DPH, DAAS, and the Health Plans.

Lead Responsibility: DAAS, DPH, Health Plans
Shared Responsibility: LTCCC, Mayor’s Disability Council, Consumer Representatives
To Be Contacted: Hospital Council

*LTCCC advisory role: The LTCCC member on the LTCI implementation body will: (1) provide the LTCCC perspective; and (2) ensure a report is made periodically to the LTCCC. The LTCCC member could provide a monthly report and a report in greater detail, when desirable. One area of interest to the LTCCC might be the communications plan.
OBJECTIVE 2: Access: Improved access to LTSS for seniors and people with disabilities.

RECOMMENDATION 2.1: Create a “central door” model of access to LTSS with the DAAS Integrated Intake Unit (IIU) as that central door.

Seniors and people with disabilities will learn about LTSS in a number of ways (news media, brochures, fliers, and websites). Individuals will seek services from a myriad of providers including: (1) initial contact locations (senior centers, churches, neighborhood organizations, and doctor’s offices); (2) major access hubs (hospitals, clinics, Health Plans, DPH, DAAS); and (3) major points of entry (ADHC, IHSS, and MSSP). No matter which entry point an individual uses, it is recommended that all individuals be referred to the DAAS IIU to ensure that they are receiving all of the services necessary to support them in the community.

This DAAS IIU central door will: (1) enhance the potential that clients will receive information on a range of alternatives and services; and (2) assist the Health Plans to organize and provide LTSS to their members. Rather than just meeting a single need like a home-delivered meal, referral to the IIU ensures consumers are made aware of the full array of community-based services that meet more of their needs and that might not be initially evident in a single service environment. With the creation of an online directory of services at DAAS (see Recommendation 3.1), expanded information on community-based services will be readily available.

While there is no wrong door for entry into this LTSS system, the central door will provide the funneling process through which clients can be screened, assessed, advised, and directed to appropriate services. Having a central door at the IIU also allows DAAS to capture data on each individual, enabling better coordination of services. This data makes possible better overall service planning and better use of available funding for services. Finally, the IIU allows the Health Plans to have a single point of contact (DAAS) for improved client access to all LTSS. This scenario may require that there be “out stations” for the IIU in San Francisco’s neighborhoods (possibly through Aging and Disability Resource Centers - ADRCs).

Lead Responsibility: DAAS
Shared Responsibility: RTZ Associates, Community-Based Organizations (CBOs), Health Plans

25 In the context of the Duals Demonstration, LTSS generally refers to four main programs: IHSS, CBAS, MSSP, and Skilled Nursing for Medi-Cal (chronic care, not medical care). It also refers to other community support systems like home-delivered meals, care coordination, etc. In the context of the SF LTCI, LTSS does not include Skilled Nursing for Medi-Cal.

26 Aging and Disability Resource Centers, or ADRCs, offer the general public a single entry point for information and assistance on issues affecting older people and people with disabilities regardless of their income. The types of services that an ADRC has to offer include: information and assistance, long-term care options counseling, benefits counseling, emergency response, prevention and early intervention, and access to publicly funded long-term care programs.
This central door at the DAAS IIU may perform the following functions:

- Serve as the primary access point for clients for all community-based LTSS. This one-stop shopping means that a client's many needs can be met without requiring each client to individually search among all the agencies for needed services.
- Match the appropriate LTSS to the individualized needs of the client.
- Use clear eligibility criteria, standardized client assessments, and preadmission screening programs.
- Conduct local needs assessments and planning activities and encourage or coordinate development of needed services and programs.
- Assure the quality of LTSS services.
- Make possible better overall service planning.
- Enable better use of available funding for needed services.

The DAAS IIU does not do intake for the Health Plans. Nor does it do intake for skilled nursing facilities. There are specific intake processes for these programs that would not change. This central door simply provides the integrated intake for DAAS and its community-based LTSS.
Community-Based Service Categories in San Francisco
(Partial List)

1. Adult day services:
   - Adult Day Care (Social Day)
   - Adult Day Health Care
   - Alzheimer’s Day Care Resource Centers

2. Caregiver support services

3. Community networks

4. Community services:
   - Activities scheduling
   - Translation
   - Social services

5. Community Health Care Services

6. Case management

7. District-wide social services workers

8. Education of consumers, families and others, in independent living skills training

9. End of life care

10. Elder abuse prevention

11. Emergency preparedness

12. Financial management services
   - Representative payee program
   - Money management

13. Conservatorship Programs
   - Probate & Mental Health (LPS)

14. Health care for the uninsured

15. Health Insurance Counseling and Advocacy Program

16. Health screening

17. Home care services

18. Home health care services

19. Home modification

20. Housing:
   - Emergency housing
   - Supportive housing
   - Assisted Living

21. Residential treatment and supported housing programs as alternatives to institutional treatment for individuals with mental disabilities.

22. Residential services

23. In-Home Supportive Services – chore, homemaker, personal care

24. Independent living resources

25. Legal services

26. Linkage to primary and acute care

27. Medication management

28. Mental health services

29. Naturalization services

30. Nutrition services:
   - Home delivered meals
   - Congregate meals
   - Bags of groceries delivered
   - Food stamps

31. Ombudsman (complaint help for nursing home residents and board & care residents)

32. Pharmacy and medication services

33. Protective services

34. Provider training and supportive services

35. Rehabilitation services

36. Respite care services

37. Resource centers

38. Senior centers

39. Senior empowerment (advocacy and training)

40. Transportation services:
   - Paratransit
   - Muni
   - Taxi

41. Veterans services

See APPENDIX G for a Sample of community-based and county LTSS service providers
OBJECTIVE 3: Information: Improved access to information for consumers and service providers.

RECOMMENDATION 3.1: DAAS should design a public information campaign targeting consumers. This will include, among other things, print media and an online listing of all LTSS service providers for consumers, with descriptions of the services that they provide and the criteria for accessing those services. The online listing should be updated on a regular basis to ensure the information is accurate.

DAAS should also create a strategy to ensure that health care providers, LTSS providers, stakeholders, and advocates are aware of the online listing and pass that information on to consumers. This should be part of Recommendation 3.2.

The development of a comprehensive public information campaign will enhance access to information for consumers. While the DAAS IIU (the central door) will simplify many of the access challenges for consumers who wish to access the LTSS service system, there is still a need to provide information about available services to consumers and their families that is clear, regularly updated, and is consistent in its messaging. To be fully effective, the campaign should include print media, other printed materials, and the best use of the Internet.

Part of this recommendation is currently being implemented as DAAS moves its annual listing of services from a print format to an online directory of services. This online directory will include descriptions of the available services provided and the criteria for accessing those services. There needs to be funding in place that will allow the directory to be updated regularly, and for information about the availability of the directory to be disseminated. The listings should be updated on a quarterly basis to be certain the information is accurate. This strategy should include a component to ensure that health care providers, LTSS providers, stakeholders, and advocates are aware of the online service directory and pass that information on to consumers.

Lead Responsibility: DAAS
Shared Responsibility: Health Plans, Aging and Disability Resource Centers, DPH, CBOs, RTZ Associates, LTCCC

RECOMMENDATION 3.2: DAAS should design a public information campaign targeting service providers. This will include information about the array of LTSS services that are available for consumers in San Francisco, with a focus on “single service” providers that may not have knowledge of or access to the larger service continuum. As part of this campaign, educate service providers about the DAAS IIU as the central door, its value and use.

__27__ RTZ Associates will update information annually. Providers may update their information as needed.
This recommendation seeks to put in place an educational campaign that will help all service providers to view consumers holistically. Rather than just meeting a single need like a home-delivered meal, they could work to get consumers into an LTSS system that will meet more of their needs not initially evident in a single service environment.

**Lead Responsibility:** DAAS  
**Shared Responsibility:** Health Plans, Aging and Disability Resource Centers, DPH, CBOs, RTZ Associates, LTCCC

**OBJECTIVE 4: Care Coordination: Enhanced coordination of services and efficiency.**

The LTCI Care Coordination Workgroup created a framework to inventory entities that provide care coordination services with an asset mapping tool. It identified over 50 care coordination agencies and 130 housing sites providing varying types of care coordination and case management to a multilingual, multicultural population of seniors and people with disabilities.

These agencies and sites receive funding from a myriad of sources including federal, state, and local funds and, as such, there is no one agency or entity that seeks to ensure efficiency in delivery, quality of services, coordination among providers, and/or cost effectiveness.

**RECOMMENDATION 4.1:** DAAS and DPH should initiate an inter-agency care coordination committee to further develop an asset mapping tool (already started) including: (1) categorizing various care coordination services in the city into intensity levels; and (2) determining procedures for maintenance of the mapping tool. Based on this information, the committee should evaluate the current case management system with the goal of overall system improvement.

This tool could be used to orient the Health Plans, service providers, decision-makers, and others. It could reduce potential duplication of care coordination activities among those serving seniors and persons with disabilities. The committee should also create a common language of care coordination intensity that will facilitate communication across the LTSS system. The committee should also define the role of lead care coordinator.

**Lead Responsibility:** DAAS, DPH  
**Shared Responsibility:** Health Plans, CBOs

**RECOMMENDATION 4.2:** DAAS and DPH should pursue re-launching the Case Management Connect (CMC) Project (formerly called the Electronic Rolodex), which allows case management programs at DPH and DAAS (both in the departments and at community agencies) to view all case management enrollments.

The re-launched version of the CMC Project should: (1) have all data provided to electronically populate CMC; and (2) enable case managers to enroll clients once in their
own case management program. **Lead care coordinators for each enrolled client should be made evident in this version. Information in the CMC Project should be viewable from the DPH tool and the DAAS case management module by sharing enrollment transactions electronically.**

The CMC Project will help case managers to learn which other case management programs are serving the same clients and provide them with needed contact information for all involved case managers. The CMC Project will also identify the lead case manager for each client and assist in the coordination of the work of case managers in San Francisco. Service will also have access to the necessary contact information for each involved care coordinator.

**Lead Responsibility:** DAAS, DPH  
**Shared Responsibility:** Health Plans, CBOs

**RECOMMENDATION 4.3:** **DAAS, DPH, and the Health Plans should initiate and support procedures for virtual case conferences.** This is not intended to replace current case conference processes, but to facilitate alternatives and more efficient communication among DAAS, DPH, and the Health Plans, as well as across settings such as hospitals, SNFs, and the community.

California’s Coordinated Care Initiative (CCI) devotes considerable mention to person-centered care planning and the need to involve health plan members and, if they choose, their caregivers and/or family members in the planning process. As such, the Health Plans, DAAS, and DPH need to create processes for face-to-face case conferences and virtual case conferences as part of the interdisciplinary care team planning process.

**Lead Responsibility:** DAAS, DPH  
**Shared Responsibility:** Health Plans, CBOs

**OBJECTIVE 5:** **Data: Linked data systems to improve efficiency and collaboration.**

The sharing of data will be critical to the functioning of an integrated system of LTSS in San Francisco. Facilitating information sharing that allows data to flow as needed in a way that is useful to Health Plans, DAAS, DPH, and providers - while also complying with the Health Insurance Portability and Accountability Act (HIPAA) - is a substantial but necessary challenge. DAAS has made some progress in this area with a number of initiatives that have been underway for the past several years.

**RECOMMENDATION 5.1:** **DAAS, DPH, and the Health Plans should form an inter-agency committee to create a data sharing solution that allows DAAS, DPH, the Health Plans, and service providers in the community to view client-level LTSS usage data in a single data report.**
The LTCI Data Workgroup identified the following needs for data as part of an improved overall LTCI system design: (1) client-level sharing of certain data elements among Health Plans, DAAS, DPH, and LTSS providers to reduce duplication of services, improve client service, and allow for data analysis and data cleaning to be certain of having an unduplicated database; and (2) aggregate-level data on client services and outcomes to allow for cost and utilization analysis.

A similar data sharing solution is used by the DPH Coordinated Case Management System and HealthShare Bay Area. The goal of this recommendation is to provide an easy-to-access data report on clients in a useable format that dovetails with current or envisioned business processes to support an improved system of long-term care service delivery. The information sharing protocol undertaken by DAAS for LTSS should coordinate with similar projects at DPH and HealthShare Bay Area.

DAAS, DPH, the Health Plans, and service providers will need to undertake a collaborative process to define which elements should be contained in the data report. Additional work needs to be done to better understand what types of information can be shared between Health Plans, DAAS, and DPH. CLF and DCIP data is important to share with Health Plans to ensure vulnerable populations receive comprehensive care that prevents institutionalization. The data report should be accessible from within users’ current operational system.

Data will be shared from multiple systems to create this single data report. To implement this recommendation, DAAS, DPH, and Health Plans should link currently used data systems to create an unduplicated client data record. Data systems must contain a common unique identifier to maintain an unduplicated data set.

Following are some additional examples of current data sharing:

- All programs funded by the DAAS Office on the Aging (OOA) share a common tool, and those programs that require client-level data share an unduplicated client database. Home-delivered meal providers use a common assessment and shared waiting list. A newly launched case management module includes a common assessment and service plan.

- The service plan library maintained by RTZ Associates is shared with Laguna Honda Hospital Social Services and CLF case management.

- The DAAS IIU launched a new version of the intake tool in April 2013 that will share data with the Transitional Care Program (TCP), CLF, and HDM. The public resource directory (a partnership of DAAS and RTZ Associates) includes a service directory that the DAAS IIU uses for I&R/A. This public site will allow consumers, caregivers, and service providers to search this online directory and complete online applications for the transitional care program, Community Living Fund, the IHSS program, and home delivered meals.
The DCIP is a collaboration between DAAS and DPH, which includes a website that integrates shared data from OOA, IHSS, LHH, and CLF.

A CBAS tool, which will coordinate information between the CBAS centers, Health Plans, DAAS, and the DAAS contractor providing CBAS eligibility assessment, is under discussion. Information sharing – including those DAAS programs and services that are not participating in these efforts, and between DAAS and DPH programs serving LTSS – is a best practice and will be increasingly necessary, given the pending introduction of managed care for LTSS.

To maximize the benefits of data sharing, there is still much to be done to create and benefit from an unduplicated client data set across programs and services and between county agencies and the Health Plans.

Lead Responsibility: DAAS, DPH
Shared Responsibility: Health Plans, CBOs

RECOMMENDATION 5.2: Given the current direction of CMS regarding de-institutionalization, DAAS and DPH should demonstrate the value provided by best practice program models that assist older adults and adults with disabilities to return to community living. The use of such models could be beneficial for transitions from all nursing homes throughout the City.

Specifically, DAAS and DPH should undertake a programmatic and financial analysis of the Diversion and Community Integration Program (DCIP). DAAS should undertake a programmatic and financial analysis of the Community Living Fund (CLF). These and other programs, which also could be analyzed, have been successful in serving older adults and adults with disabilities, assisting them to access services to move from institutional to community settings. The potential should be considered for expanding some of these programs as part of the transition to Medi-Cal managed care for LTSS.

Toward this end, following the analyses, DAAS and DPH should formulate a plan to utilize these or similar programs to assist older adults and adults with disabilities residing in nursing homes throughout San Francisco to return to community living.

DAAS and DPH should also use these or similar programs in close collaboration with the San Francisco Health Plan and Anthem Blue Cross, San Francisco’s two Medi-Cal Health Plans, to facilitate community living for their clients. In addition, DAAS and DPH should seek continued collaboration between and among City departments and community organizations to carry on the work of de-institutionalizing older adults and adults with disabilities. DAAS and DPH should also determine how to provide supportive housing for these individuals.
There are a number of cutting-edge programs in San Francisco that have been both successful and hold great promise for expansion. Following are some of these programs:

**Primary programs**

- Diversion and Community Integration Program (DCIP)
- Community Living Fund (CLF)

**Other programs**

- IHSS Consortium services and IHSS supplemental services (e.g., peer mentoring)
- ADHC, case management, and any supplemental services
- Health promotion and risk prevention services

As the City looks to become part of the Cal MediConnect Pilot Project, it makes sense to conduct a programmatic and financial analysis of the primary programs considered best practice models and additional programs that might be essential as the Medi-Medi population grows. This analysis would examine cost, impact, and potential for expansion.

Once relevant data has been analyzed, further consideration should be given to determine how these programs could be used in the future as a component of the transition to Medi-Cal managed care for LTSS.

**Lead Responsibility:** DAAS, DPH and its Direct Access to Housing Program  
**Shared Responsibility:** Health Plans, skilled nursing facilities, care coordination agencies, CBOs

**OBJECTIVE 6: Quality: Improved quality of services provided for consumers.**

**RECOMMENDATION 6.1:** DAAS, DPH, and the Health Plans should assign staff members to monitor the State’s development of standards and measures that demonstrate quality care to consumers. This effort should actively track the Cal MediConnect State Quality Workgroup. Based on that work, similar quality standards and outcome measures for LTSS should be developed and implemented in programs managed by DAAS, DPH, and the Health Plans.

This recommendation does not suggest that San Francisco create a new set of standards, but simply follow the work being done by the Center for Health Care Strategies, the Kaiser Family Foundation, DHCS, and others on LTSS quality standards. Based on that work, it should mirror standards to be implemented in San Francisco.

Standard quality measures for LTSS have not been developed, which represents a problematic gap in the context of efforts to integrate management of LTSS and medical care. In releasing its initial core set of quality measures for adult Medicaid beneficiaries in January 2012, CMS acknowledged
the lack of quality measures for those receiving home and community-based services, citing existing measures that meet scientific soundness criteria could not be identified.

See APPENDIX K for Quality of Care Performance Measures.

Widely used quality measure sets like the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) do not take into account, or include, targeted measures that reflect the nature of LTSS.

Lead Responsibility: DAAS, DPH, Health Plans
Shared Responsibility: LTCCC for advocacy

**OBJECTIVE 7: Support: Expanded supports for family caregivers, independent providers, community caregivers, and individuals who are socially isolated.**

**RECOMMENDATION 7.1: Develop strategies that expand supports for family caregivers, independent providers, community caregivers, and individuals who are socially isolated.**

*Additionally, respite services need to be developed for caregivers, particularly those caring for someone with Alzheimer's disease and other forms of dementia.*

Recent medical advances, shorter hospital stays, limited discharge planning, a shortage of homecare workers, and the expansion of homecare technology have increased the caregiving responsibilities of families. Family caregivers are being asked to shoulder greater burdens for longer periods of time. In addition to more complex care, conflicting demands of jobs and family, increasing economic pressure, and the physical and emotional demands of long-term caregiving can result in major health impacts on caregivers.

National estimates show that 44 million Americans over the age of 18 provide support to older people and adults with disabilities who live in the community. California has the highest number of family and informal caregivers of any state in the nation, with an estimated 3.4 million Californians providing care for adult family members and friends. Caregivers in California provide 3,663,000 unpaid hours of care at an estimated value of $36.3 billion.

Lead Responsibility: Family Caregiver Alliance
Shared Responsibility: Health Plans, DAAS, Openhouse, Alzheimer’s Association, IHSS Public Authority, consumers, CBOs that support families and caregivers, LTCCC
OBJECTIVE 8: Services: Incorporated long term services and supports (LTSS), crucial in keeping older adults and adults with disabilities healthy and safe in the community, into San Francisco’s managed care system.

RECOMMENDATION 8.1: Incorporate crucial LTSS into the San Francisco LTSS managed care system.

The following primary services will be incorporated based on the passage of the Coordinated Care Initiative: Community Based Adults Services (completed in October of 2012), Multi-Purpose Senior Services Program, In-Home Supportive Services, and Skilled Nursing Care. Below are the LTSS that the LTCI Scope of Services and Service Delivery Subcommittee identified as crucial to be: (1) provided, (2) coordinated, or (3) purchased in the San Francisco LTSS managed care system. With the exception of Nursing Facility Services, all play a critical role in keeping seniors and people with disabilities healthy and safe in the community. Nursing Facility Services are included as they are a component of the Coordinated Care Initiative (CCI).

LTSS services identified as crucial to be: (1) provided, (2) coordinated, or (3) purchased in the San Francisco LTSS managed care system:

- Home Care Services
- Care Management
- Adult Day Services
- Medication Management
- Nutrition
- Transportation
- Caregiver Support
- Social Interaction Opportunities
- Protective Services
- Ombudsman Services
- Prevention Services
- Behavioral Health Services
- Nursing Facility Services (CCI component)
- Assisted Living
- Accessible/Affordable Housing

See APPENDIX C for Cases used to Consider the Need for Crucial LTSS.

See APPENDIX D for Crucial Services To Be Coordinated With, Purchased By, or Included in the LTSS Managed Care System, for a full description of the crucial LTSS services in each of these service areas.

28 Not included in LTSS for the SF LTCI.
NOTE: The financial analysis undertaken by the LTCI Finance Subcommittee, which explores the costs of specific services that help people to remain at home and in the community, and which may be provided by the Health Plans, is found under the Finance Subcommittee section in this report. The services analyzed are a subset of the above list of crucial services. Accordingly, there is not an exact correlation between this list of crucial services and the specific services analyzed by the LTCI Finance Subcommittee.

NOTE: Dementia services and support competencies need to be developed in all service areas.

NOTE: Cultural sensitivity and cultural competencies need to be developed in all service areas.

In addition, unmet needs identified by the LTCI Scope of Services and Service Delivery Subcommittee are provided in the first list below. Issues identified as unaddressed or inadequately addressed, raised at Town Hall meetings attended by older adults and adults with disabilities, are provided in the second list below. Both lists should be considered in any future discussions concerning the provision of crucial LTSS in San Francisco’s LTSS managed care service delivery system.

The LTCI Scope of Services and Service Delivery Subcommittee identified unmet needs in the following areas:

- Clients on the waiting list for MSSP
- Clients on the waiting list for Community Living Fund
- Unmet need for OAA Case Management
- Unmet need in caregiver support
- Availability of Medi-Cal SNF beds within the city limits (this does not suggest expanding the number of beds, rather seek solutions to availability and reduce the number of residents who are placed in “out of county” nursing homes
- Daycare, respite, and residential services that support family caregiving
- Home-delivered meals
- Residential and day services for those with dementia
- Behavioral health services

Town Hall meetings held throughout San Francisco, attended by older adults and adults with disabilities, identified the following issues as either unaddressed or inadequately addressed:

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29 Unmet need is based on data from “Assessment of the Needs in San Francisco for Seniors and Adults with Disabilities,” April 12, 2012, and from Town Hall meetings held throughout San Francisco. This list is not meant to be all-inclusive.

30 Town Hall meetings were held at: Curry Senior Center, 30th Street Senior Center, the Mayor’s Disability Council, Bayview Hunters Point ADHC, and Jackie Chan Activity Center.
• Depression and isolation experienced by seniors
• Social supports and services, as well as programs and counseling that promote independence for younger adults with disabilities
• Vision, dental, hearing, and podiatry services
• Affordable, accessible, and adaptable housing
• Affordable, accessible, and adaptable office space for CBOs serving this population
• Improved access to information on senior services and senior housing
• An updated DAAS resource directory
• Improved planning and better coordination of services for people transitioning out of institutional settings
• Intensive case management for people living in the community on the border of a crisis
• Reduction in the waiting list to see a primary care provider
• Better communication tools for consumers to contact managed care Health Plans and their medical providers (email)
• Increased access to physical therapy
• Insufficient meals, and fresh vegetables and other foods
• Improved access to transportation services
• Assistance with Medi-Cal share of cost\(^{31}\) for people needing to access Medi-Cal services

**Lead Responsibility:** DAAS, DPH, Health Plans

**Shared Responsibility:** CBOs, LTCCC for advocacy

**RECOMMENDATION 8.2:** *DAAS, DPH, and service providers should continue to collaborate to develop and promote a city-wide program of Healthy Aging that enhances the work currently being done by DAAS, DPH, and service providers.*

An enhanced Healthy Aging program would help community-based organizations implement evidence-based programs that promote healthy living for older adults and adults with disabilities. This would include chronic disease self-management and other health promotion programs. Healthy Aging combines best practices in prevention and wellness that help to keep older adults healthy, safe, and independent at home in their communities as long as they wish to remain.

Healthy Aging does not rely on traditional medical models that focus on frailty/disability and crisis management. Healthy Aging seeks to improve the health of older adults by:

- Reducing social isolation with enhanced community-based programs and services;
- Improving access to care through team-based care coordination, technology integration, prevention programming, and public awareness and education; and

\(^{31}\) Medi-Cal rules require that recipients pay income in excess of their “maintenance need” level toward their own medical bills before Medi-Cal begins to pay
Increasing self-care through wellness screenings, education, programming, tele-health monitoring devices, and early identification of dementia.

There are a number of programs aimed at promoting Healthy Aging, but no process exists to maximize the work of these programs and/or to expand their scope beyond a single service.

**Lead Responsibility:** DAAS, DPH, Health Plans, CBOs  
**Shared Responsibility:** LTCCC for advocacy

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<th>OBJECTIVE 9: <strong>Direct Care Workforce:</strong> Enhanced workforce to meet current and projected service needs.</th>
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**RECOMMENDATION 9.1:** Ensure that the current and future generation of direct care workers are recruited, trained, and retained to improve the quality of care and quality of life for consumers. Both basic and specialized training should be provided, and best practice standards should be used.

Trends in aging are expected to increase the demand for health care services. By 2030, the share of the population ages 65 and older will increase dramatically from 13 to 19 percent. Along with an increased demand for more health care services by this older population, the demand for health care workers, including direct care workers, will likely grow faster than in the past.

Direct care workers (those working in the home and the community as well as those working in facilities) provide 80 percent of hands-on care for older adults and people with disabilities in the country. These jobs tend to be stressful, pay very low salaries, and have few benefits. Job-related injuries also occur at higher rates. The recruitment, training, and education of direct care workers are vitally important to improve quality of care and quality of life for older adults and adults with disabilities. At minimum, this should include training in universal precautions, body mechanics, and being able to identify the signs and symptoms of dementia.

Nationally, by 2020, home and community-based direct care workers are likely to outnumber facility-based direct care workers. In California, from 2008-2018, Personal Care Aides (PCAs) are the #1 occupation projected to create the most jobs (over 200,000).

In California (2008-2018), PCAs and HHAs (Home Health Aides) are the third and fourth fastest growing occupations. Yet there is a projected shortage of all direct care workers (personal care aides, home health aides, certified nursing assistants, orderlies, and attendants). In San Francisco, over the next five years, PCA’s are expected to experience the largest growth of any health care occupation. Over 10,000 jobs are projected.

**Lead Responsibility:** TAPCA (Training Academy for Personal Caregivers and Assistants)  
**Shared Responsibility:** IHSS Consortium, IHSS Public Authority, San Francisco Health Plan, SEIU United Health Care Workers West
RECOMMENDATION 9.2:  *Ensure that direct care workers are an integral part of the health care teams organized by Health Plans. Because these teams will be arranging services and support for older adults and adults with disabilities, the involvement of direct care workers is essential.*

Direct care workers are often the health care workers who have the most direct and constant contact with older adults and adults with disabilities requiring care. As such, they should be considered integral to the health care teams that are organized by Health Plans to arrange for services and support for these older adults and adults with disabilities.

**Lead Responsibility:** Health Plans  
**Shared Responsibility:** IHSS Consortium, IHSS Public Authority, SEIU United Health Care Workers West

RECOMMENDATION 9.3: *Strengthen training and career development for direct care workers*

Direct care workers are the backbone of care delivery for thousands of seniors and adults with disabilities. As such, they should have opportunities for career development. Career ladders and lattices should be created so direct care workers can have the possibility of attaining positions like home health aides (HHAs) or certified nursing assistants (CNAs), among others.

**Lead Responsibility:** TAPCA, SEIU United Health Care Workers West, SEIU Education Trust  
**Shared Responsibility:** Jewish Vocational Services, City College of San Francisco

**OBJECTIVE 10: IHSS: Improved IHSS Program**

RECOMMENDATION 10.1: *As the IHSS program moves into managed care, retain the Independent Provider and Contract modes of IHSS service delivery.*

San Francisco has created robust and successful Independent Provider (IP) mode and Contract mode of service delivery within the IHSS program, both of which provide exceptional value to consumers. As IHSS moves into managed care, it will be important to retain both the IP and the Contract mode.

**Lead Responsibility:** DAAS, Health Plans  
**Shared Responsibility:** IHSS CBOs

RECOMMENDATION 10.2: *Involve IHSS consumers and workers in designing the new LTCI service delivery system and in the care planning process. At the heart of the IHSS program is the concept of consumer direction.*
IHSS consumers should be involved in all phases of planning during the transition to managed care and implementation process for the new LTCI service delivery system. The feedback and needs of consumers will help shape the design of various programs and services. Consumers should have a voice throughout the process.

**Lead Responsibility**: DAAS, Health Plans  
**Shared Responsibility**: IHSS CBOs, SEIU United Health Care Workers West

**RECOMMENDATION 10.3**: *DAAS should take the lead to collaborate on IHSS integration into managed care. Collaboration will include input from IHSS stakeholders.*

DAAS is the county department in San Francisco that operates the IHSS program. This is a federal, state, and county-funded program for low-income elderly, blind, and people with disabilities of all ages as an alternative to out-of-home placement and institutionalization. For this reason, DAAS and its IHSS program should take the lead on collaborating with stakeholders on IHSS integration into services offered by Medi-Cal managed care plans. Collaboration will involve IHSS CBOs along with the Health Plans.

**Lead Responsibility**: DAAS, Health Plans  
**Shared Responsibility**: IHSS CBOs, SEIU United Health Care Workers West

**RECOMMENDATION 10.4**: *Continue to provide consumers with access to essential IHSS services, like emergency on-call and consumer peer mentoring, as the IHSS program is integrated into managed care.*

IHSS consumers should continue to have access to essential services like emergency on-call and consumer peer mentoring. These are important to IHSS consumers and should be maintained.

**Lead Responsibility**: DAAS, Health Plans  
**Shared Responsibility**: IHSS CBOs

**RECOMMENDATION 10.5**: *Expand training and education for: (1) consumers with long-term health conditions who are caring for themselves; (2) their family members who are also caregivers; and (3) community caregivers.*

More than 80 percent of care provided for people with long-term health conditions is undertaken by consumers themselves, family members, and community caregivers. To maximize health and quality of life, consumers need skills to “self manage.” As such, the primary focus for training should be on culturally and linguistically appropriate chronic disease management programs for consumers and caregivers. Chronic disease management and self-management programs currently in place should be evaluated and those with positive outcomes should be expanded.

**Lead Responsibility**: IHSS Public Authority, SEIU United Healthcare Workers West  
**Shared Responsibility**: N.A.
OBJECTIVE 11: Care for Alzheimer’s and other Dementias: Improved resources for people with Alzheimer’s and other dementias served by Health Plans.

People with Alzheimer’s and other dementias often go unrecognized and underserved. Nationally, more than 50 percent of people with Alzheimer’s and dementia are not identified or diagnosed. Health Plans are in an ideal position to improve identification, diagnosis, and ongoing management of this disease in community settings in a more cost-effective manner.

Nationally, there are over 5 million people with Alzheimer’s disease. That will double in the next 20 years. For people with Alzheimer’s, the costs of health care and support are three times higher for Medicare. For Medi-Cal, the costs are 19 times higher. Over half the population will have cognitive impairment and not be diagnosed. People with dementia are more likely to be hospitalized. Cognitive impairment is prevalent for older adults, but not normal for this group.

Current projections indicate San Francisco’s Baby Boomers, as they age, will cause a significant increase in the senior population that mirrors a national trend. San Francisco’s total population is now 812,216. The population 60 and over is 161,580 (19.9%). This same group of 60 and over is projected to increase to 185,418 (22.6%) by 2020. Age is the strongest factor for developing dementia and drives the growing crisis in dementia care.

The LTCCC, in collaboration with DAAS, has taken the lead in developing 2020 Foresight: San Francisco’s Strategy for Excellence in Dementia Care, which identifies the growing crisis in dementia care and how that should be addressed. This objective is linked to that strategy to improve dementia care in San Francisco.

Care for people with dementia, served by Health Plans, can be improved:

1. Screening – ensure the initial assessment used by Health Plans identifies Alzheimer’s and other dementias, and address the follow-up and referral issues.
2. Provider training – doctors in Health Plan networks must be able to recommend resources or make referrals for people with dementia and their caregivers.
3. Diagnosis – early diagnosis and disease management.
4. Support and Education – support and education in dementia care for caregivers.
5. Training and Education – training and education in dementia care for Health Plans, and their health care professionals.

RECOMMENDATION 11.1: Health Plans should receive dementia-specific training on best practices and care, and should ensure that caregivers and people with dementia have access to resources, education, and training on disease management.

Health Plans will need additional training on best practices and care so that they can provide caregivers and people with dementia access to the resources, education and training they need.

Lead Responsibility: Health Plans, Alzheimer’s Association
Shared Responsibility: LTSS providers, CPMC Brain Health Center, UCSF Memory Center
RECOMMENDATION 11.2: *Health Plans or their designees should assess, identify, and diagnose people with Alzheimer’s disease and other dementias, and make referrals to community resources as early as possible in the disease process.*

Health Plans or their designees must be able to assess, identify, and diagnose people with Alzheimer’s disease and dementia, and make referrals to community resources.

**Lead Responsibility:** Health Plans, Alzheimer’s Association  
**Shared Responsibility:** LTSS providers, CPMC Brain Health Center, UCSF Memory Center

See APPENDIX M for an explanation of Quality Managed Care for People with Dementia.

OBJECTIVE 12: *Communication: Clear, consistent messaging delivered to consumers, stakeholders, and advocates through a robust communications plan regarding the recommendations to improve access to and coordination of LTSS.*

RECOMMENDATION 12.1: *The communications plan included in this strategic plan, should guide communications with consumers, advocates, service providers, stakeholders, City departments, commissions, and elected officials about the scope of these LTCI recommendations to improve access to and coordination of LTSS.*

*The most appropriate communication mechanisms should be used to reach racial, ethnic, and cultural communities with information about how to access LTSS for older adults and adults with disabilities. These include the best types of media for sharing information, and the best kinds of community forums to educate consumers.*

The communications plan will guide communications about the LTCI Strategic Plan, and its recommendations to improve access to and coordination of LTSS for older adults and adults with disabilities.

It will demonstrate that issues raised (as either unaddressed or inadequately addressed) at Town Hall meetings held in November and December 2012, and in January 2013, have been incorporated in the LTCI Strategic Plan.

For public consumption, the LTCI recommendations must be written in a manner so their intent is clear and easy to understand.

**Lead Responsibility:** LTCI Design Group, DAAS  
**Shared Responsibility:** Long Term Care Coordinating Council
OBJECTIVE 13: Opportunities for Service Providers: Newly created opportunities for aging and disability service providers to collaborate in the development of integrated business models and plans for the delivery and financing of community-based LTSS.

Opportunities should be created for aging and disability service providers to collaborate on the development of innovative business models for the delivery and financing of community-based LTSS.

These business models could then be used for securing partnerships with Health Plans as well as under other partnerships under Medi-Cal, Medicare, Veterans Administration, private insurers, and other sources that could sustain local LTSS services.

RECOMMENDATION 13.1: Pursue federal and state opportunities for DAAS to work with aging and disability service provider organizations in the development of integrated business models and plans for the delivery and financing of community-based LTSS for purchase by Health Plans and other potential buyers.

Increasing consumer demand, the high costs of health care, and decreasing public resources have created an imperative for pursuing innovation and efficiencies for delivering quality care for those with chronic conditions and/or disabilities. A number of state, federal and local health care and social service reforms are proceeding to meet the demand and contain costs.

Several states have implemented service delivery and financing innovations that have been successful in achieving these goals. Technical experts and local aging and disability organizations collaborating on business relationships between the formal medical/health care system and community-based, supportive LTSS service systems can produce models that have the highest likelihood of success.

California’s expansion of Medi-Cal managed care, the CCI and the integrated LTSS component present some unique opportunities for local aging and disability organizations to re-envision and re-tool LTSS service delivery and financing.

By examining other funding sources as purchasers of service, local organizations can increase their sustainability by engaging a more diversified portfolio of financing sources and models; for example, as a managed care contractor (Medicare and Medi-Cal), an LTSS customer advisor/gatekeeper (private insurers and employee assistance programs), a home and community-based services manager (Veterans Health Administration), and others.

Lead Responsibility: DAAS, aging and disability service provider organizations
Shared Responsibility: Health Plans
IMPLEMENTATION OF LTCI STRATEGIC PLAN RECOMMENDATIONS

Objective 1: Collaboration: Strengthened collaboration among county departments, including the Department of Aging and Adult Services (DAAS), Human Service Agency (HSA), and Department of Public Health (DPH), and among the three managed care Health Plans (Health Plans), which include the San Francisco Health Plan, Anthem Blue Cross, and On Lok Lifeways.

Recommendation 1.1: Establish an LTCI implementation body with staff support that brings together DAAS, DPH and the Health Plans on a regular basis to create a process to: (1) oversee the implementation of the recommendations included in this LTCI Strategic Plan; and (2) ensure a successful transition to long term care integration in San Francisco.

Process and Challenges

This is one of the most important recommendations to come out of the twelve months of work on LTCI. While San Francisco looks to CMS and DHCS to create a better and more coordinated health care system through the CCI and the Cal MediConnect Pilot Project, the City itself has created silos that prevent collaboration among departments as well as across service providers and Health Plans. Currently, there is no process in place for DAAS, DPH, and the Health Plans (Anthem Blue Cross, San Francisco Health Plan and On Lok Lifeways) to craft and implement a citywide strategy for LTCI. The San Francisco Health Plan works with DAAS on a number of initiatives and separately works with DPH on additional initiatives.

The leadership of key city departments does not meet regularly. This process needs to begin with agreement among leadership at HSA, DAAS, DPH and the Health Plans that working together on a citywide LTCI strategy is important. The next step is to designate a high level staff position to manage the process. This is not a one-time meeting or planning session. It is an ongoing process that begins with implementation of the recommendations in this LTCI Strategic Plan, and then proactively works on health care system changes dictated by CMS and DHCS.

The make-up of the LTCI implementation body needs careful consideration. San Francisco has a considerable number of commissions, committees and advisory groups. The make-up of those groups is usually carefully crafted to represent key stakeholders and consumers. This implementation body needs to consist of those who can actually implement or influence the implementation of the recommendations and needs to also represent leadership from HSA, DAAS, DPH and the Health Plans. Representation from these groups may also provide easier access to the funding that will be needed to implement many of these recommendations.

The process will begin with a meeting between the directors of DHS, DPH, and DAAS. They should determine the make-up of the implementation body. Once formed, the implementation body should define the work groups and their membership. Each work group would create a series of goals and objectives and timelines for its work. The leadership group (DHS, DPH, and DAAS)
would meet regularly (monthly?) to guide the work of the implementation body. Several of the existing LTCI work groups may wish to continue their work.

**Timeline:** In the fall of 2013, the LTCI Strategic Plan should be presented to the Board of Supervisors, the Mayor’s Office, and to various city commissions, and advisory bodies. In late 2013, the LTCI implementation body should be formed, and then charged to work on the implementation of the LTCI recommendations and long range planning. The implementation body would determine: (1) its specific goals and objectives; (2) the types of the work groups needed; and (3) the membership of those work groups. The implementation body should meet at least quarterly. All implementation work groups should meet at least every other month.

**Objective 2: Access: Improved access to LTSS for seniors and people with disabilities.**

**Recommendation 2.1:** Create a “central door” model of access to LTSS with the DAAS Integrated Intake Unit as that central door.

**Process and Challenges**

Recommendation 2.1 will create a more accessible long-term care system for seniors and adults with disabilities, but it is challenging to implement without funding and without almost total support of providers in the community. This recommendation, if successfully implemented, could allow DAAS to begin the process of creating and implementing a universal assessment tool that would simplify access for those receiving multiple services, particularly those in CBAS, IHSS, and MSSP, and simplify the work of the Health Plans and City departments serving seniors and adults with disabilities.

While the use of Aging and Disability Resource Centers (ADRCs) localized in communities throughout San Francisco would be a good first step, this recommendation needs funding for a robust communications effort. Community-based providers need to understand the benefits of the central door and need consistent reassurance that “their” clients will not be diverted to DAAS.

**Timeline:** The actual implementation of this process will take time, as it needs both funding and further structuring. DAAS needs to:

- Create a communication plan that defines the process and benefits of the central door for community-based providers.
- In concert with the ADRCs, create a strategy for how clients will enter and move through this new system.

**Objective 3: Information: Improved access to information for consumers and service providers.**

**Recommendation 3.1:** DAAS should design a public information campaign targeting consumers. This will include, among other things, print media and an online listing of all LTSS service providers for consumers, with descriptions of the services that they provide.
and the criteria for accessing those services. The online listing should be updated on a regular\textsuperscript{32} basis to ensure the information is accurate.

DAAS should also create a strategy to ensure that health care providers, LTSS providers, stakeholders, and advocates are aware of the online listing and pass that information on to consumers. This should be part of Recommendation 3.2.

**Recommendation 3.2:** DAAS should design a public information campaign targeting service providers. This will include information about the array of LTSS services available for consumers in San Francisco, with a focus on “single service” providers that may not have knowledge of or access to the larger service continuum. As part of this campaign, educate service providers about the DAAS IIU as the central door, its value and use.

**Process and Challenges**

The SF-GetCare online resource directory has been developed, which will provide older adults and adults with disabilities, as well as service providers, with information about long term services and supports available in San Francisco. The implementation of Recommendation 3.1 and 3.2 is will need to be accomplished as part of the implementation efforts that will be undertaken on behalf of this entire LTCI Strategic Plan. The challenge will be to reach consumers and service providers, directing them to use this online resource directory: this is what the two public information campaigns are intended to accomplish.

The larger service providers are relatively easy to reach, given their limited numbers and DAAS’s access to them through funding streams. Most larger providers are involved in DAAS stakeholder meetings, workgroups, and LTCCC and LTCI efforts. As such, they have access to this information.

The smaller service providers create a particular challenge. They do not have the same access to information as the larger providers, so DAAS needs to create a public information campaign that will reach them. Consumers are more challenging to reach, given their large numbers, particularly consumers who are not already in the “system”. DAAS needs to create a public information campaign that will target them, and quantify the cost of implementing the campaign. This may be incorporated as part of the communication effort in Recommendation 2.1.

**Timeline:** The online resource directory has been operating since April 2013, but the public information campaign and communication strategy (for both consumers and service providers) needs to be developed ASAP - so consumers are aware of the resource, and so providers are equally aware of the resource and keep the listing updated regularly.

\textsuperscript{32}RTZ Associates will update information annually. Providers may update their information as needed.
Objective 4: Care Coordination: Enhanced coordination of services and efficiency.

Recommendation 4.1: DAAS and DPH should initiate an inter-agency care coordination committee to further develop an asset mapping tool (already started) including: (1) categorizing various care coordination services in the city into intensity levels; and (2) determining procedures for maintenance of the mapping tool. Based on this information, the committee should evaluate the current case management system with the goal of overall system improvement.

This tool could be used to orient the Health Plans, service providers, decision-makers, and others. It could reduce potential duplication of care coordination activities among those serving seniors and persons with disabilities. The committee should also create a common language of care coordination intensity that will facilitate communication across the LTSS system. The committee should also define the role of lead care coordinator.

Recommendation 4.2: DAAS and DPH should pursue re-launching the Case Management Connect (CMC) Project (formerly called the Electronic Rolodex), which allows case management programs at DPH and DAAS (both in the departments and at community agencies) to view all case management enrollments.

The re-launched version of the CMC Project should: (1) have all data provided to electronically populate CMC; and (2) enable case managers to enroll clients once in their own case management program. Lead care coordinators for each enrolled client should be made evident in this version. Information in the CMC Project should be viewable from the DPH tool and the DAAS case management module by sharing enrollment transactions electronically.

Recommendation 4.3: DAAS, DPH, and the Health Plans should initiate and support procedures for virtual case conferences. This is not intended to replace current case conference processes, but to facilitate alternatives and more efficient communication among DAAS, DPH, and the Health Plans, as well as across settings such as hospitals, SNFs, and the community.

Process and Challenges

The Coordinated Care Initiative (CCI) and the DHCS/CMS readiness review process for Cal MediConnect participating Health Plans is very focused on the issue of care coordination. Given the large numbers of individuals who have the potential to become part of Cal MediConnect and their perceived frailty, it is in the best interests of the Health Plans and the City to create a more coordinated system. Currently, a senior may have a care plan created by the adult day health center, a care plan through IHSS, and a care plan created by their primary care physician and/or specialist.
There currently is no good mechanism for coordinating all of these care plans. In many of the Cal MediConnect counties, the Health Plans are anticipating contracting with existing LTSS providers for primary care coordination. For example, the social worker at the ADHC would provide primary care coordination for each attendee (Health Plan and Cal MediConnect member). That care plan would be created in concert with case managers/care coordinators at the Health Plan and with the member’s primary care provider, but would be implemented and monitored at the ADHC with oversight from the Health Plan.

Recommendation 4.1 begins the process of understanding and organizing the current care coordination systems in preparation for Cal MediConnect and for LTCI. It makes more sense for the Health Plans to lead this process, in concert with DAAS and DPH, with a preliminary focus on their members who are dually eligible. The challenge here is that San Francisco is not yet one of the Cal MediConnect sites.

Recommendation 4.2 may be challenging in that Case Management Connect has not been used effectively. Currently, it is suggested as a tool for DAAS and DPH, but it would have greater value if the Health Plans were also connected. Particular attention needs to be paid to ensure that this tool creates value given its earlier lack of use.

Recommendation 4.3 is in line with the CCI, which highlights the need for interdisciplinary care teams and case conferences involving the member, the primary care provider, and select providers, like DAAS and DPH. This is a difficult concept to enact outside of a closed system like Kaiser or PACE.

**Timeline:** It is suggested that the San Francisco LTCI Care Coordination Workgroup be reconstituted to continue to work on this issue. Much of the work on asset mapping care coordination has been completed, but it has yet to be analyzed for efficacy and/or potential cost savings. DAAS and the Care Coordination Work Group should lead that process and provide documentation on suggested changes.

While Case Management Connect exists, the recommendation suggests enhancements to it, which may require funding. Additionally, business associate agreements must be in place for the sharing of data between DAAS and DPH and among all other parties. Care Management Connect currently exists within DPH, so there needs to be a collaborative agreement between DAAS and DPH to move this forward. For this to be successful, an IT staff member (HSA) needs to be assigned to the project.

**Objective 5:** Data: Linked data systems to improve efficiency and collaboration.

**Recommendation 5.1:** DAAS, DPH, and the Health Plans should form an inter-agency committee to create a data sharing solution that allows DAAS, DPH, the Health Plans, and service providers in the community to view client-level LTSS usage data in a single data report.
Process and Challenges

This recommendation is currently being implemented anecdotally (specific projects) between DPH and San Francisco Health Plan, and between DAAS and San Francisco Health Plan. The San Francisco LTCI Data Work Group should be reconstituted to lead this effort. The interagency committee will need to determine:

- What data is relevant and “able” to be shared?
- What the proposed outcomes are for data sharing. How will it enhance care coordination, service delivery, etc?
- What is the process for linking data systems?
- Who has and who needs access to the data and for what purposes?
- Whose data set and/or whose data system is being used as the base?
- What are the HIPAA issues, particularly in regards to sharing information on behavioral health and/or substance abuse?

This is a complex endeavor that needs to begin with as few partners as is reasonable. It is suggested that it include only DAAS, DPH, DHS, and the Health Plans in the first phase. It would then expand to include relevant providers for the second phase.

It is important to also take into consideration data sharing between the Health Plans, the California Department of Social Services (DSS) and the California Department of Health Care Services (DHCS). The following summarizes those efforts that may provide a blueprint for the interagency committee:

**Data Sharing Between DHCS and Demonstration Plans.** Demonstration plans have requested to receive data on beneficiary utilization of health care services (with all information that could identify individual beneficiaries removed from the data) and provider data prior to enrollment. Plans will use the data to review the potential scope of their (1) enrollees’ health status and needs, and (2) staff hiring and provider contract needs. The DHCS has sent Medicare provider data to plans for the purpose of building adequate networks, and is working with CMS to also send Medicare beneficiary data.

**Data Sharing Between DSS and Demonstration Plans.** At the time of this analysis, DSS planned to allow demonstration plans to have access to certain IHSS recipient data and for the plans to provide county social workers with access to data elements relevant for IHSS quality assurance and care coordination activities. The final data-sharing agreement will require an MOU between DSS and demonstration plans.33

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33 “Coordinated Care Initiative Update”, CA Legislative Analyst’s Office, February 2013.
Timeline: This could begin immediately with an inventory with what is currently being done with DAAS, DPH, DHS, and Health Plans in terms of data sharing. The work of the San Francisco LTCI Data Work Group needs to be evaluated and expanded.

**Recommendation 5.2:** Given the current direction of CMS regarding de-institutionalization, DAAS and DPH should demonstrate the value provided by best practice program models that assist older adults and adults with disabilities to return to community living. The use of such models could be beneficial for transitions from all nursing homes throughout the City.

Specifically, DAAS and DPH should undertake a programmatic and financial analysis of the Diversion and Community Integration Program (DCIP). DAAS should undertake a programmatic and financial analysis of the Community Living Fund (CLF). These and other programs, which also could be analyzed, have been successful in serving older adults and adults with disabilities, assisting them to access services to move from institutional to community settings. The potential should be considered for expanding some of these programs as part of the transition to Medi-Cal managed care for LTSS.

Toward this end, following the analyses, DAAS and DPH should formulate a plan to utilize these or similar programs to assist older adults and adults with disabilities residing in nursing homes throughout San Francisco to return to community living. DAAS and DPH should also use these or similar programs in close collaboration with the San Francisco Health Plan and Anthem Blue Cross, San Francisco’s two Medi-Cal Health Plans, to facilitate community living for their clients.

In addition, DAAS and DPH should seek continued collaboration between and among City departments and community organizations to carry on the work of de-institutionalizing older adults and adults with disabilities. DAAS and DPH should also determine how to provide supportive housing for these individuals.

**Process and Challenges**

Recommendation 5.2 has some challenges. While exceptional value has been gained from DCIP, this court-ordered program is scheduled to sunset in 2013. This recommendation doesn’t suggest that DCIP should continue; rather it acknowledges the value of both DCIP and CLF in helping to de-institutionalize those in nursing homes and wishes to quantify the benefits in relationship to the costs.

It is challenging to advocate for continuation and/or expansion without the data to show efficacy and cost savings. While Medi-Cal data can be accessed for both of these programs, it will be more challenging to access Medicare data as the San Francisco Health Plan does not have a Medicare Advantage Program.
Timeline: The data is currently available through RTZ Associates and, as such, could be accessed at any time.

Objective 6: Quality: Improved quality of services provided for consumers.

Recommendation 6.1: DAAS, DPH, and the Health Plans should assign staff members to monitor the State’s development of standards and measures that demonstrate quality care to consumers. This effort should actively track the Cal MediConnect State Quality Workgroup. Based on that work, similar quality standards and outcome measures for LTSS should be developed and implemented in programs managed by DAAS, DPH, and the Health Plans.

Process and Challenges

At present, the CCI work on quality is at a standstill. Assuming the process gets reinvigorated, DAAS should assign staff involved with quality assurance (Quality Improvement Program) to attend workgroup sessions. This work is relevant for DAAS and the Health Plans as IHSS and MSSP are integrated into managed care. Should the Cal MediConnect Pilot Project collapse, DAAS should take the relevant work done on this subject and begin its own exploration of quality measures.

Timeline: On hold for the implementation of CCI.

Objective 7: Support: Expanded supports for family caregivers, independent providers, community caregivers, and individuals who are socially isolated.

Recommendation 7.1: Develop strategies that expand supports for family caregivers, independent providers, community caregivers, and individuals who are socially isolated. Additionally, respite services need to be developed for caregivers, particularly those caring for someone with Alzheimer’s disease and other forms of dementia.

Process and Challenges

This is not an initiative that DAAS will lead. It is anticipated the Family Caregiver Alliance will be the lead. This being the case, DAAS should meet with Family Caregiver Alliance (along with the other agencies identified as having shared responsibilities) to understand its needs in regard to leading the implementation of Recommendation 7.1, and determine how the two organizations might work together.

Objective 8: Services: Incorporated long term services and supports (LTSS), crucial in keeping older adults and adults with disabilities healthy and safe in the community, into San Francisco’s LTSS managed care system.

Recommendation 8.1: Incorporate crucial LTSS into the San Francisco LTSS managed care system.
**Recommendation 8.2:** DAAS, DPH, and service providers should continue to collaborate to develop and promote a city-wide program of Healthy Aging that enhances the work currently being done by DAAS, DPH, and service providers.

**Process and Challenges**

Recommendation 8.1 is entirely dependent on the CCI moving forward and/or IHSS, MSSP, and SNF moving into managed care. DAAS worked with the Health Plans to incorporate the CBAS transition without significant challenges. It is anticipated that they would create similar processes for IHSS, MSSP, and SNF. Though IHSS and MSSP are not currently part of managed care, DAAS has a significant interest in oversight of their management, and in their continued success.

**Timeline:** These recommendations need to be monitored and evaluated by the LTCI implementation body. They should follow the progress of the first eight Cal MediConnect counties and evaluate “best practices” for implementation when the State expands Cal MediConnect. San Francisco should continue its dialogue with San Mateo and Santa Clara counties.

**Objective 9:** Direct Care Workforce: Enhanced workforce to meet current and projected service needs.

**Recommendation 9.1:** Ensure that the current and future generation of direct care workers are recruited, trained, and retained to improve the quality of care and quality of life for consumers. Both basic and specialized training should be provided, and best practice standards should be used.

**Recommendation 9.2:** Ensure that direct care workers are an integral part of the health care teams organized by Health Plans. Because these teams will be arranging services and support for older adults and adults with disabilities, the involvement of direct care workers is essential.

**Recommendation 9.3:** Strengthen training and career development for direct care workers.

**Process and Challenges**

While this is an important recommendation, DAAS does not have the funding to impact this recommendation’s successful implementation. The current direct care worker system (predominately IHSS) is challenged to move to the next level for many reasons, but one of the most important is the lack of advanced training for workers.

Without additional training, it is hard to actualize career ladders, and increased compensation. Training programs exist such as the TAPCA and SEIU-ULTCW (United Long Term Care Workers) CMS Innovations Grant training, but there are structural issues about the IHSS program that make
providing additional training to care workers challenging. As ULTCW rolls out its training program over the next 24 months, it will be important to track health outcomes for those consumers who have gone through the training with their care workers.

**Objective 10: IHSS: Improved IHSS Program**

**Recommendation 10.1:** As the IHSS program moves into managed care, retain the Independent Provider and Contract modes of IHSS service delivery.

**Recommendation 10.2:** Involve IHSS consumers and workers in designing the new LTCI service delivery system and in the care planning process. At the heart of the IHSS program is the concept of consumer direction.

**Recommendation 10.3:** DAAS should take the lead to collaborate on IHSS integration into managed care. Collaboration will include input from IHSS stakeholders.

**Recommendation 10.4:** Continue to provide consumers with access to essential IHSS services, like emergency on-call and consumer peer mentoring, as the IHSS program is integrated into managed care.

**Recommendation 10.5:** Expand training and education for: (1) consumers with long-term health conditions who are caring for themselves; (2) their family members who are also caregivers; and (3) community caregivers.

**Process and Challenges**

There are exceptional challenges ahead for the IHSS program, particularly if Medi-Cal managed care is implemented and IHSS becomes the responsibility of the Health Plans. The following are specific challenges outlined in the LAO update on the CCI:

- The CCI legislation authorizes Medi-Cal Health Plans, participating in the eight-county demonstration projects, to provide additional IHSS hours to beneficiaries as needed. However, these Health Plans do not have the authority to reduce IHSS hours assessed by county social workers. This is problematic because the Health Plans, as risk-bearing organizations, should as a general principle have the authority to determine the level of utilization for services that are factored into their capitated rate.

- Chapter 45 enacted a county IHSS MOE, which replaces the historical county contribution of 17.5 percent to IHSS program costs with a requirement that counties statewide generally maintain their 2011–12 expenditure level for IHSS beginning in 2012–13. All increases in the non–federal share of IHSS costs above the county IHSS MOE are borne by the state’s General Fund. Essentially, the county IHSS MOE removes counties’ financial liability for all increased IHSS program costs.
Chapter 33 further specifies that demonstration plans will develop care coordination
teams with LTSS recipients, recipients’ authorized representatives, and providers,
including county welfare departments.

The LAO recommends that the Legislature enact legislation to test the full integration of
IHSS as a managed care plan benefit with at least one demonstration plan in the third
year of CCI. This would allow the first two years of CCI to serve as a period for plans to
learn and prepare for IHSS assessment responsibilities. Potential candidates for receiving
enhanced authority over IHSS include plans that have made the most progress toward
LTSS integration.

This framework would enable the Legislature to compare the advantages and trade–offs
of two distinct models of integrating IHSS into managed care: (1) in the first two years, a
more restrained approach that mainly relies on care coordination between
demonstration plans and county welfare departments, and (2) in the third year, a fully
integrated approach among plans prepared for such a shift.

As DAAS begins to think through implementation of recommendations outlined in Objective 10, it
needs to give consideration to the structural issues inherent in the move to managed care.

**Timeline:** On hold for the implementation of CCI.

**Objective 11:** Care for Alzheimer’s and other Dementias: Improved resources for people
with Alzheimer’s and other dementias served by Health Plans.

**Recommendation 11.1:** Health Plans should receive dementia-specific training on best
practices and care, and should ensure that caregivers and people with dementia have
access to resources, education, and training on disease management.

**Recommendation 11.2:** Health Plans or their designees should assess, identify, and
diagnose people with Alzheimer’s disease and other dementias, and make referrals to
community resources as early as possible in the disease process.

**Process and Challenges**

In November 2008, then Mayor Gavin Newsom empanelled an Alzheimer’s/Dementia Expert
Panel that created recommendations and an action plan to address the growing crisis in dementia
care. See “San Francisco’s Strategy for Excellence in Dementia Care”, dated December 2009.

**Timeline:** Dementia specific training should be implemented either when: (1) resources are
available; or (2) the Health Plans have negotiated a contract for training and education with the
Alzheimer’s Association for this service.
Objective 12: Communication: Clear, consistent messaging delivered to consumers, stakeholders, and advocates through a robust communications plan regarding the recommendations to improve access to and coordination of LTSS.

Recommendation 12.1: The communications plan, developed by the LTCI Communications Subcommittee and included in this strategic plan, should guide communications with consumers, advocates, service providers, stakeholders, City departments, commissions, and elected officials about the scope of these LTCI recommendations to improve access to and coordination of LTSS.

The most appropriate communication mechanisms should be used to reach racial, ethnic, and cultural communities with information about how to access LTSS for older adults and adults with disabilities. Such mechanisms should include the best types of media for sharing information, and the best kinds of existing and new meetings and community forums to educate consumers.

Process and Challenges

The LTCI implementation body (discussed under Recommendation 1.1 in this Implementation section) should begin its work by ensuring the goals of the LTCI Communications Plan are met:

- Provide a blueprint for comprehensive communications and public relations efforts in support of the successful implementation of the LTCI Strategic Plan recommendations.
- Review recommended target audiences and ensure that no essential audience is missing.
- Disseminate the LTCI Strategic Plan and receive feedback on the LTCI recommendations to improve San Francisco’s long-term care service delivery system.
- Articulate the communications goals and messages in the LTCI Communications Plan.
- Prepare for the next phase of implementation, which will involve creating implementation subcommittees - responsible for implementing a specific set of LTCI recommendations.
- Prepare for the eventual transition to LTCI in San Francisco.

Objective 13: Opportunities for Service Providers: Newly created opportunities for aging and disability service providers to collaborate in the development of integrated business models and plans for the delivery and financing of community-based LTSS.

Recommendation 13.1: Pursue federal and state opportunities for DAAS to work with aging and disability service provider organizations in the development of integrated business models and plans for the delivery and financing of community-based LTSS for purchase by managed care Health Plans and other potential buyers.

Process and Challenges

The implementation of this recommendation began in May 2013, with the acceptance of a proposal from DAAS by the US Administration for Community Living to provide targeted technical
assistance for a local network of 15 CBOs. This technical assistance will help them in developing business relationships and plans so that they can market their services to integrated care organizations, including managed care Health Plans. The technical assistance will be provided from May to October 2013. A major focus will be on: (1) scaling up operationally; (2) pricing and packaging services; (3) marketing and sales; (4) contract negotiations with larger entities; (5) technology requirements and information sharing. See attached Network chart.
San Francisco Network Of Community-Based Aging and Disability Service Provider Organizations

(1) Obtaining Targeted Technical Assistance from the Administration for Community Living (ACL) for local CBOs in this network, and
(2) Being a part of a national learning collaborative in order to build business capacity to participate in integrated care partnerships.

NETWORK MEMBERS:

- Family Caregiver Alliance
- Stepping Stone Adult Day Health Care
- On Lok Day Services 30th Street Senior Center
- Curry Senior Center
- Family Service Agency of San Francisco
- Institute on Aging
- Bayview Hunters Point Multipurpose Senior Services
- Meals on Wheels of San Francisco
- In Home Supportive Services Public Authority
- In Home Supportive Services Consortium
- Alzheimer’s Association Northern California & Northern Nevada
- Independent Living Resource Center San Francisco
- Self Help for the Elderly
- Jewish Family and Children’s Services
- San Francisco Community Clinic Consortium
LTCI COMMUNICATIONS PLAN

The following LTCI Communications Plan was prepared by the LTCI Communications Subcommittee and adopted by the LTCI Design Group.

I. Communication Goals

The goals of this LTCI Communications Plan are to:

- Provide a blueprint for comprehensive communications and public relations efforts in support of the successful implementation of the LTCI Strategic Plan recommendations.
- Disseminate the LTCI Strategic Plan and receive feedback on the LTCI recommendations to improve San Francisco’s long-term care service delivery system.
- Articulate the communications goals and messages in the LTCI Communications Plan.
- Identify and define all relevant target audiences.
- Prepare for the next phase of implementation. This will include: (1) forming an LTCI implementation body to oversee implementation of the LTCI Strategic Plan recommendations; and (2) creating implementation subcommittees - responsible for implementing a specific set of LTCI recommendations.
- Prepare for the eventual transition to LTCI in San Francisco.

II. Target Audiences

Mayor’s Office:
- Mayor’s Office of Housing
- Mayor’s Office on Disability

Controller’s Office
Board of Supervisors

City Commissions:
- Aging and Adult Services Commission
- Health Commission
- Human Services Commission
- MUNI Commission
- Housing Authority Commission
- Council on Disability

Health Plans:
- San Francisco Health Plan
- Anthem Blue Cross
- On Lok Lifeways

Consumers:
- Older Adults
- Adults with Disabilities
Policy and Advocacy groups:
- Long Term Care Coordinating Council*
- Coalition of Agencies Serving the Elderly
- Senior & Disability Action
- Advisory Council on Aging
- Others

See APPENDIX F for the response from the LTCCC to the recommendations in this LTCI Strategy.

III. Overarching Messages and Supporting Messages

Overarching Message: The recommendations generated by the LTCI Design Group are detailed and explained in the LTCI Strategic Plan. Implementation activities are about to begin. An LTCI Implementation Body will be created to initiate implementation of these recommendations in order to prepare San Francisco for the transition to LTCI and Medi-Cal managed care.

Supporting Messages:

Message #1: San Francisco’s LTCI recommendations are intended to complement the implementation of the state’s Coordinated Care Initiative, and the Cal MediConnect Pilot Project, which focuses on creating a more collaborative approach for providing services to older adults and adults with disabilities eligible for Medicare and Medi-Cal.

Message #2: The process that created the LTCI recommendations was thoughtful, thorough and inclusive.
- The LTCI Design Group had representation from service providers, labor, the Long Term Care Coordinating Council, three Health Plans, DAAS, HSA, and DPH.
- The workgroups included more than 40 non-profit providers of LTSS, many currently under contract with DAAS to deliver a wide range of services and supports to seniors and people with disabilities.

Message #3: Implementation of many LTCI recommendations does not depend on what happens at the state and federal level. Based on feedback from stakeholders, consumers, and advocates, these LTCI recommendations will be implemented over the next two to three years.

Message #4: The LTCI recommendations are meant to create a more vibrant and coordinated long-term care system in San Francisco, which will benefit all older adults and adults with disabilities.

IV. LTCI Communication Strategies

The strategies of this LTCI communication plan are to: (1) ensure that the LTCI Strategic Plan reaches key target populations in San Francisco; and (2) inform them about the findings and recommendations. Additionally, the full implementation of the LTCI Strategic Plan will require both funding and approval from key legislative bodies and individuals in San Francisco (Board of Supervisors, Mayor, etc.). Dissemination of the LTCI Strategic Plan is the first step in educating those bodies and individuals.
BACKGROUND

V. San Francisco LTCI Summary

With the development and implementation of California’s Coordinated Care Initiative, the State has begun the process of integrating health care and supportive social services while looking to reduce escalating health care costs. The desired results are: (1) a coordinated health care delivery system; (2) better health outcomes for consumers; and (3) greater control on spending.

In preparation for the Coordinated Care Initiative, in December 2011, the Department of Aging and Adult Services (DAAS), in collaboration with the Department of Public Health (DPH) and the Long-Term Care Coordinating Council (LTCCC), empanelled a Long Term Care Integration (LTCI) Design Group, and contracted with a consultant (Chi Partners) to serve as the LTCI strategic planning team, to:

- Explore the potential for integrating long-term care in San Francisco;
- Determine what is required to improve the provision of long-term services and supports that will benefit Medi-Cal eligible older adults and adults with disabilities; and
- Develop a strategic plan with recommendations to guide improvements in the organization, availability and financing of long-term services and supports.

Long-term care integration (LTCI) is defined as the integration of home and community-based long-term care services with the delivery of primary and acute care services, and institutional long-term care services, for older adults and adults with disabilities. For this population that is eligible for Medi-Cal, primary and acute care services are now being reorganized into a managed care system throughout California under an 1115 Waiver. The findings and recommendations resulting from this LTCI strategic planning process will enable San Francisco to be well positioned to implement managed care for Medi-Cal eligible older adults and adults with disabilities who require long-term services and supports (LTSS). 34

The LTCI Design Group began meeting in January 2012. In addition to its own explorations, the Design Group convened a series of workgroups to investigate specific topics. The findings from these investigations contributed to the objectives and recommendations, completed in early March 2013 and incorporated into the final LTCI Strategic Plan. The workgroups included more than 40 non-profit providers of LTSS, many currently under contract with DAAS to deliver a wide range of services and supports to seniors and people with disabilities.

VI. LTCI Design Group Mission and Vision

Mission: The mission of the LTCI Design Group was to: (1) explore the potential for LTCI in San Francisco; (2) determine what is required to improve the provision of long-term services and supports (LTSS) that will benefit older adults and adults with disabilities; and (3) develop a strategic plan that includes recommendations to guide improvements in the organization, availability and financing of LTSS.

Vision: While San Francisco is already a national model for the provision of LTSS for older adults and adults with disabilities, the recommendations of the LTCI Design Group, when implemented,
will create a more integrated service delivery system, and will improve the quality of care and the quality of life for older adults and adults with disabilities.

VII. Purpose of LTCI Strategic Plan

The purpose of the LTCI Strategic Plan is to guide improvements in the organization, availability, and financing of LTSS in San Francisco. The implementation of the LTCI recommendations will make improvements in the City’s overall system for delivering long-term services and supports for the benefit of all older adults and adults with disabilities in San Francisco.

In addition, specific improvements recommended will integrate home and community-based LTSS with the delivery of primary and acute care services, and institutional long-term care services, for older adults and adults with disabilities enrolled in Medi-Cal. Assuming San Francisco becomes one of the Cal MediConnect counties in 2015, those dually enrolled in Medicare and Medi-Cal will also be included.

All three Health Plans in San Francisco (the San Francisco Health Plan, Anthem Blue Cross Health Plan, and On Lok Lifeways) will be participating in implementing the LTCI recommendations.

VIII. Situational Analysis (SWOT)

During the strategic planning process, the LTCI Scope of Services and Services Delivery Subcommittee developed an extensive analysis of the strengths and weaknesses of San Francisco’s current service delivery system as well as the opportunities and threats that provide the environment within which San Francisco’s transition to managed care will be taking place. This SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis is organized into the following components of an improved LTCI service delivery model:

1. Multiple Initial Contact Locations for Consumers
2. Defined and Coordinated Points of Entry
3. Improved Access to Information on Services for Consumers
4. Improved Access to Information on Services for Service Providers
5. Better Coordination of Services
6. Improve Access to Information on Consumers for Service Providers (Data)
7. Improved Efficiency and Better Use of Resources (Financial and Services)
8. Easier Access to Services for Consumers (Eligibility Determination/Comprehensive Intake and Assessment)
9. Improved Quality of Life
10. Improved Community and Family Support
11. Expanded Scope of Services and Capacity
12. Improved Service Quality
13. Training and Education for Consumers
14. Training and Education for Service Providers
15. Workforce Development
16. Other

See APPENDIX E for the SWOT analysis completed by the LTCI Scope of Services and Service Delivery Subcommittee.
SECTION IV. APPENDICES
**APPENDIX A:**
**COMMONLY USED ACRONYMS IN THE LONG-TERM CARE INDUSTRY AND IN SAN FRANCISCO**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAA</td>
<td>Area Agency on Aging</td>
</tr>
<tr>
<td>AAH</td>
<td>American Association of Homecare</td>
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<tr>
<td>AAHSA</td>
<td>American Association of Homes and Services for the Aging (former name for LeadingAge)</td>
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<tr>
<td>AARP</td>
<td>American Association of Retired Persons</td>
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<td>AASA</td>
<td>Aging and Adult Services Administration</td>
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<tr>
<td>ABAG</td>
<td>Association of Bay Area Governments</td>
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<tr>
<td>ABC</td>
<td>Anthem Blue Cross (Commercial Health Plan in Two-Plan Model)</td>
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<td>ABCD</td>
<td>Americans for Better Care of the Dying</td>
</tr>
<tr>
<td>ABN</td>
<td>Advance Beneficiary Notice</td>
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<tr>
<td>AC</td>
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<tr>
<td>ACCS</td>
<td>Assistive Community Care Services</td>
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<tr>
<td>ACE</td>
<td>Acute Care for Elders</td>
</tr>
<tr>
<td>ACF</td>
<td>Alternative Care Facility</td>
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<tr>
<td>ACLF</td>
<td>Assisted Care Living Facility (or Adult Congregate Living Facility)</td>
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<tr>
<td>ACOVE</td>
<td>Assessing Care of Vulnerable Elders</td>
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<tr>
<td>ACP</td>
<td>Advance Care Planning</td>
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<tr>
<td>ACS</td>
<td>Assistive Care Services</td>
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<td>AD</td>
<td>Advance Directives</td>
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<td>ADA</td>
<td>Americans with Disabilities Act</td>
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<td>ADC</td>
<td>Adult Day Care</td>
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<tr>
<td>ADHC</td>
<td>Adult Day Health Care</td>
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<tr>
<td>ADL</td>
<td>Activities of Daily Living</td>
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<td>Aging and Disability Resource Connection</td>
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<td>AFC</td>
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<td>AFCH</td>
<td>Adult Foster Care Home (or Adult Family Care Home)</td>
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<td>American Healthcare Association</td>
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<td>AHMANNH</td>
<td>Affordable Housing Management Association of Northern California, Nevada and Hawaii</td>
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<td>Association of Jewish Aging Services</td>
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<td>Assisted Living for the Elderly waiver</td>
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<td>Assisted Living Facility</td>
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<td>ALFA</td>
<td>Assisted Living Federation of America</td>
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<td>Description</td>
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<td>ALP</td>
<td>Assisted Living Program</td>
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<td>ALWPP</td>
<td>Assisted Living Waiver Pilot Project</td>
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<tr>
<td>ALZ</td>
<td>Alzheimer’s Disease</td>
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<tr>
<td>AND</td>
<td>Allow Natural Death</td>
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<tr>
<td>AoA</td>
<td>The Administration on Aging</td>
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<tr>
<td>API</td>
<td>Asian/Pacific Islander</td>
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<td>Adult Protective Services</td>
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<td>ASA</td>
<td>American Society on Aging</td>
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<tr>
<td>B&amp;C</td>
<td>Board and Care (Board and Care facility provides food, shelter, supervision and some help with ADLs for six or fewer seniors)</td>
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<td>California Association of Adult Day Services</td>
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<td>CAAP</td>
<td>County Adult Assistance Program</td>
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<td>CADA</td>
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<td>CAHF</td>
<td>California Association of Health Facilities</td>
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<td>California Association of Homes and Services for the Aging (former name for LeadingAge California)</td>
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<td>CALCRA</td>
<td>California Continuing Care Residents Association</td>
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<td>CANHR</td>
<td>California Advocates for Nursing Home Reform</td>
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<td>CARES</td>
<td>Comprehensive Assessment and Review for Long-Term Care Services</td>
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<td>CARF-CCAC</td>
<td>Commission on Accreditation of Rehabilitation Facilities; Continuing Care Accreditation Commission – accreditation program for CCRCs</td>
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<td>CARA</td>
<td>California Alliance for Retired Persons</td>
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<td>CASE</td>
<td>Coalition of Agencies Serving the Elderly</td>
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<td>CASP</td>
<td>Certified Aging Services Professional (formerly Retirement Housing Professional)</td>
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<td>CBAS</td>
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<td>CCLC</td>
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<td>Community Care Licensing Division</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<tr>
<td>CCPED</td>
<td>Community Care Program for the Elderly and Disabled</td>
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<td>Centers for Disease Control and Prevention</td>
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<td>CDDIC</td>
<td>Care Delivery &amp; Design Improvement Committee</td>
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<td>CHAPCA</td>
<td>California Hospital and Palliative Care Association</td>
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<td>CIL</td>
<td>Center for Independent Living</td>
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<td>CLF</td>
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<td>U.S. Department of Health and Human Services</td>
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<td>DOEA</td>
<td>Department of Elder Affairs</td>
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<td>DPAHHC</td>
<td>Durable Power of Attorney for Health Care</td>
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<td>Department of Public Health – San Francisco</td>
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<td>DRC</td>
<td>Disability Rights California</td>
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<td>EADACPA</td>
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<td>Extended Care Facility</td>
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<td>ENP</td>
<td>Elderly Nutrition Program</td>
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</table>
EOEA Executive Office of Elder Affairs
EOL End of Life
ESRD End Stage Renal Disease
FCA Family Caregiver Alliance
FPL Federal Poverty Level
GAFC Group Adult Foster Care
GEC Geriatrics and Extended Care
GNP Geriatric Nurse Practitioner
HHA Home Health Agency
HAN Healthy Aging Network
HBPC Hospital-Based Primary Care
HCB Home and Community-Based Care Waiver
HCBS Home and community-based services
HCE Home Care for the Elderly
HHS U.S. Department of Health and Human Services
HHS Home Health Services
HIPAA Health Insurance Protection and Accountability Act
HICAP Health Insurance Counseling and Advocacy Program
HMO Health Maintenance Organization
HPRD Hours per Resident Day
HRQL Health-Related Quality of Life
HSA Human Services Agency
IADL Instrumental Activity of Daily Living
IAHSA International Association of Homes and Services for the Aging
ICF Intermediate Care Facility (licensed same as SNF)
IFAS Institute for the Future of Aging Services
IHSS In-Home Supportive Services
IL Independent Living
ILA Independent Living Apartments (or Arrangements)
ILC Independent Living Center
ILRSF Independent Living Resource Center of San Francisco
ILTC Institutional Long-Term Care
ILU Independent Living Units
IOA Institute on Aging
JCAHO Joint Commission on the Accreditation of Health Care Organizations
LHH Laguna Honda Hospital and Rehabilitation Center
LGBT Lesbian, Gay, Bisexual and Transgender
LOC Level of Care
LOS  Length of Stay
LPN  Licensed Practical Nurse
LTAC  Long-Term Acute Care facility
LTC  Long-Term Care
LTCCC  Long-term Care Coordinating Council
LTCI  Long-Term Care Integration
LVN  Licensed Vocational Nurse
LWD  Living with Dignity

MCO  Managed Care Organization
MFP  Money Follows the Person Demonstration
MLRC  Multi-Level Retirement Community
MLTSS  Managed Long-Term Services and Supports
MOCI  Mayor’s Office of Community Interest
MOD  Mayor’s Office on Disability
MOH  Mayor’s Office of Housing
MSSP  Multipurpose Senior Services Program
Muni  Municipal Railway

N4A  National Association of Area Agencies on Aging
NaCCRA  National Continuing Care Residents Association
NA  Nurse Aide (or Assistant)
NAHC  National Association for Home Care
NAOWES  National Association of Older Worker Employment Services
NARFE  National Association of Retired Federal Employees
NASUA  National Association of State Units on Aging
NCAL  National Center for Assisted Living
NCBA  National Caucus and Center on Black Ages
NCCNHR  National Citizens’ Coalition for Nursing Home Reform
NCEA  National Center on Elder Abuse
NCOA  National Council on the Aging
NCPHS  Northern California Presbyterian Homes and Services
NCRA  National Center on Rural Aging
NCRF  National Center of Residential Facilities
NCSC  National Council of Senior Citizens
NCVLA  National Center for Voluntary Leadership in Aging
NF  Nursing Facility
NF/AC  Nursing Facility/Acute Hospital (Waiver)
NFCSBP  National Family Caregiver Support Program
NHAP  Nursing Home Administrator Program
NHCA  Nursing Home Component
NHCA  National Hispanic Council on Aging
NHCU  Nursing Home Care Unit
NHD  Nursing Home Diversion waiver
NHHCS  National Home and Hospice Care Survey
NHO  National Hospice Organization
NHRA  Nursing Home Reform Act
NIA  National Institute on Aging
NIAD  National Institute on Adult Day Care
NICA  National Interfaith Coalition on Aging
NICOA  National Indian Council on Aging
NIFSE  National Institute on Financial Issues and Services for Elders
NISC  National Institute of Senior Centers
NISH  National Institute of Senior Housing
NF  Nursing Facility
NORC  Naturally Occurring Retirement Community
NPA  National PACE Association
NSCLC  National Senior Citizen Law Center
NSRCF  National Survey of Residential Care Facilities
NVOILA  National Voluntary Organizations for Independent Living for the Aging

OAA  Older Americans Act
OLTC  Office of Long-term Care
OSHPD  Office of Statewide Health Planning and Development
OWL  Older Women’s League

PACE  Program of All-Inclusive Care for the Elderly
PADL  Performance Activities of Daily Living Scale
PCA  Personal Care Aide (or Assistant)
PCU  Personal Care Unit
PoC  Plan of Care
POP  Protect Our Parents
PPO  Preferred Provider Organization
PRC  Prevention Research Center
PSDA  Patient Self-Determination Act
PSO  Provider Service Organization

QA  Quality Assurance
QI  Quality Improvement
QIO  Quality Improvement Organization

RC  Resource Center for Seniors and Adults with Disabilities
RCFCI  Residential Care Facility for the Chronically Ill
RCFE  Residential Care Facility for the Elderly
RCH  Residential Care Home
RLA  Residential Living Apartments (or Arrangements)
RN  Registered Nurse
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>SCPP</td>
<td>Services Connection Pilot Project</td>
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<tr>
<td>SCSEP</td>
<td>Senior Community Service Employment Program</td>
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<td>SDSD</td>
<td>Senior and Disabled Services Division</td>
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<td>SFGH</td>
<td>San Francisco General Hospital</td>
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<td>SFHA</td>
<td>San Francisco Housing Authority</td>
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<td>SFHP</td>
<td>San Francisco Health Plan (Local Initiative Health Plan)</td>
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<td>San Francisco Redevelopment Agency</td>
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<td>SHMO</td>
<td>Social HMO</td>
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<td>SILC</td>
<td>State Independent Living Council</td>
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<td>Service Payments for Elderly and Disabled program</td>
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<td>SUA</td>
<td>State Unit on Aging</td>
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<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunities and Threats</td>
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<td>TCM</td>
<td>Targeted Case Management</td>
</tr>
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<td>TCU</td>
<td>Transitional Care Unit</td>
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<td>WARP</td>
<td>Wage Adjustment Rate Program</td>
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<td>WDD</td>
<td>Workforce Development Division</td>
</tr>
<tr>
<td>WID</td>
<td>World Institute on Disability</td>
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</tbody>
</table>
APPENDIX B:
REQUIREMENTS FOR MEDI-CAL AND MEDICARE PROGRAMS

Requirements for Medi-Cal

There are a number of different ways people may qualify for Medi-Cal. People may automatically be eligible for Medi-Cal if they receive cash assistance under one of the following programs:

- SSI/SSP (Supplemental Security Income/State Supplemental Program)
- CalWORKs (California Work Opportunity and Responsibility to Kids). Previously called Aid to Families with Dependent Children (AFDC).
- Refugee Assistance
- Foster Care or Adoption Assistance Program.

Even if cash assistance is not received, people may be eligible for Medi-Cal if they meet the following criteria:

- 65 or older
- Blind
- Disabled
- Under 21
- Pregnant
- Diagnosed with breast or cervical cancer
- In a skilled nursing or intermediate care facility.
- Refugee status during a limited period of eligibility. Adult refugees may or may not be eligible depending upon how long they have been in the U.S.
- Parent or caretaker relative of a child under 21 and
- The child's parent is deceased or does not live with the child, or
- The child's parent is incapacitated, or
- The child's parent who is the primary wage earner is unemployed or underemployed.

Requirements for Medicare

There are many ways to qualify for Medicare. Medicare has four parts, each of which has its own requirements:

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35 http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFAQs.aspx#whocangetmedi-cal
36 http://ssa-custhelp.ssa.gov/app/answers/detail/a_id/400/~/how-to-qualify-for-medicare
Hospital Insurance (also known as Part A)

65 or Older – Most people 65 or older are eligible for Medicare hospital insurance (Part A) based on their own—or their spouse’s—employment. People are eligible at 65 if they:

- Receive Social Security or railroad retirement benefits;
- Are not getting Social Security or railroad retirement benefits, but have worked long enough to be eligible for them;
- Would be entitled to Social Security benefits based on spouse’s (or divorced spouse’s) work record, and that spouse is at least 62 (spouse does not have to apply for benefits in order for other spouse to be eligible based on their work); or
- Worked long enough in a federal, state, or local government job to be insured for Medicare.

Under 65 – Those under 65 are eligible for Medicare hospital insurance if they:

- Get Social Security disability benefits and have amyotrophic lateral sclerosis (Lou Gehrig's) disease; or
- Have been a Social Security disability beneficiary for 24 months; or
- Have worked long enough in a federal, state, or local government job and meet the requirements of the Social Security disability program.

Eligibility For Family Members – Under certain conditions, an individual’s spouse, divorced spouse, widow or widower, or a dependent parent may be eligible for hospital insurance when their spouse turns 65, based on that individual’s record.

Also, disabled widows and widowers under age 65, disabled divorced widows and widowers under 65, and disabled children may be eligible for Medicare, usually after a 24-month qualifying period. (For disabled widows/widowers, previous months of eligibility for Supplemental Security Income (SSI) based on disability may count toward the qualifying period.)

Kidney Failure – Special rules apply to people with permanent kidney failure. Under these rules, individuals are eligible for hospital insurance at any age if they receive maintenance dialysis or a kidney transplant and:

- Are insured or are getting monthly benefits under Social Security or the railroad retirement system; or
- Have worked long enough in government to be insured for Medicare.
In addition, an individual’s spouse or child may be eligible, based on that individual’s work record, if she or he receives continuing dialysis for permanent kidney failure or had a kidney transplant, even if no one else in the family is getting Medicare.

**Individuals Who Do Not Qualify Under Previous Rules** – Certain aged people who do not qualify for Medicare hospital insurance under these rules may be able to get it by paying a monthly premium. They also must always enroll in medical insurance (Part B) to get this coverage. Certain disabled people who lost premium-free hospital insurance because they work can get Medicare hospital insurance again by paying a premium.

**Medicare Medical Insurance (also known as Part B)** – Almost anyone who is 65 or older or who is under 65 but eligible for Medicare hospital insurance under these rules can enroll for Medicare medical insurance by paying a monthly premium. Anyone aged 65 or older does not need any Social Security or government work credits to enroll in this part of Medicare.

**Medicare Advantage Plans (also known as Part C)** – People with Medicare Parts A and B can choose to receive all of their health care services through an approved provider organization under Part C. There might be additional premiums required for some plans.

**Prescription Drug Coverage (also known as Part D)** – Anyone who has Medicare hospital insurance (Part A), medical insurance (Part B) or Medicare Advantage plan (Part C) is eligible for prescription drug coverage (Part D). Joining a Medicare prescription drug plan is voluntary and you pay an additional monthly premium for the coverage.

**Challenges around Medicare and Medicaid**

The Budget Control Act of 2011 mandated that if legislation to meet budget targets were not enacted by January 2013, a process known as “sequestration” would be initiated to meet budget targets. Sequestration is a budget process under which spending cuts (with certain exceptions) are made across the board to meet budget goals. These cuts are required to be spread equally among the fiscal years 2013 through 2021 and divided evenly between both defense and non-defense functions, including Medicare payments to providers.

While these mandatory cuts were postponed for two months, they went into effect April 1, 2013, causing payment to Medicare providers (Medicare Parts A and B) to be cut by approximately 2 percent; this affects approximately 90 percent of Medicare spending. Approximately 8 percent of Medicare spending is exempt from these mandatory cuts. These include low-income subsidies and additional subsidies for beneficiaries whose spending exceeds catastrophic levels in Part D. The remaining 2 percent would be subject to a 7.6 percent cut because it falls under non-exempt non-defense mandatory programs. According to preliminary White House Office of Management and Budget estimates, Medicare will be hit with a total of $11.085 billion in reimbursement cuts in 2013. These cuts will begin for services delivered starting April 1, 2013, on Medicare Part A and B payments. Unless new legislation is passed,
Sequestration is scheduled to last almost nine years (2013 through 2021). Medicaid is exempt from the sequester.

In addition to the sequestration cuts that went into effect April 1, physicians will be hit with payment cuts caused by reductions in the Medicare Sustainable Growth Rate (SGR) payments. Medicare SGR is a method currently used by the Centers for Medicare and Medicaid Services (CMS) to control Medicare spending on physician services to ensure that the yearly increase in the expense per Medicare beneficiary does not exceed the growth in the gross domestic product. Each year, CMS prepares a report to advise Congress on the previous year’s total expenditures and target expenditures. This report contains a conversion factor that will change the payments for physician services for the next year to match the target SGR. If the expenditures for the previous year exceeded target expenditures, the conversion factor will decrease payments to physicians the following year. If expenditures were less than expected, the conversion factor will increase payments.

The SGR was set to reduce physician payments by 19.7 percent compared to 2012 beginning March 1, 2013. In a letter to Congress sent September 12, 2012, the American Medical Association and more than 100 other provider lobbying organizations wrote, “The combination of the sequestration cut and looming Medicare Sustainable Growth Rate (SGR) payment cut would not only impede improvements to our health care system, it could lead to serious access to care issues for Medicare patients as well as employment reductions in medical practices.” On January 1, 2013, Congress passed the American Taxpayer Relief Act of 2012 which delays the implementation of the SGR reduction until January 1, 2014.

There are some additional changes to Medicare for 2013:

- Medicare Part B adds coverage for eight face-to-face counseling sessions for people who want help to stop smoking – also offers obesity screening and intensive counseling for those who screen positive.
- In 2013, Part D plans will be allowed to cover benzodiazepines and barbiturates such as those used in the treatment of chronic mental disorder, epilepsy, or cancer.
- Medicare Part B premiums will increase by a few dollars each month in 2013. The monthly premium for the part of Medicare that covers doctor visits and outpatient hospital care will increase for most people by about $5 in 2013. The Part B deductible for physician appointments and other outpatient care will increase about $7.
- The Part A deductible for up to 60 days of inpatient hospital services will increase about 2 percent. To encourage hospitals, doctors, and other providers to work together, PPACA allows for payment bundling. This means hospitals, doctors, and providers are paid a flat rate for an episode of care rather than the current fragmented system where each service or test is billed separately to Medicare.

Changes to Medicaid for 2013:

- Beginning January 1, 2013, states are allowed to cover specified preventative services at no cost to Medicaid adult beneficiaries. States receive a 1 percent increase in federal matching payments to provide these services.

- As Medicaid programs and providers prepare to cover more patients in 2013, the Affordable Care Act requires states to pay primary care physicians no less than 100 percent of Medicare payment rates in 2013 and 2014 for primary care services. The increase above current payment levels is fully funded by the federal government. States will need to shift to a uniform income eligibility standard (modified adjusted gross income) for most coverage groups and coordinate closely with exchanges in implementing these processes to establish a “no wrong door” enrollment approach so that, regardless of a person’s point of entry, eligibility is determined for all insurance affordability programs. States must these new requirements regardless of whether they expend Medicaid coverage in 2014. States must be set by October 1, 2013, to accept electronic enrollment.
APPENDIX C:

CASES USED TO CONSIDER THE NEED FOR CRUCIAL LONG TERM SERVICES AND SUPPORTS

Case #1: Younger adult with brain injury. The client is a dependent adult, male, Pacific Islander, 36. He suffered a traumatic brain injury at 27. His father was his primary care giver until he passed away and he was being taken care of by extended family. He has had his case opened several times since 2007 when he had poor medical follow-up and poor personal hygiene. In this follow-up case, his extended family members were the alleged abusers and he was being isolated.

The case was opened because his family members moved all of his Social Security checks to Englewood and there were allegations of IHSS fraud. His family took him off his housing lease and out of the Stepping Stone program. He spends his day wandering around Sunnydale projects. DPS has had an assessment done on him; they are trying to get him re-enrolled into Stepping Stone and get him a rep payee, as his benefits were suspended. His IP (Independent Provider) is his neighbor and he has been referred to Walden House and Mission Creek as well as Linkages.

<table>
<thead>
<tr>
<th>Gaps</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>- Information tracking – flow information among providers</td>
<td>- How to manage family dysfunction (theft, abuse, etc.)</td>
</tr>
<tr>
<td>- Training for providers in the use of assistive technology</td>
<td>- Losing the client – the bridge between the system and the person</td>
</tr>
<tr>
<td>- Linkages – wait list (2 months)</td>
<td></td>
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<tr>
<td>- APS – often the gap filler and point of entry</td>
<td></td>
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<tr>
<td>- Multi-disciplinary team model</td>
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<table>
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<tr>
<th>What Works</th>
<th>Efficiencies Needed</th>
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</thead>
<tbody>
<tr>
<td>- Stepping Stone</td>
<td>- Need centralized data system, so that clients don’t get lost</td>
</tr>
<tr>
<td>- IP was a great asset</td>
<td>- Intake as the hub</td>
</tr>
<tr>
<td></td>
<td>- Databases are not integrated – they don’t talk to each other (DPH, DAAS, etc.)</td>
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Coordination Challenges

<table>
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<tr>
<th>Resources Needed</th>
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<tbody>
<tr>
<td>- None</td>
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**Case #2: Middle aged adult, homeless, with alcohol and substance abuse.** The client is a 54 year old Caucasian male with a history of numerous admissions to San Francisco General Hospital and Laguna Honda Hospital over the past five years. He has a history of homelessness/marginal housing and alcohol and heroin use. In May 2012 he was discharged to a unit at Civic Center Residences through the Diversion and Community Integration Program (DCIP). His primary needs are:

- **Medical Care/Physical Health** – Diabetes, methadone program, receives meals delivered and purees food.
- **Mental Health** – He has mild cognitive impairment, history of depression and psychosis. Symptoms managed with medications. Client considering meeting with a home-based psych student for brief therapy re: depressive symptoms.
- **Housing** – He refused Board and Care and now has a studio apartment with on-site Case Manager. CLF purchased home set-up items. Client pays 50% of his SSI income to rent and West Bay Housing provides the other 50% through the DCIP rental subsidy program. Client receives redirection and reassurance as necessary from the Case Manager as well as facilitation in getting him to providers and reminders about appointments.
- **Finances** - Client requires assistance with budgeting and maintaining good standing with utilities, etc. Client has poor judgment with purchases.
- **Functional Abilities** – Client requires some assistance with bathing and personal care. He also requires assistance with IADLs and some adaptive equipment.
- **Habilitation/Vocational Rehab** – Client reports being interested in going back to school but has some previous issues with student loan debt. Client is not engaging in activities at his building and has yet to find activities in the community.
- **Case Management** – Client is unable and often unwilling to coordinate the array of services that he receives. Client misses appointments with providers, at time is not compliant with medications, has poor judgment and insight into his medical frailty.

<table>
<thead>
<tr>
<th>Gaps</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>Services delivered in housing that build community</td>
<td>Creating a bridge between DAAS and DPH</td>
</tr>
<tr>
<td>Without West Bay Housing and CLF, this client would have really struggled</td>
<td>Meaningful activities for this age group</td>
</tr>
<tr>
<td>Social centers for younger disabled – senior centers are seeing younger clients and are they prepared from a programming point of view</td>
<td>Cognitive issues combined with physical issues</td>
</tr>
<tr>
<td>Substance abuse treatment</td>
<td>Compatibility with provider</td>
</tr>
<tr>
<td>Need social wellness models</td>
<td>Personal choice against the back drop of substance abuse</td>
</tr>
<tr>
<td>Services provided at scattered sites</td>
<td>Addiction</td>
</tr>
<tr>
<td>MDT care planning</td>
<td>Creating community across age and culture</td>
</tr>
<tr>
<td>What Works</td>
<td>Efficiencies Needed</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>• Housing</td>
<td>• Incorporating aging well and chronic disease management programs</td>
</tr>
<tr>
<td>• Combination of CLF and West Bay</td>
<td>• How to take advantage of the fact that clients are coming back to natural support systems like Laguna Honda</td>
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<thead>
<tr>
<th>Coordination Challenges</th>
<th>Resources Needed</th>
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<tbody>
<tr>
<td>• Medication monitoring (done in the Consortium)</td>
<td>• Real single entry point</td>
</tr>
<tr>
<td>• MDT care planning</td>
<td>• Information tracking system that is accessible to all relevant providers</td>
</tr>
<tr>
<td>• Consolidated and integrated care plan and providers having access to that plan</td>
<td>• Case #2 highlights the cost of extensive service needs. How will this be handled in managed care?</td>
</tr>
<tr>
<td>• Lead care coordinator</td>
<td></td>
</tr>
<tr>
<td>• Coordinating myriad of services and the providers</td>
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**Case #3: Older adult, mono-lingual Chinese, with dementia.** The client is with the IHSS Consortium for home care and support, and this case was started by DPS. He is a 79 year old man who speaks Chinese and very little English. He has dementia, is legally blind but can still do things for himself. The MSSP program handled the medical part of his case and an IHSS Social Worker was handling part of the case at the time of intake. In 2011, there were multiple reports from his Independent home care provider of self-neglect and sexual harassment after his wife went into a long-term care facility. He was also calling 911 many times a day reporting that family or others were stealing money from him. He was reportedly losing weight so the case was referred to the Consortium to stabilize his care. Without community supports, this client would have been hospitalized for malnutrition and self-neglect. He was at one point a 5150 and SF General Hospital recommended him to a Skilled Nursing Facility but he refused and he didn’t meet the criteria for conservatorship. The interventions the IHSS Consortium put in place match him with a Cantonese male home care provider, work with him on his behavior so that he took responsibility for his actions, and train his home care providers – this has helped the case currently be stable.
<table>
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<tr>
<th>Gaps</th>
<th>Challenges</th>
</tr>
</thead>
</table>
| • How do we track and quantify improvement in a client’s condition? | • Entry point – so much depends on where the client enters the system  
• Behavioral issues are more complex to manage than health care issues  
• Ability to honor individual choice  
• Cultural diversity, language diversity, neighborhood diversity |

<table>
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<tr>
<th>What Works</th>
<th>Efficiencies Needed</th>
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</table>
| • IHSS Consortium  
• Ability to have a mixed IP/Contract role  
• Para-medical services allow the client to stay home longer | • |

<table>
<thead>
<tr>
<th>Coordination Challenges</th>
<th>Resources Needed</th>
</tr>
</thead>
</table>
| • Process for referral to PACE (On Lok)  
• How 911 connects to services | • Good cost benefit with this client |

**Case #4: Older adult, living alone, using senior center services, case management, and home care services.** Client is an 89 year old Chinese male, living alone in his self-owned condominium in the OMI neighborhood. He speaks fluent English and Chinese. He attends a Senior Center on a daily basis for lunch, food distribution programs, healthy aging activities, socialization and other activities. He uses a cane, has limited vision and limited hearing. He most recently has started having issues with his teeth which cause difficulties and pain in eating and has lost weight as a result.

The client started receiving Case Management Services in 2007 from Catholic Charities when he was planning to have knee surgery and knew he would need some help at home. He also had a deep house cleaning back in 2007 and in 2011 had a home safety evaluation. His SSI has increased because of help from legal assistance and he now receives home care service from IHSS for his ADL’s and IADL’s. He is pretty independent in his ADL’s and only needs some verbal assistance with most of his IADL’s. This case shows that providing key services works. The Senior Center has been available and built a relationship with this man, and 20 years later the services are there to help him. His primary needs are:

• Nutrition services  
• Health aging activities  
• Socialization  
• Vision and hearing problems  
• Dental problems  
• Case management services  
• Home care services
<table>
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<tr>
<th>Gaps</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>• Healthy food (fruits and vegetables)</td>
<td>• Language and cultural issues</td>
</tr>
<tr>
<td>• Knowledge of what is out there to help people</td>
<td>• Nature of the introverted individual</td>
</tr>
<tr>
<td>• Training for IPs (minimum training standards)</td>
<td>• Some clients don’t want help and don’t reach out until it is an emergency</td>
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<tr>
<td>• Dental Care</td>
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<tr>
<th>What Works</th>
<th>Efficiencies Needed</th>
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<tbody>
<tr>
<td>• Senior Center involvement</td>
<td>• In this case, the relationship among APS, CLF and Catholic Charities was crucial</td>
</tr>
<tr>
<td>• Healthy Aging activities</td>
<td>• Good point of entry in this case (Catholic Charities), not through SNF, DPH or LHH</td>
</tr>
<tr>
<td>• Catholic Charities case manager</td>
<td></td>
</tr>
<tr>
<td>• Work of committed individuals within the system</td>
<td></td>
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<tr>
<td>• Nutrition/meals/food pantry services</td>
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<tr>
<th>Coordination Challenges</th>
<th>Resources Needed</th>
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</thead>
<tbody>
<tr>
<td>• Seniors making future planning decisions</td>
<td>• Highlights the importance of smaller safety net programs and the funding for those:</td>
</tr>
<tr>
<td>• Coordination with family members</td>
<td>o CHIPPS</td>
</tr>
<tr>
<td>• Multi-Disciplinary Team (or Inter-Disciplinary Team)</td>
<td>o Rebuilding together</td>
</tr>
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<td></td>
<td>o EOC fund (PG &amp; E)</td>
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APPENDIX D: CRUCIAL LONG-TERM SERVICES AND SUPPORTS (LTSS) TO BE COORDINATED WITH, PURCHASED BY, OR INCLUDED IN THE SAN FRANCISCO LTSS MANAGED CARE SYSTEM

Below are the service areas the LTCI Scope of Services and Service Delivery Subcommittee identified as crucial to be: (1) provided, (2) coordinated, or (3) purchased in the San Francisco LTSS managed care system. Within each of these service areas, specific services are listed. With the exception of Nursing Facility Services, all of these services play a critical role in keeping seniors and people with disabilities healthy and safe in the community. Nursing Facility Services are included because they are a component of the CCI. Unless otherwise specified, data provided is as of December 2012.

This document also identifies existing programs and gaps in each of the service areas. It is important to be aware that dementia services and support competencies need to be developed across all these listed service areas. The Subcommittee also identified the need to create a set of values that would guide its work in this area and highlighted cultural sensitivity and appropriateness and the ability to reach transient populations as key values.

The financial analysis undertaken by the LTCI Finance Subcommittee, which explores the costs of specific services that help people remain at home and in the community, and which may be provided by Health Plans, is found earlier in this report. The services analyzed are a subset of this list of crucial services. Accordingly, there is not an exact correlation between this list of crucial services and the specific services analyzed by the LTCI Finance Subcommittee.

- **Home Care Services**

San Francisco has a high usage of IHSS with an average of 26.7 individuals per 1,000 receiving IHSS, the state average is 12.1 per 1,000.

- IHSS (CCI component): 21,611 individuals receive IHSS services at an average cost of $16,054 per person. IHSS is one of the services that would be transitioned to managed care and the Health Plans under the Coordinated Care Initiative.

- Office on Aging (OOA) Home Care: 320 individuals receive IHSS Emergency Chore, Homemaker, and Personal Care services averaging between $47 and $55 per person.

- Private Pay Home Care: There are 32 home care agencies in San Francisco. These range from home health agencies that provide skilled therapies and licensed staff (RN, PT, OT, RD, etc.) to home care agencies that provide

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38 DAAS 2011 Services for Seniors and Adults with Disabilities.
homemaker and chore services. Those that provide skilled therapies usually take Medicare. There are a limited number of organizations that take Medi-Cal.

- **Other funding sources:** A limited amount of home care may be provided by other funding sources, such as Community Living Fund (CLF) and the DHCS In-Home Operations Waiver (IHO).

**Issues:** The Governor’s budget for FY 2013-14 calls for a 20 percent cut in funding for IHSS. This may impact providers and consumers.

**Care Management**

- **Multipurpose Senior Services Program (CCI component):** MSSP has 450 active slots for individuals in San Francisco. MSSP serves about 700 unduplicated clients per year. The number served is capped and there is currently a waiting list. MSSP is one of the services that would be transitioned to managed care and the Health Plans under the Coordinated Care Initiative. MSSP has a level of care determination for entry.

- **Community Living Fund:** CLF has about 250 active clients (18+ in age and up to 300 percent poverty) who are receiving intensive time-limited case management services as they transition to the community. It is important to note that CLF is the “payor of last resort” and would seek to access home care services from other programs prior to paying for them out of the fund. CLF works with the client for approximately six months and then transitions them to other programs. CLF is also available to those clients who are residing in the community, but are at risk of institutional placement. This covers the difference between SSI/SSP payment and the true cost of board and care. CLF collaborates with the DCIP which seeks “to identify and secure housing and services for 100 eligible Laguna Honda clients each year who wish to move to community-based settings.

- **Transitional Care Program:** For seniors and adults with disabilities coming out of acute care settings. Transitional Care is a short-term intervention involving coaching patients on issues related to their health, their understanding of their diagnosis and treatment, and their medications. There is short-term care coordination for those in need of a more extensive intervention. Transition specialists can access a limited number of meals, transportation, and home care hours for those clients who need them.

- **Office on Aging Case Management:** OOA, through contracts with service providers in San Francisco, provides case management services to 2,046 individuals at a cost of about $3,500 per person per year. DAAS funds long and short term and transitional case management services in at least 13 languages.
- **Targeted Case Management**: San Francisco serves 202 clients at a cost of $411 per client.

- **Linkages**: There are 162 younger adults with disabilities served through Linkages at a cost of $1,783 per person.

- **IHSS Consortium** provides intensive supervision services for its clientele.

- **Department of Public Health**: DPH Community Behavioral Health Services funds a variety of case management programs for people with behavioral health issues.

- **Office on Aging – Money Management**: OOA provides money management for 90 individuals at a cost of $1,114 per person. DHS and DPH also have a Rep Payee program through Conard House focused on homeless and individuals with behavioral health issues as requested by SSI. DAAS also has direct service Rep Payee program (Conard House) that services 1,500 individuals.

- **Care Coordination for people with developmental disabilities**: The Lanterman Act and services provided by the Regional Center.

**Issues:**
- Care coordination for younger adults with disabilities.
- Depending on the number of CBAS clients who are determined to no longer be eligible, the need for MSSP services as “enhanced case management” for these clients will increase.

- **Adult Day Services**
  - **Community-Based Adult Services (CBAS - CCI component)**: CBAS, formerly Adult Day Health Care (ADHC), is one of the services that is being transitioned to managed care and the Health Plans under the Coordinated Care Initiative. There are nine ADHC Centers in San Francisco.
  
  - **PACE (Program of All-inclusive Care for the Elderly)**: On Lok Lifeways includes ADHC as part of community-based services offered by its PACE program. Five of those ADHC centers are operated by On Lok and two are operated by the Institute on Aging.
  
  - **Alzheimer Day Care Resource Centers (ADRCs)**: There are three ADCRCs in San Francisco (Rosenberg Center IOA, Self Help for the Elderly, and Catholic Charities

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39 DAAS Assessment of the Needs of Seniors and Adults with Disabilities.
San Francisco provides support for 96 people in ADCRCs at $2,539 per person.

- **Adult Day Care (ADC - Social Day):** There are four stand-alone ADCs in San Francisco: two operated by IOA, one by Catholic Charities, and one by Kimochi. Most of the ADHCs have now become dually-licensed as ADHC/ADC sites.

**Issues:**
- People who don’t qualify under new CBAS rules.
- People who can’t afford to pay their share of cost.
- San Francisco lacks sufficient day facilities for individuals with dementia.

**Medication Management**

There are numerous organizations like ADHC, home health and others that provide medication management as part of their scope of services including:

- **Direct Access to Housing (DAH-DPH):** As part of this program, the service provider may provide medication management for select individuals.

- **OOA provides funding for medication screening** and education to an individual and/or caregiver to prevent incorrect medication and adverse drug reactions.

**Issues:** Given that there are 1.5 million adverse drug events resulting in 7,000 deaths annually in the U.S., it is safe to assume that this is a significant issue in San Francisco.

**Nutrition**

DAAS is the primary funder of meals programs (congregate and home-delivered meals) in San Francisco.

- **OOA Meal Programs**

  - **Congregate meals:** San Francisco provides funding for 14,546 individuals who received congregate meals at a cost of $284 per person. There are 57 congregate meal sites in San Francisco. These include both senior centers and adult day care sites.

  - **Home-delivered meals:** San Francisco provides funding for 3,872 people receiving home-delivered meals at a cost of $1,132 per person. Eleven providers deliver meals to homes. Six of those providers focus on culturally appropriate meals in the following categories: Latino (Central Latino), Kosher (JCC), Japanese (Kimochi), persons with HIV, Russian (Russian American Community Services) and Chinese (Self Help for the Elderly). One of the providers, Meals on Wheels SF, delivers two seasonal, culturally diverse meals citywide.
• SRO Food Program: San Francisco provides food for 187 people at a cost of $401 each.

• Emergency Home-Delivered Meals (CLF funded)

  o Free Grocery Programs

    • Brown Bag: San Francisco provides food for 288 individuals at a cost of $181 per person.

    • Groceries for the OMI Food Network: San Francisco provides funding for 40 people at a cost of $600 each.

    • Senior Emergency Grocery Bag: San Francisco provides funding for 800 individuals at a cost of $63 each.

    • Supplemental Grocery Food Projects: OOA funding for culturally appropriate supplemental groceries and delivery services to homebound seniors and adults with disabilities who live in SROs.

    • Federal commodity distributions

    • Food pantries

    • Free grocery delivery programs

    • Free produce at community farms

  o Food Voucher Programs

    • CalFresh

    • Senior Farmer’s Market Nutritional Program

Issues:

• Waiting lists for home-delivered meals

• SSI recipients in California cannot access CalFresh and are at high nutritional risk. Over 19,000 seniors in San Francisco living on SSI ($845/month) are below the poverty line and are not eligible for CalFresh

• Transportation to meal sites

• Transportation

  o Paratransit: While San Francisco has four paratransit services (Central Latino, Kimochi, Mobility Plus, and Self Help for the Elderly), Mobility Plus (Muni) is the primary provider. Centro Latino, Kimochi, and Self Help provide services using DAAS funds. Additionally, it has transit services that are specific for individuals
who are receiving chemotherapy, who are blind, and who are receiving services at St. Francis Hospital. DAAS funds the paratransit program in a direct grant to Muni through Older American Act funds.

- **Taxi Vouchers**: San Francisco provides subsidized taxi vouchers and wheelchair equipped vans for adults with disabilities and seniors.

- **OOA Paratransit supplement**
  - Door-to-door
  - Fixed route
  - Ridesharing

**Issues**: Given the expanding senior population, it is anticipated that there will be additional need for transportation services. Efforts need to continue to make regular and ramp taxis available in a more equitable way to those that need them.

- **Caregiver Support**

Adult Day Health Care Centers, Adult Day Care Centers, and Alzheimer’s Day Care Resource Centers are extremely important caregiver supports. Additionally, the following groups provide support directly or put individuals in touch with other caregivers with whom they can share emotional support, understanding, and suggestions for handling challenges: Alzheimer’s Association, Catholic Charities, Edgewood Center for Children and Families, Family Caregiver Alliance, Institute on Aging, Jewish Family and Children’s Services, Kimochi, and Self Help. Additional programs are:

- **Respite**: San Francisco provides some funding for respite services.

- **Family Caregiver Support Program**: OOA provides funding for outreach to caregivers who assist older adults including I & R, counseling, respite, case management, transportation, counseling, and supplemental home care services. The majority of the funding goes to Family Service Agency.

**Issues**: Asian and Latino communities’ access
• **Social Interaction Opportunities**

12,000 men and 22,000 women age 65+ live alone in San Francisco. Between 8,000 and 11,000 adults with disabilities and seniors have limited social contact. 19 percent of those over age 60 need assistance with socialization. LGBT seniors face particular challenges – the pressure to live a closeted life as an LGBT senior is in itself isolating, and LGBT seniors who are “out” sometimes struggle with lack of acceptance from family members.

**Senior Activity Centers:** San Francisco has 57 seniors centers scattered throughout the city, many focused on specific ethnic groups providing language access and culturally appropriate programming and meals.

**Community Living Campaign:** The Community Living Campaign uses the power of relationships to reduce isolation and to eliminate barriers to aging in community. They do this by strengthening networks of support for individuals and across neighborhoods – networks that promote acts of kindness and a spirit of justice. They teach people how technology and social media are new tools to help individuals and organizations better reach these goals.

**SF Connected:** DAAS and the Dept of Technology have a 3-year federal grant to provide extensive training, computers, and broadband connections throughout San Francisco with a series of partners, including senior centers, adult day and supportive housing sites, after school programs, youth organizations, digital media partners, and City College of San Francisco.

**Hoarders and Clutterers:** San Francisco provides funding for 70 people at $2,734 per person.

**Issues:** While there is no shortage of senior centers, many seniors are home bound and, as such, are not able to access the centers. Additionally, there are limited transportation options to bring seniors to the centers. There is a lack of centers for younger people with disabilities.

• **Protective Services**

  o **Public Guardian (PG):** Many people have physical and mental limitations that make them unable to handle basic personal and financial needs. The situations of these people vary greatly, but all are highly vulnerable to either physical, emotional or financial abuse, and neglect. The San Francisco Superior Court, under the authority of the California State Probate Code, can appoint the Public Guardian’s office to serve as the conservator to these persons.

The Public Guardian is responsible for: assessing physical, mental, and financial needs of the conservatee, ensuring appropriate medical care, social work services, money management services and budgeting, locating appropriate housing or shelter, establishing eligibility for government and private benefit programs, developing a comprehensive care plan encompassing both immediate and long-term care.
Adult Protective Services (APS): APS investigates possible abuse or neglect of elders, adults with disabilities, and dependent adults. The abuse may be physical, emotional, financial, neglect by others, or self-neglect. Any services provided by APS are voluntary; the adult who is offered the services must consent to receive them.

If abuse is suspected, social workers provide short-term counseling, case management, and referral services to stop the abuse and ensure the ongoing safety of the person, involving the courts if required, and if the victim agrees. These services are available to all residents 65 and over, or disabled/dependent younger adults, 18-64. There are no fees for these services.

Issues: For the PG, a major issue is a shortage of placement/housing options, including a severe shortage of board and care beds and lack of placement/housing options in San Francisco. For PS, a shortage of community service resources means that APS can't be as effective as possible.

- Ombudsman Services

The Ombudsman Program is required by federal and state law to advocate for the rights of people living in San Francisco's skilled nursing facilities, residential care facilities for the elderly, and assisted living programs. The Ombudsman receives and responds to individual complaints and issues by, or on behalf of, these residents. These may include allegations of elder abuse.

Those eligible are older adults, 60 years of age or older, or dependent adults (18 - 60 years) who are residents of long-term care facilities (nursing, skilled nursing, distinct part nursing facilities, residential care facilities for the elderly, and other adult care homes similar to these facilities) regardless of their income. The Ombudsman Program also may serve residents under 60 years of age if a majority of the residents of the facility where the younger person resides are over 60.

Issues: Inadequate funding to meet state and federal mandates for ombudsman services.

- Prevention Services

  - DPH Community Health Promotion and Prevention Unit: This DPH program promotes health and prevents disease and injury. While a spectrum of prevention programs exist throughout the Department, DPH is modeling an approach to prevention that changes the societal context in which disease and injury occur (called the "environmental" approach). To be effective, this approach depends upon the active involvement of the community. DPH also provides consultation, program planning, professional development, and organizational development and mentoring, with a focus on primary, community based prevention.

The Community Health Education Section (CHES) constitutes the main part of the Community Health Promotion and Prevention Branch. CHES focuses on primary prevention, emphasizing
strategies, alliances, and interventions that change the physical and socioeconomic environment. CHES approaches, theories, and practice are grounded in the core public health functions of prevention and social justice, and involve residents in the diagnosis of problems, assessment of strengths and resources, and the implementation of solutions.

- **DAAS Health Promotion Program: Always Active SM**
  30TH Street Senior Center serves as the lead agency in a citywide, evidence-based health promotion program, called Always Active SM, in collaboration with experienced providers. They are: the University of San Francisco’s Department of Exercise and Sport Science, San Francisco Senior Centers, and nine different senior services organizations. The program designed for older adults offers:
  - Group exercise classes for strength training, balance and flexibility
  - Fall Prevention Workshops designed for frail older adults
  - Health and Wellness Education Presentations
  - Capacity Building Training
  - Wellness Trainer Workshop
  - One-on-one consultation with professional personal trainers
  - Wellness plan development

- **DAAS Healthier Living-Managing Ongoing Chronic Health Conditions**
  This program consist of a series of 2 ½ hour workshops presented over a 6-week period by two trained leaders, one or both of whom are non-health professional with a chronic disease themselves. This award-winning program was developed by Stanford University. The curriculum includes workshops and appropriate behavior modifications and coping strategies to enable the participants to manage their chronic diseases and medications and increase physical activity levels. The program enables the participants to work on effective communication skills with family, friends, and health professionals.

  On Lok/30th Street Senior Center is the lead contract agency that helps to coordinate, plan and conduct the Healthier Living workshops in various senior centers located throughout the city. The free workshops are offered in different languages including English, Chinese, Spanish, Tagalog, and Russian.

- **DAAS Medication Management**
  The goal of the Medication Management Program (MMP) is to improve the quality of life of seniors and adults with disabilities and prevent unnecessary hospitalization or institutionalization. Potentially inappropriate medications continue to be prescribed and used by the most vulnerable of older adults. The toxic effects and drug related problems resulting from adverse drug reactions have profound medical and safety consequences for older adults and economically affect the health care system.
The approach has three components. First, the integration of technology in conducting thorough assessment of client's medication history. Second, the introduction of a consulting pharmacist who uses an evidenced-based criteria, Beers Criteria by the American Geriatrics Society, to routinely monitor prescribed and over-the-counter medications being taken by the clients. Lastly, the team approach in medication review and assessment. The pharmacist, case managers and clinician work together in assisting at-risk seniors and adults with disabilities to avoid adverse drug reactions (ADR) and to assess potential risks associated with changes in client’s prescribed medications or use of over-the-counter (OTC) medications, vitamins, minerals, and herbal supplements.

**Issues:** The main issue for both DPH and DAAS is the lack of monetary resources.

- **Behavioral Health Services**

The San Francisco Behavioral Health Plan offers a full range of specialty behavioral health services provided by a culturally diverse network of community behavioral health programs, clinics, and private psychiatrists, psychologists, and therapists. Most people seeking behavioral health services need only basic counseling services. For those who are in need of more extensive treatment, the Behavioral Health Plan offers an array of services.

Services are available to residents of San Francisco who receive Medi-Cal benefits, San Francisco Health Plan members, and to other San Francisco residents with limited resources. Services are approved and provided based on individual clinical need.

- DPH Community Behavioral Health Services (CBHS) strives to provide a system of care that is welcoming, culturally and linguistically competent, gender responsive, and integrated. Subscribing to a policy that “any door is the right door,” CBHS provides a medical home and timely access to treatment for individuals and families with behavioral health issues, allowing clients to maximize opportunities for recovery and healthy, meaningful lives in the community.

**Issues:** Limited resources.

- **Nursing Facility Services (CCI component)**

San Francisco has 122 seniors for every Skilled Nursing Facility (SNF) bed. The state average is 64. As of December 2012:

- Laguna Honda Hospital: 780 beds, 100 percent occupancy with waiting list, 52 percent of the residents were between the ages of 45-64, 62 percent are male, and 47 percent listed as “extensive, complex or special care.”
Other San Francisco Skilled Nursing Facilities: 29 SNF facilities with 23 accepting Medi-Cal. A total of six are rated as below average and one is rated as poor.40 Several of these are hospital-based SNFs and, as such, don’t keep long-term custodial patients. Several are also rehabilitation facilities which also don’t want to take and/or keep long-term custodial patients.

Issues: Most of the SNF facilities that take Medi-Cal prefer to use their Medi-Cal beds for existing residents who are moving from Medicare to Medi-Cal or from private pay to Medi-Cal rather than taking Medi-Cal intakes.

- Assisted Living

Existing Services: Assisted living is divided into two categories: larger facilities of 30 beds of more, which are all private pay ranging from $3,500 to $5,500 per month, and smaller board and care facilities, usually with from six to eight beds. San Francisco has 93 residential care facilities for the elderly (RCFEs) with 3,100 beds. Only 24 of those facilities (board and care) accept persons receiving SSI/SSP and none serve non-ambulatory residents.

The following program may provide reimbursement of assisted living services when fully implemented:

- **Leno Waiver:** The San Francisco Community-Living Support Benefit (CLSB) implements the Leno Bill (AB 2968) for persons who meet nursing facility A or B level of care. This is a 1915(c) home and community-based services (HCBS) waiver. The Centers for Medicare and Medicaid Services (CMS) approved the waiver for implementation to begin July 1, 2012.

This particular HCBS waiver serves Medi-Cal eligible adults 22 years or older at nursing facility level of care (NF-A or NF-B). It targets persons who would otherwise be homeless and who cannot reside safely in the community using other available Medi-Cal options like IHSS, NF/AH waiver, etc. Participants will reside in RCFs, RCFEs, ARFs, Direct Access to Housing (DAH), or other housing units that have been approved by the State DHCS for participation.

DPH RNs will assess for level of care and eligibility using MDS-HC. For persons with a mental illness or substance abuse diagnosis, the MDS-HC will be supplemented with the LOCUS assessment tool. Once determined eligible and the person chooses the waiver, they will select a waiver care coordinator (DPH RN or social worker or a contracted care coordinator).

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40 CalQualityCare.org gives performance ratings for intermediate care facilities for the developmentally disabled, home health care agencies, hospice programs, and nursing facilities. The ratings are based on California state and U.S. government data sources. The data are gathered in various ways — including facility visits, self-reported data, and information submitted by clients or family members — and at different times. CalQualityCare.org aggregates new data every three months and updates the Web site accordingly.
The CLSB enables wrap-around daily service provided by: (1) RCFE or ARF providers; or 2) in DAH or other housing sites, DPH, or home health agency. There are three levels of support and three tiers of payment:

Level I: Includes access to LVN for nursing oversight and intermittent nursing.
Level II: Includes access to LVN and behavior plan implemented by staff.
Level III: Includes access to RN and behavior plan implemented by staff.

Other services include:

- Environmental accessibility adaptations for unlicensed settings.
- Behavior assessment and behavior plan development.
- Meals (when needed for participants in unlicensed settings).
- Rent/Facility Costs are not federally reimbursable.

Funding: SF General Fund and federal matching funds. $3.17 million in federal matching funds available in year 1 (FY 12-13) increasing to $8.14 million in year 5 (FY 17-18).

Anticipated enrollment: (1) persons in RCFE and housing settings funded with 100 percent San Francisco funds; (2) persons leaving SNFs; and (3) persons diverted from SNFs. DPH estimated 221 participants in year 1 (FY 12-13), and CMS capped participation at 486 participants in year 5 (FY 17-18).

Issues: Access to Medi-Cal funding for assisted living and board and care.

- Accessible/Affordable Housing

There are 61 projects in San Francisco that are subsidized for low-income persons over the age of 62 and/or physically disabled. Of those projects, 38 have closed waiting lists, meaning the waiting list exceeds three years. The remaining 24 have waiting lists that, while not closed, require individuals to wait for years.

The following programs provide a number of services/supports to assist individuals to find and move into housing, and to provide community-based options for those whose current housing is no longer accessible/suitable because of stairs or other factors:

- **Housing Counseling**: San Francisco provides counseling services to 635 people at a cost of $216 per person.

- **Supportive Housing Program**: San Francisco serves 2,007 individuals at a cost of $1,655 per person.

- **Diversion and Community Integration Program (DCIP)**: This came out of the Chambers lawsuit and requires the City to provide 100 units of housing per year for five years to individuals who wish to come out of Laguna Honda Hospital. The program provides rental subsidies.
Direct Access to Housing (DAH): Established by the Department of Public Health- Housing and Urban Health Section in 1998, DAH is a permanent supportive housing program targeting low-income San Francisco residents who are homeless / at-risk of homelessness and have special needs. A "low threshold" program that accepts adults into permanent housing directly from the streets, shelters, hospitals, and long-term care facilities, DAH strives to help tenants stabilize and improve their health outcomes despite co-occurring mental health issues, alcohol, and substance abuse problems, and/or chronic medical conditions. Unique in its onsite provision of wrap-around support services, DAH currently houses close to 1,000 formerly homeless persons across 24 sites. By 2013, DAH will expand to house at least 650 additional tenants at seven new housing sites.

Transitional Housing (HSA): If you are a homeless single adult, family, or youth, the Human Services Agency (HSA) may be able to provide transitional housing to help you move from the street to permanent housing. Clients using transitional housing may stay in the housing for six months to two years and receive intensive services such as education, job training and placement, substance abuse counseling, parenting classes, and child care services. They usually pay 30 percent of their income for services and housing.

Rental Assistance (HSA): The Season of Sharing Fund helps with move-in costs to permanent housing. To be eligible one must be 60 or over and/or disabled.

Issues: San Francisco has a significant need to access affordable/accessible housing to assist with deinstitutionalization efforts from Laguna Honda specifically and from other SNFs, and to provide community-based options for those whose current housing is no longer accessible/suitable because of stairs or other factors.
APPENDIX E:
STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS/CHALLENGES (SWOT) ANALYSIS
By LTCI Scope of Services and Service Delivery Subcommittee

Long-term Care Integration (LTCI) is defined as the integration of home and community-based long-term services and supports (LTSS) with the delivery of primary and acute care services, and institutional long-term care services, for older adults and adults with disabilities. Those in this population who are eligible for Medi-Cal are being enrolled into managed care – for primary and acute care services – throughout California under an 1115 Waiver. If implemented, some services included under LTCI in San Francisco would become part of this managed care system.

WHAT SHOULD AN IMPROVED LTCI SERVICE DELIVERY MODEL LOOK LIKE?
Based on the four case studies presented—along with input from Care Coordination Workgroup

Strengths, Weaknesses, Opportunities, and Threats/Challenges (SWOT) Analysis

Overview

FRAMEWORK: This SWOT analysis is organized into the following components of an improved LTCI service delivery model:

- Multiple Initial Contact Locations for Consumers
- Defined and Coordinated Points of Entry (No-Wrong-Door Model with Central Door)
- Improved Access to Information on Services for Consumers
- Improved Access to Information on Services for Service Providers
- Better Coordination of Services
- Improve Access to Information on Consumers for Service Providers (Data)
- Improved Efficiency and Better Use of Resources (Financial and Services)
- Easier Access to Services for Consumers (Eligibility Determination/Comprehensive Intake and Assessment)
- Improved Quality of Life
- Improved Community and Family Support
- Expanded Scope of Services and Capacity
- Improved Service Quality
- Training and Education for Consumers
- Training and Education for Service Providers
- Workforce Development

DEFINITIONS: This SWOT analysis is using the terms below in the following ways:
**Strengths**
What San Francisco’s network of home and community-based service providers currently does well.

**Weaknesses**
What San Francisco’s network of home and community-based service providers currently does NOT do well.

**Opportunities**
The things that the network can take advantage of over the next four years that will help address the critical needs – in an improved LTCI service delivery model – either locally, or at a state or national level.

**Threats/Challenges**
The things that challenge the network’s ability to address the critical needs identified – in an improved LTCI service delivery model – either locally, or at a state or national level.

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**SWOT ANALYSIS - IN RELATION TO PROPOSED COMPONENTS OF AN IMPROVED LTCI SERVICE DELIVERY MODEL**

1. **Multiple Initial Contact Locations for Consumers (Seniors and People with Disabilities)**

Examples include: senior centers, nutrition programs, senior housing, Independent Living Resource Center, public safety (911 calls), other Information and referral (211 calls), long-term care providers, case managers, social workers, religious institutions, media outreach, homeless shelters, physicians, Social Security Administration, Unified School District, among others.

<table>
<thead>
<tr>
<th><strong>Strengths</strong></th>
<th><strong>Weaknesses</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple initial contact locations are a strength as they provide many ways for people to get referred to LTSS</td>
<td>Initial contact locations do not have common information about the array of LTSS</td>
</tr>
<tr>
<td>People are comfortable getting information about LTSS at their own initial contact location</td>
<td>Initial contact locations have their own unique vocabulary</td>
</tr>
<tr>
<td>A single electronic database of LTSS is in the works, which can be refreshed and coordinated with a major access hubs and the central door</td>
<td>Because San Francisco is relatively service rich, it is hard to get information out about all LTSS</td>
</tr>
<tr>
<td></td>
<td>There is no good way of communicating across all initial contact locations</td>
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<tr>
<td></td>
<td>May make contact and be given information or</td>
</tr>
<tr>
<td>Opportunities</td>
<td>Threats/Challenges</td>
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<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Getting initial contact locations better, more comprehensive information for all LTSS</td>
<td>Getting all initial contact locations to send people to designated points of entry</td>
</tr>
<tr>
<td>Getting initial contact locations to refer to defined points of entry</td>
<td>Different languages spoken (Mandarin, Cantonese, Japanese, Spanish, etc.)</td>
</tr>
<tr>
<td>Electronic resource directories can provide updated information on services</td>
<td>Unable to describe what is happening to them thus has challenges connecting to the most appropriate services</td>
</tr>
<tr>
<td>Training needs to be made available to all staff at initial contact locations</td>
<td></td>
</tr>
<tr>
<td>Initial contact, if signs of cognitive impairment are evident, ask person if they can send information to their primary residence to a family member (to involve them early in the process)</td>
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<tr>
<td>We have the opportunity to do education prior to the Cal MediConnect coming to San Francisco</td>
<td></td>
</tr>
<tr>
<td>Need to do training and outreach for the NPOs ahead of the Cal MediConnect</td>
<td></td>
</tr>
<tr>
<td>NPOs to reach out to consumers ahead of time</td>
<td></td>
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<tr>
<td>Training for PCPs, CBOs, and others</td>
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</tr>
<tr>
<td>Be proactive with the State</td>
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<tr>
<td>PACE as a choice in the initial screening process</td>
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</tbody>
</table>
2. Defined and Coordinated Points of Entry for Consumers (No-Wrong-Door Model of Improved Access -- with a Central Door)

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>APS is often point of entry and gap filler</td>
<td>Points of entry unclear</td>
</tr>
<tr>
<td>IHSS as point of entry</td>
<td>When care plan breaks down, consumers end up seeking services from other locations. As a result, care coordination falls apart</td>
</tr>
<tr>
<td></td>
<td>911 as point of entry</td>
</tr>
<tr>
<td></td>
<td>Emergency room for patients with Alzheimer’s is often very expensive and unproductive (i.e., what is happening to the person is unknown)</td>
</tr>
<tr>
<td></td>
<td>Points of entry have their own unique vocabulary</td>
</tr>
<tr>
<td></td>
<td>While Regional Centers are a hub, they have not historically worked with Managed Care Plans</td>
</tr>
<tr>
<td></td>
<td>Managed Care Plans don’t get comprehensive information on Regional Center clients</td>
</tr>
<tr>
<td></td>
<td>Managed Care Plans have little or no information on people in residential care facilities for the elderly</td>
</tr>
<tr>
<td></td>
<td>Initial point of contact for consumers moving into the Cal MediConnect is Health Care Options. They perform the enrollment function. This can be challenging</td>
</tr>
<tr>
<td></td>
<td>Voluntary versus mandatory enrollment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need clear points of entry</td>
<td>Getting all current points of entry to agree on defined points of entry.</td>
</tr>
<tr>
<td>Role for Managed Care Plans as points of entry</td>
<td>Agreement on usage of a Universal Assessment Tool</td>
</tr>
<tr>
<td>No wrong door model needs <strong>major access hubs</strong> as significant points of entry, including:</td>
<td></td>
</tr>
<tr>
<td>• DAAS</td>
<td></td>
</tr>
<tr>
<td>• DPH</td>
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</tr>
</tbody>
</table>
• Managed Care Plans:
  - San Francisco Health Plan
  - Anthem Blue Cross
  - On Lok

Secondary Access Hubs:
• Acute Care Hospitals
• Regional Center
• Veteran’s Administration
• Prison System (County Jail?)

Transitional care program involving hospitals
DAAS and DPH need to coordinate services and programs more effectively
DPH medical homes are a whole new way to coordinate access to services
Role for DAAS Integrated Intake Unit – as the central door
Ability to share data among defined points of entry as well as major access hubs
Involve a care partner or care advocate at time of transition

3. Improved Access to Information on Services for Consumers

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong connection to nonprofit organizations</td>
<td>Duplication with different message</td>
</tr>
<tr>
<td>CBOs very focused on consumers and their needs</td>
<td>No direct access to consumers</td>
</tr>
<tr>
<td>Lots of providers delivering services and providing access</td>
<td>Language and technology</td>
</tr>
<tr>
<td></td>
<td>Literacy issues</td>
</tr>
<tr>
<td></td>
<td>No easy way to contact consumers (names and addresses)</td>
</tr>
<tr>
<td></td>
<td>Medi-Cal tapes are not accurate</td>
</tr>
<tr>
<td></td>
<td>Mistrust and lack of understanding of the “system” by consumers</td>
</tr>
<tr>
<td></td>
<td>No easy way for consumers to get information (one-stop shop for info)</td>
</tr>
</tbody>
</table>
### Opportunities

- San Francisco is starting the LTCI process early – will have done lots of work before the Cal MediConnect gets to San Francisco
- Good involvement of agencies throughout San Francisco
- Opportunity to create a better system
- Clear consistent messaging from all those involved in the process: DPH, DAAS, Health Plans, DHCS

### Threats/Challenges

- Too many differing messages
- How to separate our message (LTCI) from all the “noise” that you hear about health care
- It is expensive to try to reach people and LTCI doesn’t have the money to spend

### 4. Improved Access to Information on Services for Service Providers

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training procedures already exist for many services and programs.</td>
<td>Managed Care Plans don’t have sufficient information on long-term services and supports (LTSS). Improving based on experience with SPD population</td>
</tr>
<tr>
<td></td>
<td>Managed Care Plans do not understand all available dementia care services, and the need for a diagnosis</td>
</tr>
<tr>
<td></td>
<td>Not enough information on LTSS – universally by all service providers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Care Plans want information on LTSS</td>
<td>Minimize duplication of messages that are not in synch</td>
</tr>
<tr>
<td>Managed Care Plans want information on LTSS used by clients</td>
<td>Need to be sure that information on LTSS is accurate and up-to-date</td>
</tr>
<tr>
<td>More training need to be incorporating technology</td>
<td>Difficulty to share “real time” client information, medical and LTSS, between information systems</td>
</tr>
<tr>
<td>Providers need a hub for information on services</td>
<td></td>
</tr>
<tr>
<td>DAAS and RTZ Associates are developing a web-based service directory</td>
<td></td>
</tr>
<tr>
<td>Central Door – information resource on services – one place to call</td>
<td></td>
</tr>
<tr>
<td>Aging and Disability Resource Centers – another resource for information</td>
<td></td>
</tr>
</tbody>
</table>
Ability to share “real time” client information, medical and LTSS, between information systems. This would help in tailoring service recommendations that would be useful.

DAAS to sponsor information packets for PCPs providing key contact information, list of services and DAAS as the key entry point.

5. **Better Coordination of Services:** It is anticipated that the Care Coordination Work Group will provide additional detail in this area.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are many case management programs coordinating services</td>
<td>Case management programs do not work effectively together</td>
</tr>
<tr>
<td>APS is strong and creative</td>
<td>Case management programs do not always transition clients well from one program to another</td>
</tr>
<tr>
<td>The DCIP coordinates care and support for people avoiding institutionalization or returning to community living</td>
<td>There are too many care coordinators – and they don’t work effectively together. The Care Coordination Work Group felt this sent a negative message and probably wasn’t accurate</td>
</tr>
<tr>
<td>San Francisco has a strong safety net including care coordination</td>
<td>Many clients have several case managers</td>
</tr>
<tr>
<td>Many clients have several case managers (both a strength and weakness)</td>
<td>There is some stagnation in the case management system</td>
</tr>
<tr>
<td>San Francisco provides lots of opportunity for input by consumers, stakeholders and providers</td>
<td>Homeless people are underserved. Outreach to this population is challenging and functional criteria for services doesn’t always match capacity of homeless population</td>
</tr>
<tr>
<td>Good outreach and peer support systems</td>
<td>Missed appointment – who checks or intervenes in this situation?</td>
</tr>
<tr>
<td>San Francisco has a culture of creativity</td>
<td>A lot of duplication of services by different case management programs for clients</td>
</tr>
<tr>
<td></td>
<td>Managed Care Plans have limited experience coordinating LTSS</td>
</tr>
<tr>
<td></td>
<td>Knowledge about how managed care plans can coordinate care</td>
</tr>
<tr>
<td>Opportunities</td>
<td>Threats/Challenges</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Need centralized data system for predictive modeling and improved coordination of services</td>
<td>Some consumers think having multiple case managers is a good thing. This needs to be changed. Care Coordination Work Group felt this was “our” fault and not that of the consumer</td>
</tr>
<tr>
<td>Need more coordinated Inter-Disciplinary Team (IDT) planning</td>
<td>HIPAA requirements for privacy for data sharing</td>
</tr>
<tr>
<td>Need for good communication and coordination in transition of clients from one provider to another</td>
<td>Engagement of homeless people is difficult</td>
</tr>
</tbody>
</table>
### Need for a lead case manager for care coordination

Homeless people don’t always function at a level to qualify for case management. This affects more than just the homeless.

### Need to have a lead case manager identified in centralized client database

Money/funding are issues/challenges.

### Process for Managed Care Plans coordinating care given each case is different

Ensure that an individual has cognitive ability to help in process or that there is durable medical power of attorney in place.

### Inter-Disciplinary Team meetings need to be established to coordinate services

### Case conferences are needed to coordinate services

### Stagnation in the case management system – this is an opportunity for better transitions

### Multiple roles and a level of specialty provided by case management programs need to be articulated

### Engage care partner/caregiver in coordination of services

### Clearly identify “lead care coordinator”

#### 6. Improved Access to Information on Consumers for Service Providers (Data)

- It is anticipated that the Data Work Group will provide additional detail in this area.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many databases have been developed</td>
<td>Difficulty in sharing data</td>
</tr>
<tr>
<td>The DPH Coordinated Case Management System is a good but not comprehensive resource</td>
<td>Databases are not integrated</td>
</tr>
<tr>
<td>Similar data is input by multiple providers through a myriad of tracking systems</td>
<td>Managed Care Plans don’t have sufficient information on LTSS currently being used by clients</td>
</tr>
<tr>
<td>Quality is not now measured effectively</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need for data tracking on clients</td>
<td>Multiple data systems that don’t talk to each other</td>
</tr>
<tr>
<td>Ability to share “real time” client information, medical and LTSS, between information systems</td>
<td>Difficulty to share “real time” client information, medical and LTSS, between information systems</td>
</tr>
<tr>
<td>Need for a centralized data system so clients don’t get lost</td>
<td>Boundaries on ownership of data</td>
</tr>
<tr>
<td>Need for a centralized data system to create efficiencies around care coordination</td>
<td>Resources have been devoted to creating data systems that, in the end, were not usable and/or used</td>
</tr>
<tr>
<td>Need process for data tracking among providers</td>
<td>There are significant privacy issues - HIPPA</td>
</tr>
<tr>
<td>Need to coordinate information with Police, Fire and 911</td>
<td></td>
</tr>
<tr>
<td>Need to provide assistance to case managers in transitioning clients</td>
<td></td>
</tr>
<tr>
<td>Need for effective quality measurement – standards and outcomes</td>
<td></td>
</tr>
<tr>
<td>More Olmstead-focused federal programs will become available</td>
<td></td>
</tr>
<tr>
<td>Alzheimer’s or signs of dementia can be slight for many years. Have area of medical record that has cognitive impairment section can help show possibly signs or prompt cognitive testing</td>
<td></td>
</tr>
<tr>
<td>Use data to inform practice, improve access and eligibility to services, etc.</td>
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</tr>
</tbody>
</table>

7. **Improved Efficiency and Better Use of Resources (Financial and Services) for Service Delivery Network**

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controller’s report on LTSS in San Francisco entitled <em>Fiscal Analysis of the City and County of San Francisco’s Commitments to Home and Community-Based Long-term Care Services</em> - sets a baseline</td>
<td>Difficulty in sharing data</td>
</tr>
<tr>
<td></td>
<td>Databases are not integrated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data needed to demonstrate the effectiveness (quality and cost) of LTSS</td>
<td>State cuts to CBAS program and potentially to other LTSS programs</td>
</tr>
<tr>
<td>Data needed to demonstrate that LTSS can reduce the need for institutional care</td>
<td>Legal requirements for data sharing (HIPAA).</td>
</tr>
</tbody>
</table>
Data needed to assist Health Plans with negotiating capitation rates | Expanding elder and Medi-Cal population
---|---
Data needed to better understand the shift of costs from Medi-Cal to Medicare | Resources and services for younger adults with disabilities, including younger On Set Alzheimer’s
Development of standards and outcome measures to show efficiencies and better use of resources. (Metrics needed) | |
MFP programs (?) and other federal programs | |
Need to take advantage of more evidence-based programs on LTSS | |
Preventive services are efficient | |
Data needed to show how appropriate diagnosis for Alzheimer’s and care planning can reduce medical costs | |

8. Easier Access to Services for Consumers (Eligibility Determination/Comprehensive Intake and Assessment) – Clarify that this is about “access” not “capacity or eligibility”

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPH delivers a range of Behavioral Health Services</td>
<td>Larger LTSS network not well coordinated</td>
</tr>
<tr>
<td>DPH is creating medical homes</td>
<td>Limited systems for medication monitoring</td>
</tr>
<tr>
<td>DAAS has created the Integrated Intake Unit</td>
<td>Medi-Cal access (unsure if this is an issue)</td>
</tr>
<tr>
<td></td>
<td>Carve out of behavioral health</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Behavioral Health Services needs to be well coordinated with Managed Care Plans</td>
<td>Issues around geographic and cultural coverage and competency</td>
</tr>
<tr>
<td>Transition to managed care provides opportunities to make positive changes in the system/network</td>
<td>Outcome of CBAS dis-enrollments and how to ensure that individuals with Alzheimer’s aren’t dis-enrolled because of their appeared higher functionality</td>
</tr>
<tr>
<td>Transition to managed care provides opportunities to make positive changes in the system/network</td>
<td>Financial uncertainty of the CBAS program</td>
</tr>
<tr>
<td>State’s openness to change and innovation</td>
<td>Uncertainty about long-term viability of enhanced case management (ECM) for CBAS dis-enrollees</td>
</tr>
<tr>
<td>Need for additional transportation services</td>
<td>Service providers challenged by provision of cross-age and cross-disability services</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Often Alzheimer’s is not included in Behavioral Health Services as an additional category</td>
<td>Linkages – waiting list for services</td>
</tr>
<tr>
<td>Need for a universal intake form</td>
<td>Unresolved issues around the transfer of IHSS to managed care (to be resolved by the IHSS Work Group)</td>
</tr>
<tr>
<td>Integration of primary care with behavioral health</td>
<td>Limited availability of Medi-Cal SNF beds – the beds are there, but the access is limited as many SNFs are holding those beds for rehab (Medicare clients)</td>
</tr>
<tr>
<td></td>
<td>Limited availability of key services like day care, respite, and residential</td>
</tr>
<tr>
<td></td>
<td>Limited availability of Medi-Cal funding for assisted living and board and care (outside the Leno Waiver)</td>
</tr>
<tr>
<td></td>
<td>Limited availability of accessible and affordable housing to assist with de-institutionalization efforts</td>
</tr>
<tr>
<td></td>
<td>Waiting list for home-delivered meals</td>
</tr>
<tr>
<td></td>
<td>Waiting list for any needed service</td>
</tr>
<tr>
<td></td>
<td>Limited transportation services</td>
</tr>
</tbody>
</table>

### 9. Improved Quality of Life

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>There have been major improvements in self-direction over the last decade</td>
<td>Self-direction reforms that have been “won” around SNFs have not carried over to HCBS</td>
</tr>
<tr>
<td>Consumers have greater opportunities to choose non-institutional options</td>
<td></td>
</tr>
<tr>
<td>CA’s Coordinated Care Initiative</td>
<td></td>
</tr>
<tr>
<td>Diversity of choices – individuals have the right to accept their care plans or not (also could be a weakness)</td>
<td></td>
</tr>
<tr>
<td>Residential hospice options rather than hospital</td>
<td></td>
</tr>
<tr>
<td>Health living, health promotion and chronic disease self-management programs have been tested and are in use in a number of settings</td>
<td></td>
</tr>
<tr>
<td>Respect for diversity of culture is an important value in San Francisco</td>
<td></td>
</tr>
</tbody>
</table>
Oppportunities | Threats/Challenges
--- | ---
Prevention programs can lead to improved quality of life – programs are ongoing | Managed care creates confusion which can be a threat to health
Quality at end of life | Need to balance choice with safety and risk tolerance of providers
Create more self-direction around HCBS | Service providers are uneven in their incorporation of softer quality measures
Creation of an assessment tool to measure data on quality of life – there has been research completed in this area. Evidence quality of life measures are being used | 
CMS is looking into quality of life indicators | 
Much work has been done at Laguna Honda regarding choice | 

10. Improved Community and Family Support

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from family and friends – when available</td>
<td>Family member(s) and “friends” taking advantage of clients</td>
</tr>
<tr>
<td>APS and other protective services in San Francisco are good</td>
<td>Family dysfunction</td>
</tr>
<tr>
<td></td>
<td>Caregiver burnout</td>
</tr>
<tr>
<td></td>
<td>The system doesn’t do a good job with the homeless population in regards choice</td>
</tr>
<tr>
<td></td>
<td>Early communication on advance directives and quality of life issues (POLST) – there is a gap here in family participation</td>
</tr>
<tr>
<td></td>
<td>What about people without family supports?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate support for caregivers can help keep a person with Alzheimer’s at home longer and avoid placement</td>
<td>Managing family dysfunction</td>
</tr>
</tbody>
</table>
## 11. Expanded Scope of Services and Capacity

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>San Francisco is a relatively service rich community particularly LTSS</td>
<td>Limited activities and centers for younger adults with disabilities</td>
</tr>
<tr>
<td>City willing to invest general funds – in the Community Living Fund (CLF) and other programs – good political environment</td>
<td>Social wellness models are limited or don’t exist</td>
</tr>
<tr>
<td></td>
<td>[Many of the items listed as “weaknesses” in #8 might be moved to this section]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need to transform senior centers into community centers with appropriate programming for younger individuals</td>
<td>Money – funding</td>
</tr>
<tr>
<td>Need to create support group(s) based on social wellness model at Laguna Honda Hospital for past residents who wish to maintain relationships with current residents</td>
<td>Scaling up for the increasing demographic of seniors</td>
</tr>
<tr>
<td>Need to create social wellness models</td>
<td></td>
</tr>
<tr>
<td>Need for more activities for younger adults with disabilities including people with Alzheimer’s</td>
<td></td>
</tr>
<tr>
<td>Need for social centers for younger adults with disabilities including people with Alzheimer’s</td>
<td></td>
</tr>
<tr>
<td>Work with religious and churches</td>
<td></td>
</tr>
<tr>
<td>Managed care plans may expand LTSS under Cal MediConnect</td>
<td></td>
</tr>
<tr>
<td>Health plans to incentivize wellness programs</td>
<td></td>
</tr>
<tr>
<td>Better collaboration = better efficiencies = more services</td>
<td></td>
</tr>
</tbody>
</table>
12. **Improved Service Quality**: To be determined by State with LTSS performance measures

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lack of current standards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development of standards and outcome measures to demonstrate improved quality of services</td>
<td>Need to financially incent quality</td>
</tr>
<tr>
<td>Quality assurance standards for LTSS – do we wait for the State to create or advocate for our own</td>
<td></td>
</tr>
<tr>
<td>Create incentives for organizations to improve on quality</td>
<td></td>
</tr>
</tbody>
</table>

13. **Training and Education for Consumers**

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health plans already do training around chronic disease management</td>
<td>Lack of funding for training and education</td>
</tr>
<tr>
<td></td>
<td>Consumer might not be able to be educated</td>
</tr>
<tr>
<td></td>
<td>System navigation is challenging for those who don’t understand managed care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training needed for families providing care – chronic disease management, etc.</td>
<td>Ability to reach ethnically diverse populations</td>
</tr>
<tr>
<td>Training needed for families for LTC needs and supports</td>
<td></td>
</tr>
<tr>
<td>Develop consumer education tools</td>
<td></td>
</tr>
<tr>
<td>Expand chronic disease management programs</td>
<td></td>
</tr>
<tr>
<td>Need to contact consumers early on so that they are part of the process and the choice</td>
<td></td>
</tr>
<tr>
<td>Need to develop more consumer education programs</td>
<td></td>
</tr>
</tbody>
</table>
14. Training and Education for Service Providers – Service providers are not just nonprofit organizations, but also physicians and others who provide predominately medical services.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHSS training institute</td>
<td>Lack of funding for training and education</td>
</tr>
<tr>
<td>Need to prioritize training – identify priorities</td>
<td>Unclear who would provide training (LTSS and/or Managed Care Plans)</td>
</tr>
<tr>
<td></td>
<td>Information on Assistive Technology is not easily accessed by providers</td>
</tr>
<tr>
<td></td>
<td>Lack of an official Alzheimer’s diagnosis by physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats/Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTSS training for physicians and the Health Plans</td>
<td>Misconceptions of the reasons for diagnosing Alzheimer’s</td>
</tr>
<tr>
<td>Training for Providers on Assistive Technology</td>
<td></td>
</tr>
<tr>
<td>Training for providers on why diagnosis is critical for families and the integrated care system</td>
<td></td>
</tr>
<tr>
<td>Health plans and advance directives</td>
<td></td>
</tr>
<tr>
<td>DAAS trainings that might be natural vehicles for training other service providers (Bethany training, etc.)</td>
<td></td>
</tr>
<tr>
<td>Move to a wellness model in the US</td>
<td></td>
</tr>
</tbody>
</table>

15. Workforce Development

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>IHSS training of direct care workforce</td>
<td>Lack of specialists and PCPs to work with homeless and capacity to manage needs of homeless population</td>
</tr>
<tr>
<td>Persons with disabilities often continue to see their pediatricians even after they are adults as regular PCPs don’t have training in working with people with disabilities</td>
<td>High rates of turnover in the CNA worker</td>
</tr>
<tr>
<td></td>
<td>Lack of living wage and health benefits for CNA worker</td>
</tr>
<tr>
<td></td>
<td>City’s lack of support for nonprofit workforce means lots of turnover</td>
</tr>
<tr>
<td>Opportunities</td>
<td>Threats/Challenges</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Expanding IHSS training of direct care workforce</td>
<td>San Francisco’s high cost of living</td>
</tr>
<tr>
<td>CCI inclusion of home care providers on care teams and better focus on IDTs</td>
<td>Rising health care benefits for providers, increased mandates around health care</td>
</tr>
<tr>
<td>and care coordination. Structure that is more inclusive of LTSS and medical</td>
<td>coverage and the rising cost of health care</td>
</tr>
<tr>
<td>providers together</td>
<td></td>
</tr>
<tr>
<td>Care management training</td>
<td>National workforce shortage</td>
</tr>
<tr>
<td>Development of career ladders</td>
<td>People with disabilities are under-employed</td>
</tr>
<tr>
<td>Workforce development to train the next generation of worker for senior care</td>
<td></td>
</tr>
<tr>
<td>Focus on self-care and moving clients from dependency to self-care model</td>
<td></td>
</tr>
<tr>
<td>Creating internships</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F:
RESPONSES TO LTCI STRATEGIC PLAN RECOMMENDATIONS
FROM THE LONG TERM CARE COORDINATING COUNCIL

PART I: GENERAL RESPONSES (in italics)

The lead in organizing the LTCI implementation body.

Who will take the lead in getting this implementation body started?

Answer: There will be a conversation about this among the entities that will be involved in the formation of the LTCI implementation body.

The need for a team leader once the LTCI implementation body is organized.

Who is the team leader on the LTCI implementation body? If the LTCCC is to have shared responsibility, who do we hold accountable for progress and resolution of issues.

Answer: There will be a conversation about this among the individuals identified that will serve on the LTCI implementation body.

Administrative costs related to recommendations.

There are administrative costs that will need to be identified.

Answer: It is difficult to estimate all administrative costs at present. It is envisioned that there is some administrative support already at DAAS, but additional support may be needed.

The need for administrative costs to be in a budget.

The LTCI implementation body will start in the fall of 2013 or early in 2014. If no further action is undertaken, additional staff support will not be in any departmental budget.

Answer: DAAS has determined that there are only about three new workgroups that will need to be established. The LTCI implementation body will be supported by DAAS. A staff person at DAAS will be identified that will provide this support.

The potential for duplication.

There could be overlap and duplication between this work and the work of the subcommittees of the LTCCC.

Answer: Duplication will be avoided.

The need for a technology budget.

There are many recommendations that have technology as a backbone. This costs money. In the next year, would a technology budget be developed? The technology budget is developed for a five year period, and it is not too soon to start.
Answer: Given that managed care may not be implemented in San Francisco until 2015 or even 2016, this does not have to be done immediately. This does have to be done, but we have a lot of time. Even for the eight counties moving ahead under Cal MediConnect, the implementation date has been moved back.

**Involvement of people with disabilities.**

Are there people with disabilities who will be involved in the LTCI implementation body?

Answer: This implementation body will include representatives of city departments and the Health Plans, the Mayor’s Disability Council and consumers. Also, California’s Coordinated Care Initiative requires that there be an advisory body that would include older adults and adults with disabilities.

**The need for outcomes.**

What are the expected outcomes and how will progress toward these outcomes be determined? How will we know? There will need to be some outcomes for each recommendation, with some benchmarks identified. For example, with the recommendation for a public information campaign, does there need to be a demonstration that we did educate the public?

Answer: Some of this will happen when we develop the implementation timeline. We can define steps along the way. Process measurements are easier than outcome measurements.

**The need for a legislative agenda.**

Gaps were identified, which are expensive. Could there be a legislative agenda developed for San Francisco to lobby to have some of these gaps addressed by managed care at the state level? A legislative agenda is important.

We must be proactive. We have the opportunity to recommend a legislative agenda as we are the Mayor’s LTCCC. For example, CalFresh is not available to all people. This could come up under a legislative agenda. People on SSI are struggling every day.

Answer: A legislative agenda could be incorporated into the LTCI Strategic Plan. Also, some of these gaps are already being debated at the state level. If the managed care plans don’t get adequate rates, they cannot provide the services will be needed and gaps will not be addressed.

**Access to services.**

There is a concern about access to services in neighborhoods. It is essential that there be strong neighborhood locations for access.

Answer: We don’t have the neighborhood base we used to have. The concept in the LTCI Design Group recommendations is that people will link primarily to the central door at the DAAS Integrated Intake Unit, which will provide a coordinated intake for
consumers. But there are also Aging and Disability Resource Centers in several neighborhoods that will be working in coordination with the DAAS Integrated Intake Unit. However, it may be that some consumers should talk directly to organizations such as the Alzheimer’s Association about specific dementia support and services.

When people are in managed care, it will be helpful to have a central door to get access to services in the community that are not provided by the Health Plans. This will help to assure people to get access to services.

The LTCI Design Group’s strategic planning process built a strong relationship between the Health Plans, City departments, and service providers, which will assist consumers in gaining access to services.

**The involvement of hospitals.**

Hospitals are not identified and these should be included in the entities that will be involved in LTCI implementation activities.

Answer: There are a number of entities that need to be contacted. This discussion should take place with the Hospital Council. Ron Smith has been coming to some LTCI Design Group meetings, but this is more of an operational issue.

**Data challenges.**

The recommendation for a single data sharing solution will be very challenging to accomplish. This is desirable, but it will be a challenge.

Answer: Most of the DAAS Software is developed by RTZ Associates. DPH software is also developed by RTZ Associates. Yes, this will be a formidable issue, but we are already working with other service providers and hospitals on transitional care issues – and this may set a good example for a data solution. This is what everyone is striving toward. It is not about being on the same system now. We have to be able to share appropriate information.

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**PART II: RESPONSES TO INDIVIDUAL RECOMMENDATIONS AND APPENDICES**

**Recommendation 2.1. The creation of a central door at DAAS.**

The central door for referral will not be successful unless there is a centralized source for consumer friendly information that will allow individuals to better understand the timeline and progress and how it will impact them.

**Recommendation 2.1. How the DAAS Integrated Intake Unit will function.**

Being referred to the DAAS Integrated Intake Unit makes an assumption that services and supports needed to support people in the community are available. If the rule of thumb is that 20% of the support people need is provided by formal services, and the
remaining 80% is provided by family, friends, faith communities, membership organizations, someone really needs to think through this interface.

**Recommendation 2.1. How the DAAS Integrated Intake Unit will function.**

On this same issue, the biggest disconnect is with individuals who are not eligible for the services they need because they are the upper poor or middle class. A small savings or pension puts this improved system out of reach for many. The target group here, where some real strategy might make a difference, includes those who could be Medi-Cal eligible on a share of cost basis where they are assisted to pay their share of cost.

**Recommendation 2.2. The need to examine best practice models that assist older adults and adults with disabilities to return to community living.**

It is not just about formal services but also informal support that helps people age successfully in community. Support should include training that helps them re-connect with friends and family. People should be assisted in getting the kind and level of support that formal services can’t provide. This can also provide “witness” to what is working and what is not.

**Recommendation 3.1. DAAS should design a public information campaign targeting consumers.**

Where will responsibility for this lie? How will it coordinate with the significantly more robust marketing and communication efforts of the Health Plans and health care provider networks?

**Recommendation 3.1. Updating the online directory of service listings.**

The regular update of the directory and on-line website are a great improvement from the past, especially once the website is finally launched. But most people get their information “on the grapevine” from friends, family, churches, newspapers, etc. Multi-lingual programs like Senior Survival School, outreach through faith communities and ethnic media, are equally important.

**Recommendation 4.1. The asset mapping tool could be used to reduce potential duplication in care coordination activities among those agencies serving seniors and people with disabilities.**

Will consumers have the right to choose which case manager is the best match for them? While important to reduce duplication, will the data collection also inform us how additional case management or more consumer-directed options counseling is needed?

**Recommendation 4.3. DAAS, DPH and the Health Plans should initiate and support procedures for virtual case conferences.**

Does this include assuring patients and their family will be able to participate using these new technologies?
Recommendation 5.1. DAAS, DPH and the Health Plans should form an interagency committee to create a data sharing solution that allows DAAS, DPH, the Health Plans, and service providers in the community to view client-level LTSS usage data in a single data report.

*How will consumers and family caregivers be a part of the process? Will they have the ability to view or access their records, provide information, share their insights.*

Recommendation 6.1. DAAS, DPH, and the Health Plans should assign staff members to monitor the State’s development of standards and measures that demonstrate quality care to consumers.

*Who is the team leader for accountability purposes?*

Recommendation 8.1. Incorporate crucial long-term services and supports (LTSS) into the San Francisco LTSS managed care system.

- *Lead Responsibility: DAAS, DPH, Health Plans.* Where does primary accountability rest?

- *Shared Responsibility: LTCCC for Advocacy.* How should this happen? Who will collect the data on unmet need, help move the discussion from problems to solutions that will be effective and mobilize to make a difference? Programs like the Community Living Fund tend to focus on how well they are doing rather than on needs they are unable to meet.

Recommendation 8.2. DAAS, DPH and service providers should continue to collaborate to develop and promote a city-wide program of Healthy Aging that enhances the work currently being done by DAAS, DPH and service providers.

*How should this happen? Are we really talking about getting both the health care system and patients/community members to rethink roles and responsibilities?*

Recommendation 10.1. Ensure that the current and future generation of direct care workers are recruited, trained, and retained to improve the quality of care and quality of life for consumers. Both basic and specialized training should be provided, and best practice standards should be used.

*Someone has to better plan for the growing number of workers - who are aging out as providers and moving into the system as consumers - for whom their small savings and pensions will prevent them from accessing Medi-Cal services the clients they cared for received.*

Recommendation 10.2: Increase wages and expand benefits for direct care workers, focusing on Personal Care Aides (PCAs).

*Same issue was raised above under Recommendation 10.1.*
**Recommendation 10.4:** Expand training and education for: (1) consumers with long-term health conditions who are caring for themselves; (2) their family members who are also caregivers; and (3) community caregivers.

How might this be reflected in the over-all restructuring and information gathering/sharing that is described in the first group of recommendations?

**Recommendation 11.2.** Involve IHSS consumers and workers in designing the new LTCI service delivery system and in the care planning process. At the heart of the IHSS program is the concept of consumer direction.

Some of the other groups may have a role – faith communities, neighborhood associations, plus senior and disability groups.

**Recommendation 11.3.** DAAS should take the lead to collaborate on IHSS integration into managed care. Collaboration will include input from IHSS stakeholders.

How can consumers be involved in this integration into managed care?

**Recommendation 11.4.** Continue to provide consumers with access to ancillary services to the IHSS program, like emergency on-call and consumer peer mentoring, as the IHSS program is integrated into managed care.

We need to think outside the current box – think of the Villages, networks, faith communities and other places where we can mobilize social capital and a history of relationships to better meet the 80% not provided by formal services.

**Recommendation 13.1:** The communications plan, developed by the Communications Subcommittee and included in this strategic plan, should guide communications with consumers, advocates, service providers, stakeholders, city departments, commissions, and elected officials, about the scope of these LTCI recommendations to improve access to and coordination of LTSS.

Where will the staff time and expertise come from to make this effective now and over the next few years as the system shakes out?

**Appendix A. Crucial Services. CBAS (CCI component).**

The creation of this new program was the trial for the transition into managed care. Assessing how the participants and the agencies fared in the transition provides some important lessons and cautions for the future.

**Appendix A. Crucial Services. ADHC services – share of cost.**

A more aggressive strategy to use local dollars to expand eligibility and draw down more federal dollars would be helpful here.
Appendix A. Crucial Services. Groceries for the OMI Food Network: San Francisco provides funding for 60 people at a cost of $400 each.

It should be noted that the funding for the delivery of food and the coordination of support to recipients has also: (1) mobilized a neighborhood network to provide other practical support; (2) establish a large, monthly breast cancer support group, and a weekly walking group; and (3) stimulated a host of other neighborhood based activities, like the recent Aging While Black seminar. We also over-serve our contract, so actual cost is $400.

Appendix A. Crucial Services. Transportation.

Given the expanding senior population, it is anticipated that there will be additional need for transportation services. Efforts need to continue to make regular and ramp taxis available in a more equitable way to those that need them.
APPENDIX G:
SAMPLE OF COMMUNITY-BASED AND COUNTY LONG-TERM SERVICES AND SUPPORTS (LTSS) SERVICE PROVIDERS (SAMPLE LIST ONLY)
To review the full list of LTSS, go to: www.sfgetcare2.com

Community-Based Long-Term Services and Supports (LTSS) Service Providers:

- Alzheimer’s Association of Northern California and Northern Nevada
- Bayview Hunters-Point Multipurpose Senior Services
  - Adult Day Health
  - George Davis Senior Center
  - Western Addition Senior Center
- Bernal Heights Neighborhood Center
- Catholic Charities
  - Adult Day Services
  - Alzheimer’s Day Care Resource Center
- Centro Latino de San Francisco
- Chinatown Community Development Corp.
- Conard House
- Curry Senior Center
- Disability Rights California
- Episcopal Community Services
  - Canon Kip Senior Center
  - Resource Centers for Seniors and Adults with Disabilities
- Family Caregiver Alliance
- Family Service Agency
  - Long-Term Care Ombudsman Program
- Glide Memorial Church
- Golden Gate Regional Center
- Golden Gate Senior Services
- Hearing and Speech Center of Northern California
- IHSS Consortium
  - TAPCA
- IHSS Public Authority
  - Peer Mentoring Program
- Independent Living Resource Center
- Institute on Aging:
  - Community Living Fund
  - Multipurpose Senior Services Program
  - Linkages
    - Irene Swindells Center for Adult Day Services (Alzheimer’s care)
    - Ruth Ann Rosenberg Adult Day Health and Alzheimer’s Day Care Resource Center
- Janet Pomeroy Center
- Jewish Community Center of San Francisco
- Jewish Family and Children’s Services
  - L Chaim Adult Day Health
  - Seniors at Home
- Kimochi, Inc.
  - Senior Center
- Legal Assistance to the Elderly
- Lighthouse for the Blind and Visually Impaired
- Little Brothers Friends of the Elderly
- Meals on Wheels Of San Francisco
- Mental Health Association
- Mercy Housing
- Mission Neighborhood Centers
- No. California Presbyterian Homes and Services
  - San Francisco Senior Center
  - Services Connection Program
- On Lok, inc.
  - 30th Street Senior Center
  - On Lok Lifeways
- openhouse
- Progress Foundation
- Project Open Hand
- Russian American Community Services
- San Francisco Community Clinic Consortium
- South of Market Health Center
- San Francisco Food Bank
- San Francisco Veterans Administration (VA) Medical Center
- Senior and Disability Action
- Self Help for the Elderly
  - Adult Day Health
  - Alzheimer’s Day Care Resource Center
- Stepping Stone Adult Day Health
  - Mabini Day Health
  - Golden Gate Day Health
  - Presentation Day Health
  - Mission Creek Day Health
- Swords to Plowshares
- Tenderloin Neighborhood Development Corporation
- The Arc of San Francisco
- TODCO Group
- Toolworks
- United Way of the Bay Area/211
- Veteran Equity Center
- YMCA

**County Long-Term Services and Supports (LTSS) Providers:**

*Department of Aging and Adult Services*

- Adult Protective Services
- In-Home Supportive Services
- Office on the Aging
- Public Administrator
- Public Conservator
- Public Guardian
- Representative Payee Program
- County Veterans Service Office

**Long Term Care Operations:**

  - Community Living Fund
  - Diversion and Community Integration Program
  - Transitional Care
- Integrated Intake and Screening Unit Information, Referral & Assistance – handles intake for:
  - Adult Protective Services
  - Community Living Fund
  - Home-Delivered Meals
  - In-Home Supportive Services
  - Transitional Care

Department of Human Services
- Food Stamp Program
- Housing and Homeless Program
- Medi-Cal Health Connections Program

Department of Public Health*
- Community Behavioral Health Services
- Dental Services
- Disease Prevention
- Emergency Services
- Health at Home
- Housing and Urban Health
- Primary Care
  - Community-Based Primary Care Clinics and hospital-based primary care clinics
- Laguna Honda Hospital & Rehabilitation Center
- San Francisco General Hospital & Trauma Center

* DPH also provides jail health services, maternal, child, and adolescent health, and public health services - community health promotion, environmental health, public health emergency preparedness and response, disease prevention and control, and emergency medical services.

Department of Parks and Recreation
Mayor’s Office of Community Investment
Mayor’s Office on Disability
Mayor’s Office of Housing
Municipal Transportation Agency
San Francisco Housing Authority
San Francisco “311” Municipal Services Information Line
APPENDIX H
CALIFORNIA’S LONG TERM CARE INTEGRATION PILOT PROGRAM (AB 1040 - 1995)

Assembly Bill 1040 was passed October 13, 1995. It provided for the establishment of the Long-Term Care Integration Pilot Program to integrate the financing and administration of long-term care services in up to five pilot project sites around the state, with one site being located in a rural or underserved part of the state – contingent upon a state-approved administration action plan. Each pilot project site would be responsible to develop a model integrated service delivery system to meet the needs of all beneficiaries (including those who live in their own homes and those in out-of-home placements) that is humane, appropriate and cost-effective. Costs of the program must not exceed the amount that would have been expended in the absence of the pilot program.

Goals of the pilot program included (as stated in AB 1040):

- Provide a continuum of social and health services that foster independence and self-reliance, maintain individual dignity, and allow consumers of long-term care services to remain an integral part of their family and community life
- If out-of-home placement is necessary, to ensure that it is at the appropriate level of care, and to prevent unnecessary utilization of acute care hospitals
- If family caregivers are involved in the long-term care of an individual, to support caregiving arrangements that maximize the family’s ongoing relationship with, and care for, that individual
- Deliver long-term care services in the least restrictive environment appropriate for the consumer
- Encourage as much self-direction as possible by consumers, given their capability and interest, and involve them and their family members as partners in the development and implementation of the pilot project
- Identify performance outcomes that will be used to evaluate the appropriateness and quality of services provided, as well as the efficacy and cost effectiveness of each pilot project, including but not limited to, the use of acute and out-of-home care, consumer satisfaction, the health status of consumers and the degree of independent living maintained among those served
- Test a variety of models intended to serve different geographic areas, with differing populations and service availability
- Achieve greater efficiencies through consolidated screening and reporting requirements
- Allow each pilot project site to use existing funding sources in a manner that it determines will meet local need and that is cost-effective.
- Allow the pilot project sites to determine other services that may be necessary to meet the needs of eligible beneficiaries.
• Identify ways to expand funding options for the pilot program to include Medicare and other funding sources.

San Francisco developed an LTCI Pilot Project based on AB 1040. But in 1998, after three years of investigation, it was decided not to continue exploring LTCI under this initiative.
Community Living Fund

In July 2007, the Mayor and Board of Supervisors created the Community Living Fund (CLF), a collaboration between the City and the Institute on Aging. CLF assists with the transition of individuals with limited incomes who have been living in hospitals or care facilities and who wish to return to living independently within the community. CLF also provides services to individuals who are at imminent risk of becoming institutionalized. Clients can have an annual income of no more than 300 percent of the federal poverty level (currently $33,510) to qualify.

All CLF clients go through a very comprehensive assessment process from which a specialized care plan is developed. Intensive case management follows a client as they transition out of institutional care and into independent living. CLF uses trained professional nurses and social workers to provide service coordination and, when necessary, to purchase items and/or services needed by an individual to enable them to live independently. Most clients need assistance with coordinating their overall care, in-home supportive services, and housing assistance. Clients are normally supported by CLF from six months to a year—sometimes longer—until they are stabilized and can live independently with existing social services. Prior to the creation of CLF, individuals had to remain institutionalized or struggle to get the help they needed on their own.

Diversion and Community Integration Program

The Diversion and Community Integration Program (DCIP) began in January of 2008 as a result of a legal settlement. DCIP is a joint venture of the Department of Public Health and the Department of Aging and Adult Services designed to evaluate individuals who are referred to or discharged from Laguna Honda Hospital and assist them in accessing the most integrated setting appropriate to their needs and preferences. DCIP provides housing and community-based services that promote and maintain independence and support quality of life. The goal of the program is to focus on enhancing services that allow clients to remain in the community for as long as possible.

IHSS Consortium

The IHSS Consortium was founded by a group of community-based organizations to provide quality home care services to seniors and people with disabilities — enabling them to exercise their rights under the Supreme Court Olmstead Decision and to live independently and safely in their homes and communities, rather than in nursing homes or other institutions.

The Consortium has provided over 8.5 million hours of home care services to approximately 12,000 multi-lingual, multi-ethnic residents of San Francisco who are either too frail, ill, cognitively or behaviorally impaired to hire or supervise a home care worker. Home care
services may include cleaning, laundry, meal preparation, shopping and errands; non-medical personal-care services and certain paramedical services ordered by a physician; and accompaniment to medical appointments. The Consortium’s staff also links clients with other vital community services and works with these service providers, Adult Protective Services, and DAAS to ensure continuity of IHSS services. Clients are referred to the Consortium by the DAAS In-Home Supportive Services Program, which determines eligibility, assesses needs, and authorizes services.

The Consortium’s innovative model meets the growing and increasingly complex needs of San Francisco’s contract mode clients. Its integrated service model maximizes collaboration and support for both clients and home care providers. In addition to providing contract mode services, the Consortium offers training for the IHSS provider workforce – for both contract mode and Independent Provider mode – through TAPCA – the Training Academy for Personal Care Assistants. TAPCA offers both basic and specialized training.

IHSS Public Authority

In 1995, a San Francisco ordinance permitted by state law established the In-Home Supportive Services (IHSS) Public Authority to improve the services in the “independent provider” or IP mode of IHSS, where consumers hire and supervise their home care worker of choice. This quasi-governmental public agency was the 3rd such entity created in the state and the first overseen by an independent governing body with a majority of consumer members.

As of 2013 in San Francisco, the Authority offers services to and advocates on behalf of 22,000 consumers and serves as “employer of record” for the IP workforce which exceeds 18,000 people (predominantly family members), allowing them to be unionized. Its main service is the maintenance of a Central Registry of screened home care workers in order to provide referral lists of workers that match the individual consumer’s needs. It also offers referral lists to private paying consumers on a sliding scale.

IHSS services include chore and house cleaning services as well as personal care, such as assistance with eating, bathing, dressing, and using the toilet. The Authority offers emergency On-Call and Consumer Peer Mentoring services, which are free to IHSS consumers. For the IP workforce, the Authority made it possible to offer and administer medical and dental coverage and also partners with TAPCA to provide access to homecare skills training.
APPENDIX J:
LONG-TERM SERVICES AND SUPPORTS (LTSS) WITHIN A MANAGED CARE ENVIRONMENT:
CONSUMER PROTECTIONS, RISKS & OPPORTUNITIES

As San Francisco begins to explore the integration of Medicare and Medi-Cal, it needs to be aware of challenges for both seniors and adults with disabilities. The following highlight some of those challenges:\(^{41}\)

- Experience with Medicaid managed long-term services and supports (MLTSS) is limited because, while the number of Medicaid LTSS beneficiaries covered under managed care more than doubled from 2004 to 2008, managed care payments account for only 6 percent of spending for Medicaid beneficiaries using LTSS\(^ {42}\).

- Evidence about the impact of MLTSS is limited. Among interviewees currently involved with Medicaid MLTSS, some note that it is difficult to draw conclusions about the financial implications of establishing Medicaid LTSS programs. In instances where savings have been demonstrated, the reason for the savings is not always clear. In addition, results from studies regarding costs and outcomes in Medicaid managed care programs for individuals with disabilities – who may or may not need LTSS – have also been limited and mixed.\(^ {43}\)

- Program design is important, but it varies widely among the states incorporating Medicaid managed care. Programs also differ on their target populations.

- Behavioral health – Financing and delivery models can affect efforts to manage and coordinate behavioral health services, which are often “carved out” of the MLTSS program and provided by a separate behavioral health organization on a fee-for-service (FFS) basis. This is significant due to the fact that a substantial portion of the Medicaid LTSS population needs behavioral health services. Among dual eligibles, 26 percent of the elderly and 44 percent of individuals with disabilities have mental illness.\(^ {44}\)

- Mandatory vs. voluntary enrollment – Some argue that mandatory enrollment is necessary so there are enough participants to attract managed care organizations

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\(^{41}\) “Expanding Managed Long Term Services and Supports: Key Issues to Consider”, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2011.

\(^{42}\) Medicaid and CHIP Payment Access Commission, The Evolution of Managed Care in Medicaid, Report to the Congress, MACPAC, June 2011

\(^{43}\) Saucier, P., Managed Care for Medicaid Beneficiaries with Disabilities, National Health Policy Forum presentation, Washington, DC, May 2011

\(^{44}\) The Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System, MedPAC, June 2011
(MCOs), warrant investments on the part of states and plans and help ensure financial viability. Others say beneficiaries should have the freedom to choose to enroll. Mandatory enrollment requires authorization by the Centers for Medicare and Medicaid Services (CMS).  

- In the most fully integrated programs, MCOs are at risk for the management of all long-term services (community-based and institutional) as well as for medical services. There are currently two models for fully integrated care (blending Medicare and Medicaid) – PACE, a daycare-based program for frail elderly beneficiaries, and Special Needs Plans (SNPs) that target services to dual eligibles that have contracts with state Medicaid programs and receive monthly payments from Medicare and Medicaid. SNPs are Medicare Advantage plans that limit enrollment to subgroups of Medicare beneficiaries.

- MLTSS programs have contracts with different numbers of MCOs, and MCO sponsorship differs. State Medicaid programs have contracts with for-profit and not-for-profit MCOs. Large national commercial MCOs account for a substantial portion of MLTSS enrollment, which is likely to continue since sizeable initial investments are required to establish MLTSS plans.

- Establishing high quality MLTSS programs is not a simple process. Enough time needs to be taken in the program development phase to glean feedback from stakeholders, collaborate among affected state agencies and obtain CMS authority to operate new programs. In addition, if state governments are downsizing, they may not have the staff or expertise to develop, implement and monitor a new program.

- Input from stakeholders is critical during the design phase not only so that programs will be well accepted but also so that they will operate effectively.

- The term “managed care” may cause some concerns among consumers who are apprehensive about program changes that may put someone else in charge of their care, limiting their ability to access a set of services and supports that supports them to function independently and maintain continuity of care. They are wary of a “one-size-fits-all” approach on the part of MCOs. They want to know that facilities will be accessible to people with disabilities and that linguistic and cultural accommodations will be available when needed.

- Providers wonder whether or not they will be included in networks, how much they’ll be reimbursed, about the administrative ramifications of new arrangements including

--45 Historically, states have applied to operate MLTSS programs using a combination of 1915(b) enrollment authority with 1915(c) home and community-based service waiver authority. A few states, including Arizona and Tennessee, which enroll all beneficiaries in a MLTSS program, operate their programs under section 1115 of the Social Security Act. That approach appears to be more popular now as states seek more flexibility in program design. 
apprehension about possible new rules and procedures established by MCOs and whether or not they’ll have different rules for each MCO they contract with.

- Community-based organizations play a vital role. They are trusted in the community and have played an active role advising and assisting consumers about LTSS. In a few states, they actually function as MCOs but most do not have the resources to meet financial and regulatory requirements. Many worry that their funding may be cut if some of their traditional functions are assumed by MCOs, and they may lose experienced staff to large national plans to help them develop a community presence leaving an inadequate supply of assistance to those consumers who do not qualify for Medicaid but also rely on these organizations.

- Strong state oversight is essential and clear, explicit contract language about what plans must do and when and how they must report results helps to ensure it. Clear metrics need to be established to monitor plan performance.

- Processes need to be put into place to engage consumers and providers and obtain their feedback.

- Quality measures need to be established. For the most part, quality measures tend to be clinically oriented, but there is also a need to develop measures that will include LTSS outcomes and population-specific data and provide information about quality of life.

- Certain program features, such as service coordination, particularly coordination to facilitate smooth transitions among service settings, promote a shift to more community-based and better-coordinated services. Service coordination is often cited as a key feature of MLTSS programs that promotes effective and efficient delivery of services for populations with complicated medical and social needs. However, different states and MCOs often take very different approaches to service coordination.

- Over the last several years, CMS and states have aggressively promoted policies and practices to divert consumers from nursing facilities or to help those already in facilities make the transition back to the community. When MCOs are responsible and at risk for a broad array of services, they are more able to achieve diversions or transitions. Reimbursement policies can have an effect on the extent to which diversions and transitions occur.

- When states think about how to design MLTSS programs, they must consider what types of services or supports consumers can direct.

- The need persists for adequate affordable housing and a well-trained workforce to keep people who need LTSS in the community. The lack of affordable accessible housing alternatives continues to be one of the biggest barriers to keeping people who need LTSS in the community. In many places, the supply of formal caregivers, particularly
those that provide paid services in the home, is not adequate to meet the demand for services.

The needs of adults with disabilities often differ from those of seniors. The following highlights specific challenges for adults with disabilities as the State moves into managed care.46

Payment

- Establishing capitation rates for persons with disabilities is fairly complicated due to the fact that Medicaid beneficiaries with disabilities have a wide range of conditions and diseases and require diverse, extensive, and specialized services and supports. In addition, the rates need to be high enough to enable MCOs to recruit the variety of providers and specialist needed to care for this population. The current FFS utilization data may not provide a good basis for capitation rates because there is evidence of a significant unmet need among beneficiaries with disabilities in the FFS system.

- If capitation rates are adequate, they could provide MCOs with flexibility to allocate payments among a variety of services including, for example, member education and outreach materials, and improved care coordination through case managers.

- Establishing minimum medical loss ratios, the share of premium dollars spent on health services ensures that Medicaid dollars finance services to beneficiaries.

- Risk-sharing arrangements, which limit plan financial risk, may help to protect beneficiaries as well, particularly while states and plans gain more experience serving individuals with disabilities in capitated managed care.

- Short-term savings from managed care for persons with disabilities are likely to be elusive. Medicaid FFS payment rates, on which capitation rates may be based, are already so low in many states there is little room for savings by reducing price. That leaves utilization as the remaining source of potential savings. However, there is no evidence of over-utilization by beneficiaries with disabilities.

- Sound efforts to reduce Medicaid spending associated with individuals with disabilities will focus on improving access and care management for these beneficiaries.

Provider Networks and Delivery Systems

- To serve Medicaid beneficiaries with disabilities adequately, many MCOs will need broader provider networks that include a wide variety of specialists and specialized

46 “People with Disabilities and Managed Care: Key Issues to Consider”, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, February 2012.
facilities to deal with the developmental, mental health and physical conditions, both acute and long-term care, represented in the disabled population.

- Reasonable travel and wait times for appointments are key considerations in developing and evaluating provider networks for beneficiaries with disabilities.

- Physical accessibility of health care facilities and an array of other accommodations are needed to ensure meaningful and adequate access for persons with disabilities – also effective communication, such as use of sign language interpreters.

- Improved integration of behavioral and physical health care is a priority concern, as more than half of Medicaid beneficiaries with disabilities have a diagnosed mental illness.

- Beneficiaries with chronic conditions, particularly severe mental illness, may face special challenges in navigating managed care and may require special assistance, such as special outreach or follow-up, to help them with getting to appointments or following through with treatment.

- Co-location of mental health and primary care providers can facilitate integration of their services.

- Delivery systems, capitated or not, that rely on multi-disciplinary care teams that include primary care providers, behavioral health specialists, community health workers, and support specialists can enhance the coordination of care for persons with disabilities.

- Coordination between acute care and LTSS is an important issue for many in the population with disabilities.

- The new Medicaid “health home” option under the Affordable Care Act provides a new funding opportunity for states to improve care for people with complex and chronic medical needs.

Beneficiary Protection and Oversight of Managed Care

- Stakeholder and beneficiary engagement are crucial through all stages of program development to fully identify the needs and concerns of people with disabilities.

- Adequate outreach, information and assistance are vital to ensure that beneficiaries with disabilities understand managed care. Thus, several modes of communication may be necessary to inform beneficiaries and engage them in choosing a plan and managing their care.
• It’s important that those providing assistance to beneficiaries in choosing a plan have substantial knowledge of the particular services and supports their clients need, and of the strengths and limitations of different managed care plans relative to those needs.

• Voluntary enrollment or, in a mandatory enrollment context, strategies to smooth transitions for beneficiaries currently in FFS, could mitigate disruptions in established patient-provider relationships and ongoing treatment.

• Patient navigators or other strategies for assisting beneficiaries with disabilities in managed care could help individuals obtain the services and supports they need.

• Collection and analysis of encounter data are essential to assessments of quality of care and to setting actuarially sound capitation rates.

• Specialized measures of access and quality and robust monitoring efforts are needed to ensure access, coordination and a satisfactory patient experience across the range of services and supports needed by individuals with disabilities.

• Careful contracting and state oversight of managed care programs are essential for ensuring that plans cover and adequately deliver a defined set of services and supports to enrollees.

• Federally required grievance and appeals procedures protect beneficiaries in MCOs, but states can take additional steps, such as using External Quality Review Organizations, to strengthen beneficiary protections.

Enhanced Primary Care Case Management as an Alternative to Risk-Based Managed Care

• Particularly in light of limited state and health plan experience serving Medicaid beneficiaries with disabilities, primary care case management (PCCM) may be an attractive alternative to capitated managed care for improving access and care coordination for beneficiaries with disabilities. Recent evidence indicates that enhanced PCCM can yield savings, through improved patterns of care rather than price reductions.
Appendix K: Quality of Care Performance Measures

Standard quality measures for LTSS have not been developed, which represents a problematic gap in the context of efforts to integrate management of LTSS and medical care. In releasing its initial core set of quality measures for adult Medicaid beneficiaries in January 2012, CMS acknowledged the lack of measures for those receiving home and community-based services, citing existing measures that meet scientific soundness criteria could not be identified. Widely used quality measure sets like the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), do not take into account, or include, targeted measures that reflect the nature of LTSS.

As part of California’s Coordinated Care Initiative and Cal MediConnect, DHCS has empanelled a Quality Work Group, one of seven stakeholder workgroups, to provide input to the Coordinating Committee on issues related to the quality of care for Medicare/Medi-Cal dual-eligible beneficiaries across the care continuum. The workgroup will develop a measurement framework specific to the quality issues dual-eligible beneficiaries face, assess current measures and measurement efforts, and consider potential new measures. To date, that workgroup has raised the following key issues:

- It is important to find a balance between the abundance of desired data stakeholders would like to collect while staying realistic about what is possible to analyze, given available resources.
- The demonstration should build on existing performance measures collected and reported by Health Plans, with the addition of new measures related to LTSS.
- When establishing protocols for quality and evaluation management, tools are needed to measure non-medical outcomes, such as the beneficiaries’ desired outcomes.
- The focus should be on developing protocols for quality and evaluation management that remain applicable and relevant beyond the Cal MediConnect.
- Evaluation data should be made available to the public in a way that is useful for consumers to make informed choices about their care.

Performance measures are central to understanding progress in improving quality and can provide valuable information to providers, public and private sector payers, beneficiaries and their caregivers. While there has been considerable work on quality measures as they relate to medical care, quality measures for LTSS have not been fully developed. Given that the Cal MediConnect involves some of the most frail and most vulnerable individuals covered by Medicare and Medi-Cal, it is crucial to be able to measure the quality of their care (medical and LTSS) and seek ways to improve quality over time.

The Department of Health and Human Services (HHS) engaged a multi-stakeholder group of public and private sector organizations and experts (Measure Applications Partnership – MAP)
to assist in the development of these quality measures. MAP has identified the following core aspects of care it believes could provide high value signals of quality improvement over time:

- Individuals’ quality of life and functional status—including symptom control, progress toward treatment and recovery goals and, in time, psychosocial factors such as level of engagement in community activities.
- Individuals’ preferences and experience of care, and engagement in decisions about their care.
- The coordination of care among multiple providers and facilities, particularly when a dual-eligible beneficiary transitions from one care setting to another (from a hospital to a nursing home or home care, for example).
- The continual need for follow-up care and the availability of community support services and systems.
- The ongoing management of chronic health conditions and the risks for chronic conditions.\(^ {47} \)

MAP identified a specific set of measures applicable to the Cal MediConnect population including:

- Measures of detecting and treating depression;
- Screening older adults for fall risk; and
- Use of surveys that allow patients to give their own views of the care they receive.

MAP also selected potential measures for Medicaid home and community-based services (HCBS). MAP followed three national efforts related to long-term care quality to examine potential measures of quality in home and community-based services. National Quality Forum (NQF) has not endorsed any measures of quality in HCBS to date, and MAP is not recommending this list for immediate implementation. Rather, the concepts described below are illustrative of the person-centered care MAP desires to promote and evaluate.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub-domain</th>
<th>Potential Measure</th>
<th>Source</th>
<th>Notes</th>
<th>High-Leverage Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Functioning</td>
<td>Change in daily activity function</td>
<td>Degree to which consumers experience an increased level of</td>
<td>Commission on Accreditation of Rehabilitation</td>
<td>Tested with multiple disabilities populations</td>
<td>Quality of Life, Screening and Assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>Sub-domain</th>
<th>Potential Measure</th>
<th>Source</th>
<th>Notes</th>
<th>High-Leverage Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Functioning</td>
<td>Availability of support with everyday activities when needed</td>
<td>Unmet need in ADLs/IADLs (11 measures total)</td>
<td>Participant Experience Survey</td>
<td>Item present in all three versions (elderly/disabled, mental retardation/developmental disabilities, and acquired brain injury); additional money management item in brain injury tool</td>
<td>Quality of Life, Structural</td>
</tr>
<tr>
<td>Client Functioning</td>
<td>Presence of friendships</td>
<td>Degree to which people express satisfaction with relationships</td>
<td>Commission on Accreditation of Rehabilitation Facilities</td>
<td>Tested with multiple disabilities populations</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>Client Functioning</td>
<td>Presence of friendships</td>
<td>Satisfaction with close friends</td>
<td>Quality of Life Scale (modified by Burkhardt)</td>
<td>Developed and tested with populations with chronic illness</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>Client Functioning</td>
<td>Maintenance of family relationships</td>
<td>Satisfaction with relationships with parents, siblings, and other relatives</td>
<td>Quality of Life Scale (Burkhardt version for chronic illness)</td>
<td>Developed and tested with populations with chronic illness</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>Client Functioning</td>
<td>Community integration</td>
<td>Participants reporting unmet need for community involvement</td>
<td>Participant Experience Survey</td>
<td>Item supported by all three versions; additional community involvement measures related to specific activities such as shopping present in brain injury and mental retardation/developmental disabilities versions</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>Client Functioning</td>
<td>Receipt of recommended preventative health care services</td>
<td>Degree to which people with identified physical health problems obtain appropriate services and degree to which health status is maintained and improved</td>
<td>Commission on Accreditation of Rehabilitation Facilities</td>
<td>Tested with multiple disabilities populations</td>
<td>Screening and Assessment, Structural</td>
</tr>
<tr>
<td>Domain</td>
<td>Sub-domain</td>
<td>Potential Measure</td>
<td>Source</td>
<td>Notes</td>
<td>High-Leverage Opportunities</td>
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</tr>
<tr>
<td>Client Experience</td>
<td>Respectful treatment by direct service providers</td>
<td>Degree to which consumers report that staff are sensitive to their cultural, ethnic, or linguistic backgrounds and degree to which consumers felt they were respected by staff</td>
<td>Commission on Accreditation of Rehabilitation Facilities</td>
<td>Developed and tested with multiple disability populations</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>Client Experience</td>
<td>Opportunities to make choices about services</td>
<td>Degree of active consumer participation in decisions concerning their treatment</td>
<td>Commission on Accreditation of Rehabilitation Facilities</td>
<td>Tested with multiple disability populations</td>
<td>Care Coordination, Structural</td>
</tr>
<tr>
<td>Client Experience</td>
<td>Satisfaction with case management services</td>
<td>Case management helpfulness</td>
<td>Participant Experience Survey</td>
<td>Item present in all three survey versions</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>Client Experience</td>
<td>Client perception of quality of care</td>
<td>Degree to which consumers were satisfied with overall services</td>
<td>Commission on Accreditation of Rehabilitation Facilities</td>
<td>Developed and tested with multiple disability populations</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>Client Experience</td>
<td>Client perception of quality of care</td>
<td>Service satisfaction scales: home worker; personal care; home-delivered meals</td>
<td>Service Adequacy and Satisfaction Instrument</td>
<td>Developed and tested with service recipients age 60 and older</td>
<td>Quality of Life</td>
</tr>
<tr>
<td>Program Performance</td>
<td>Access to case management services</td>
<td>Ability to identify case manager</td>
<td>Participant Experience Survey</td>
<td>Supported by all three survey versions</td>
<td>Care Coordination, Structural</td>
</tr>
<tr>
<td>Program Performance</td>
<td>Access to case management services</td>
<td>Ability to contact case manager</td>
<td>Participant Experience Survey</td>
<td>Supported by all three survey versions</td>
<td>Care Coordination, Structural</td>
</tr>
<tr>
<td>Domain</td>
<td>Sub-domain</td>
<td>Potential Measure</td>
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</tr>
<tr>
<td>Choice of Setting and Provider</td>
<td>N/A</td>
<td>Tools and programs to facilitate consumer choice (composite indicator, scale 0-4)</td>
<td>AARP conducted a state survey to collect information about states’ single entry point systems and various functions that facilitate consumer choice. Data from State LTSS Scorecard Survey (AARP PPI, Scorecard 2010)</td>
<td>States were scored from 0 (no use of tool or program) to 1 (full use of tool or program) in each of four categories: 1. Presumptive eligibility (scoring: 1 point) 2. Uniform assessment (scoring: proportion of Medicaid and state-funded programs that use a uniform assessment tool, with multiple HCBS waivers counting as two programs regardless of the number of waivers) 3. Money Follows the Person and other nursing facility transition programs (scoring: 1/3 point if a program exists, 1/3 point if statewide, 1/3 point if it pays for one-time costs to establish community residence) 4. Options counseling (scoring: whether offered to individuals using each of five types of payment source)</td>
<td>Quality of Life, Structural</td>
</tr>
<tr>
<td>Quality of Life and Quality of Care</td>
<td>N/A</td>
<td>Percent of adults 18+ with disabilities in the community usually or always getting needed support</td>
<td>Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)</td>
<td>Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who usually or always received needed social and emotional support</td>
<td>Structural</td>
</tr>
<tr>
<td>Quality of Life and Quality of Care</td>
<td>N/A</td>
<td>Percent of adults 18+ with disabilities in the community satisfied or very satisfied with life</td>
<td>Data from 2009 BRFSS (NCCDPHP, BRFSS 2009)</td>
<td>Percent of adults limited in any way in any activities because of physical, mental, or emotional problems who were satisfied or very satisfied with their life</td>
<td>Quality of Life, Structural</td>
</tr>
<tr>
<td>Support for Family Caregivers</td>
<td>N/A</td>
<td>Percent of caregivers usually or always getting needed support</td>
<td>Institute analysis of 2009 BRFSS (NCCDPHP, BRFSS 2009)</td>
<td>Percent of adults who provided regular care or assistance to a friend or family member during the past month and who usually or always received needed social and emotional support</td>
<td>Structural</td>
</tr>
<tr>
<td>Domain</td>
<td>Sub-domain</td>
<td>Potential Measure</td>
<td>Source</td>
<td>Notes</td>
<td>High-Leverage Opportunities</td>
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</tr>
<tr>
<td>Sustainability</td>
<td>N/A</td>
<td>Proportion of Medicaid HCBS Spending of the Total Medicaid LTC Spending</td>
<td>NBIC using Thomson Reuters</td>
<td>The proportion of Medicaid HCBS spending of the total Medicaid long-term care spending</td>
<td>Structural</td>
</tr>
<tr>
<td>Self-determination/Person-centeredness</td>
<td>N/A</td>
<td>Availability of Self-Direction Options</td>
<td>NBIC using CMS Medicaid Waiver Database, and State Self-Assessment</td>
<td>Does the State have one or more Medicaid waivers that offer participant-directed services? If yes, what is the employer status of participant?</td>
<td>Quality of Life, Structural</td>
</tr>
<tr>
<td>Community Integration and Inclusion</td>
<td>N/A</td>
<td>Waiver Waitlist</td>
<td>NBIC using CMS Medicaid Waiver Database, and State Self-Assessment</td>
<td>There is a process for tracking people who are unable to gain access to services (e.g., waiting list management and protocols)</td>
<td>Structural</td>
</tr>
<tr>
<td>Prevention</td>
<td>N/A</td>
<td>Proportion of People with Disabilities Reporting Recent Preventive Health Care Visits (individual-level)</td>
<td>NBIC calculations using the Centers for Disease Control and Prevention Behavioral Risk Factor Surveillance System (BRFSS) data</td>
<td>The proportion of individuals with disabilities who report having had a preventative health care visit within the past year</td>
<td>Screening/Assessment</td>
</tr>
<tr>
<td>Coordination and Transparency</td>
<td>N/A</td>
<td>Proportion of People Reporting That Service Coordinators Help Them Get What They Need</td>
<td>NBIC using National Core Indicators (NCI) Data</td>
<td>The proportion of people reporting that service coordinators help them get what they need</td>
<td>Care Coordination, Structural</td>
</tr>
<tr>
<td>Domain</td>
<td>Sub-domain</td>
<td>Potential Measure</td>
<td>Source</td>
<td>Notes</td>
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</tr>
<tr>
<td>Coordination and Transparency</td>
<td>N/A</td>
<td>Coordination Between HCBS and Institutional Services</td>
<td>State Self-Assessment</td>
<td>Coordinated Policymaking: The State coordinates budgetary, programmatic, and oversight responsibility for institutional and home and community-based services</td>
<td>Care Coordination</td>
</tr>
</tbody>
</table>

As one of the recommendations of the San Francisco LTCI (Design Group?) is to ‘monitor the State’s development of standards and outcomes measures that demonstrate quality care to consumers’48, it will be important to continue to follow the work of HHS (MAP), the Center for Health Care Strategies, the Kaiser Family Foundation and DHCS’s Dual’s Quality Workgroup. Based on that work, it should mirror standards to be implemented in San Francisco.

48 San Francisco LTCI Recommendation 6.1: Assign existing DAAS and DPH staff members to monitor the State’s development of standards and outcome measures that demonstrate quality care to consumers. This effort should actively track the Duals Demonstration State Quality Work Group. Based on that work, similar quality assurance standards for LTSS should be developed and implemented in programs managed by DAAS and DPH.
APPENDIX L:
SUMMARY OF CAL MEDICONNECT PILOT PROJECT MOU
BETWEEN CALIFORNIA AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES -
FROM THE SCAN FOUNDATION

See next 13 pages
Cal MediConnect: A Summary of the Memorandum of Understanding Between California and the Centers for Medicare and Medicaid Services

On March 27, 2013, the State of California and the Centers for Medicare and Medicaid Services (CMS) formalized a Memorandum of Understanding (MOU) to establish a Federal-State partnership to implement the Dual Eligibles Integration Demonstration, now referred to as “Cal MediConnect.” This Fact Sheet provides background information about Cal MediConnect and summarizes the key points of the MOU.

Background: The Dual Eligible Integration Demonstration and the Coordinated Care Initiative

The enacted 2012-2013 state budget established the Coordinated Care Initiative (CCI) with the goal of “transforming California’s Medi-Cal care delivery system to better serve the state’s low-income older adults and persons with disabilities.” The main components of the CCI include the following: 1) provisions of the Dual Eligible Integration Demonstration; 2) mandatory enrollment of dual eligibles into Medi-Cal managed care; 3) integration of Medi-Cal long-term services and supports (LTSS) into Medi-Cal managed care; and 4) coordination of behavioral health services. Eight counties were selected as the implementation sites: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. For a detailed description of the CCI, please refer to The SCAN Foundation’s previously published fact sheet.

Memorandum of Understanding: Establishing the Framework for the Cal MediConnect Program

In May 2012, California submitted its proposal to CMS to establish the Dual Eligibles Integration Demonstration. The signed Memorandum of Understanding (MOU), finalized on March 27, 2013, signifies federal approval for the Demonstration. The MOU includes the operational plan as well as “the principles under which CMS and California plan to implement” the Demonstration, now referred to as Cal MediConnect (page 3). The MOU establishes the general parameters and framework for Cal MediConnect. However, many of the specifics will be outlined in the three-way contracts between the state, CMS, and the participating health plans in each county. The key features of the MOU are described below.

Changes from California’s Original Proposal

The MOU reflects changes from what was submitted in California’s original Demonstration proposal in May 2012. The major changes include the following:
• **Timeline:** The original proposal outlined a start date of March 2013. The MOU calls for implementation to start no sooner than October 2013, continuing through December 31, 2016. The first year of the Demonstration spans from October 1, 2013 to December 31, 2014. Years 2 and 3 of the Demonstration will encompass the entire calendar years of 2015 and 2016, respectively.

• **Geographic Regions:** The original proposal intended to phase-in all California counties into the Demonstration over a three-year period, beginning with eight counties in 2013, expanding to other Medi-Cal managed care counties in 2014, and all remaining counties in 2015 (see Appendix 1 of the original proposal). In contrast, the MOU limits the Demonstration to the following eight counties for the three-year period: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

• **Six-Month Lock-In Period:** In the original proposal, California outlined an initial enrollment lock-in of six months, referred to as the “stable enrollment” period, during which time beneficiaries would have been required to remain in the health plan for both their Medicare and Medi-Cal covered benefits. The MOU does not include a stable enrollment period, providing beneficiaries the ability to change plans and/or opt out of the Medicare portion of the Demonstration at any time.

• **Home- and Community-Based Services Benefits:** The original proposal defined home- and community-based service (HCBS) benefits as In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) as well as additional “in-lieu of institutionalization” benefits (page 3) such as respite, nutritional assessment, minor home adaptions, habilitation, among others. The proposal did not specify whether the “in-lieu of institutionalization” benefits would be required for participating health plans to provide. In addition, it was the state’s intent to close enrollment in HCBS waivers, as the services were expected to be provided as part of the Demonstration. In contrast, the MOU indicates that “participating plans will have discretion to use the capitated payment to offer HCBS, as specified in the Individual Care Plan, as appropriate to address the member’s needs” (page 93). Enrollment in the HCBS waivers will remain open, but beneficiaries cannot be enrolled in both Cal MediConnect and an HCBS waiver, other than MSSP.

• **Size:** The Governor’s proposed 2012-13 budget from January 2012 estimated approximately 800,000 enrollees, whereas the submitted proposal estimated about 685,000 enrollees in the first phase-in counties. The MOU estimates the total number of enrollees to be about 456,000.

• **Number of Participants in Los Angeles County:** The original proposal did not include an enrollment cap for any county. The MOU set a cap of no more than 200,000 enrolled beneficiaries in Los Angeles County.

• **Vision, Dental, Transportation Benefits:** The original proposal did not include dental, vision and non-emergency medical transportation benefits. The MOU specifies that, in addition to the other required Medicare and Medi-Cal services, health plans are required to provide these services.

**Demonstration Authority**

Section 1115A of the Social Security Act authorizes the CMS Center for Medicare and Medicaid Innovation to test different models of service delivery and evaluate those models within the Medicare and Medicaid programs. Using the federal Medicare waiver authority, CMS has “waived” certain Medicare program
Eligible individuals include adults enrolled in Medicare, receiving full Medi-Cal benefits, and residing in one of the eight counties. Individuals receiving full Medi-Cal benefits also include those enrolled in the Multipurpose Senior Services Program (MSSP), those who meet the share of cost (including nursing facility residents with a share of cost, MSSP enrollees with a share of cost, and In-Home Supportive Services recipients who met their share of cost in the fifth and fourth months prior to their enrollment into the Demonstration), and individuals eligible for full Medi-Cal per spousal impoverishment provisions. Figure 1 provides a summary of Cal MediConnect’s eligibility criteria.

**FIGURE 1 Cal MediConnect Eligibility Criteria**

<table>
<thead>
<tr>
<th>Inclusion Criteria:</th>
<th>Excluded from Enrollment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age 21 and older at time of enrollment</td>
<td>• Under age 21</td>
</tr>
<tr>
<td>• Entitled to Medicare Part A and enrolled in Parts B and D</td>
<td>• Enrolled in other private or public health insurance</td>
</tr>
<tr>
<td>• Receiving full Medicaid benefits</td>
<td>• Receiving services through California’s regional centers, state developmental centers, or intermediate care facilities for the developmentally disabled (ICF-DD)</td>
</tr>
<tr>
<td>• Residing in one of the eight Demonstration counties</td>
<td>• Individuals with a share of cost not meeting requirements as defined in the MOU</td>
</tr>
<tr>
<td>• Individuals residing in San Mateo County or Orange County with a diagnosis of end-stage renal disease (ESRD)</td>
<td>• Individuals residing in one of the Veterans’ Homes of California</td>
</tr>
<tr>
<td>• Individuals with ESRD in Demonstration counties other than San Mateo or Orange</td>
<td>• Individuals living in selected (rural) zip codes in Los Angeles, Riverside, and San Bernardino counties†</td>
</tr>
</tbody>
</table>

**Source:** Memorandum of Understanding (MOU) Between the Centers for Medicare and Medicaid Services (CMS) and the State of California (2013).

*For more information, please see The SCAN Foundation’s Long-Term Care Fundamental entitled “What is a Medicaid Waiver?”: [http://www.thescanfoundation.org/what-medicaid-waiver](http://www.thescanfoundation.org/what-medicaid-waiver).

† Residents of the following rural zip codes are not eligible for enrollment in the Demonstration: Los Angeles County – 90704; Riverside County – 92225, 92226, 92239; San Bernardino County – 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 92280, 93592, 92558.
**Enrollment Timeline**

Cal MediConnect will commence no sooner than October 1, 2013. Participating health plans may begin to accept enrollments two months prior to this start date (August 1, 2013). The first notices to beneficiaries will be mailed 90 days prior to the effective date of passive enrollment with subsequent notices mailed 60 and 30 days prior. With the exception of San Mateo and Orange Counties, which are both County Organized Health Systems with only one participating plan, the state will work through its enrollment broker to support the enrollment process. All notices will be reviewed and approved jointly by CMS and the state prior to initial mailings. The enrollment process differs for certain counties, as detailed in Figure 2 below. The MOU indicates that enrollment will be closed within six months prior to the end of the Demonstration.

**Enrollment Process**

- **Passive Enrollment into Cal MediConnect:** Most eligible individuals will be passively enrolled into Cal MediConnect, meaning that unless they notify the state that they do not wish to enroll in a Cal MediConnect plan, the state will automatically enroll them into one. Medicare passive enrollment will begin on or after October 1, 2013. The enrollment process will vary from county to county, but generally will be based on beneficiary birthdate for most eligible individuals (see Figure 2 for a county-specific enrollment process).

Certain populations are excluded from passive enrollment. These include:

- Beneficiaries who reside in selected rural zip codes in San Bernardino County will need to voluntarily enroll in a participating health plan because there is only one plan operating in those areas (see page 9 of the MOU for the full list of zip codes).

- Beneficiaries enrolled in the Nursing Facility/Acute Hospital Waiver, the HIV/AIDS Waiver, the Assisted Living Waiver, or the In-Home Operations Waiver may choose to enroll in Cal MediConnect only after disenrolling from these waiver programs.

- Beneficiaries enrolled in the Program of All-Inclusive Care for the Elderly (PACE) or the AIDS Healthcare Foundation may choose to enroll in Cal MediConnect only after disenrolling from these programs.

- **Medicare Advantage Enrollees:** Beneficiaries currently enrolled in a Medicare Advantage plan, including Dual Eligible Special Needs Plans (D-SNPs) (except for Kaiser Medicare Advantage enrollees) will be passively enrolled into the demonstration no sooner than January 1, 2014.

- **Program For All Inclusive Care for the Elderly (PACE):** Individuals already enrolled in a PACE plan will not be passively enrolled into a Cal MediConnect plan. They can only join a Cal MediConnect plan if they first disenroll from PACE. PACE will be presented as an enrollment option for individuals who meet PACE program eligibility criteria (age 55 and older and need a higher level of care to live at home).

*Mandatory enrollment into Medi-Cal Managed Care: Nearly all dual eligibles in the eight counties will be required to enroll in Medi-Cal managed care for their LTSS and any other Medi-Cal benefits. The mandatory enrollment into a Medi-Cal plan will coincide with their scheduled date for passive enrollment. This means that if a beneficiary chooses not to enroll in a Cal MediConnect plan or “opts out” at that time, he or she will still have to enroll in a Medi-Cal health plan for their Medi-Cal benefits only. If a beneficiary opts out after enrolling in a Cal MediConnect plan, he or she will be required to stay enrolled in a Medi-Cal managed care plan. These provisions related to mandatory enrollment into Medi-Cal managed care for dual eligibles are not included in the MOU, but will be specified in the amendments to the state’s 1115 waiver.*
For all Demonstration counties with multiple plans (this includes Alameda, Los Angeles, Riverside, San Bernardino, San Diego and Santa Clara), the state will employ an “intelligent assignment” process for selecting plans in the passive enrollment process. This process will prioritize continuity of care using claims history data to identify the most frequently used providers and the extent to which providers match the plan network. Beneficiaries have the option to disenroll from the Medicare portion of Cal MediConnect at any time. Plan transfers (in those counties where two or more options exist) or disenrollment will be allowed on a month-to-month basis.

### County-Specific Enrollment Approach for Cal MediConnect

#### Bay Area:

**Alameda and Santa Clara Counties:** Beneficiaries currently enrolled in Medi-Cal managed care will be passively enrolled in Cal MediConnect all at once, no sooner than October 1, 2013. Beneficiaries in fee-for-service Medi-Cal will begin enrollment effective the first day of their birth month, beginning no sooner than October 1, 2013 and ending after 12 months.

**San Mateo County:** Beneficiaries will be passively enrolled into Cal MediConnect at the same time, no sooner than October 1, 2013 (except for those in a Medicare Advantage plans and low-income subsidy plan reassigned; they will be passively enrolled in January 2014).

#### Southern California:

**Los Angeles County:** As specified in the MOU, DHCS is required to release for comment a proposal regarding the enrollment approach for Los Angeles that will occur over 15 months and start with an initial three-month voluntary, opt-in only period. There is an enrollment cap for Los Angeles County of 200,000 individuals.

**Orange County:** Beneficiaries will be passively enrolled in Cal MediConnect beginning on or after October 1, 2013, based on birth month over a 12-month period. Beneficiaries with a birthday in January 2014 will be enrolled on February 1, 2014.

**San Diego County:** Beneficiaries will be passively enrolled in Cal MediConnect beginning on or after October 1, 2013, based on birth month over a 12-month period. Beneficiaries with a birthday in January 2014 will be enrolled on February 1, 2014.

#### Inland Empire:

**Riverside and San Bernardino Counties:** Beneficiaries will be passively enrolled in Cal MediConnect beginning on or after October 1, 2013, based on birth month over a 12-month period. Beneficiaries with a birthday in January 2014 will be enrolled on February 1, 2014.

#### Exceptions:

**Multi-Purpose Senior Service Program (MSSP) Enrollees:** All beneficiaries enrolled in MSSP across the seven counties with passive enrollment beginning on October 1, 2013 will be enrolled at the start of the Demonstration. MSSP enrollees residing in Los Angeles County will all be passively enrolled into the Demonstration beginning on January 1, 2014. These rules for MSSP enrollees supersede the county-specific enrollment plans described above.

**Source:** Memorandum of Understanding (MOU) Between the Centers for Medicare and Medicaid Services (CMS) and the State of California (2013).

**Note:** Exceptions to all these county-specific enrollment scenarios include beneficiaries enrolled in a Medicare Advantage plan, including D-SNPs, and beneficiaries who are reassigned to a new low-income subsidy plan for 2013. These beneficiaries all would be passively enrolled in January 2014.
**Covered Benefits**

Cal MediConnect will integrate the financing and service delivery of Medicare and Medi-Cal covered benefits, as well as other benefits, as follows:

- **Medicare**: Parts A, B, and D (prescription drug)
- **Medi-Cal**: All Medicaid state plan services (except for specialty mental health and Drug Medi-Cal treatment services, see below)
- **Dental Benefits**: Plans will be required to provide preventative, restorative, and emergency oral health benefits
- **Vision**: Plans will be required to provide preventative, restorative, and emergency vision benefits
- **Transportation**: Plans will be required to provide non-emergency, accessible medical transportation available in sufficient supply so that individuals can access medical appointments.

**IHSS**: The MOU details requirements for participating health plans to coordinate IHSS benefits for eligible enrollees through county IHSS agencies. Plans will be required to pay for the IHSS hours for which an enrollee has been deemed eligible by the county IHSS agency. Plans have the option to authorize additional hours above those determined by the county IHSS agency for which an enrollee is eligible.

**Other HCBS**: The MOU indicates that “plans will have the discretion to use the capitated payment to offer HCBS, as specified in the member’s Individual Care Plan, as appropriate to address the member’s needs” (page 93). Discretionary HCBS include, but are not limited to, the following items:

- Supplemental personal care services
- Supplemental chore
- Supplemental protective supervision
- In home skilled nursing care and therapy services for chronic conditions
- Respite Care (in home or out-of-home)
- Nutritional supplements for home-delivered meals
- Care in licensed residential care facilities
- Home maintenance and minor home or environmental adaptation services
- Medical equipment operating expenses and Personal Emergency Response System (PERS)
- Non-medical transportation
- Non-emergency medical transportation.
**Behavioral Health:** Participating health plans will be required to provide or coordinate behavioral health services for all enrollees with these needs. Medi-Cal specialty mental health services currently administered by county Mental Health Plans under a 1915(b) waiver and Drug Medi-Cal services will not be included as Cal MediConnect health plan benefits (see MOU Table X, page 74 for a list of the excluded county-administered Medi-Cal mental health and substance use benefits). Participating health plans will be required to coordinate with county agencies to ensure enrollees have seamless access to these services. Additionally, plans will have the discretion to use their capitated payment to offer behavioral health services beyond those traditionally reimbursed by Medicare.

**Hospice Benefit:** If a Cal MediConnect enrollee elects to receive the Medicare hospice benefit, the enrollee will remain with the participating plan but will receive the hospice benefit through fee-for-service Medicare. The plan will no longer receive payment for the Medicare Part C benefit, as Medicare hospice services and all other Medicare services would be paid for under Medicare fee-for-service. Plans and providers of hospice services would be required to coordinate these services with the rest of the enrollee’s care, including with Medi-Cal and Part D benefits.

**Individual Care Plan, Care Coordination and Interdisciplinary Care Teams**

An individual care plan will be developed for each enrollee. This care plan will specify the individual’s preferences, goals, objectives, and timetables to meet medical, behavioral health, and LTSS needs. The MOU specifies that plans must engage enrollees and/or their representatives to play an active role in designing these care plans.  

All participating plans will be required to provide care coordination services to all enrollees reflecting a “member-centered, outcome-based approach” (page 69). The state has updated its draft Care Coordination Standards, which include guidance on enrollment and assessment of beneficiary health and functional status, delivery of basic and complex case management services, and requirements for referring to behavioral health, IHSS, and other HCBS. The revised Care Coordination Standards as released by DHCS will be incorporated into the three-way contracts between the health plans, DHCS and CMS.

Plans will be required to offer an Interdisciplinary Care Team (ICT), as necessary and as desired by the member. The purpose of the ICT is to ensure the integration of medical, behavioral health, and supportive services. The MOU details those individuals who may be members of the ICT: the enrollee, family members and other caregivers, designated primary physician, nurse, case manager, social worker, patient navigator, county IHSS social worker, IHSS provider, MSSP coordinator, pharmacist, behavioral health service providers, and other professional staff within the provider network. The enrollee has the option to choose to limit or disallow the role of IHSS providers, family members, and other caregivers on the team.

**Assessment Process**

Every enrollee will be assessed using a health risk assessment (HRA), which will be the starting point for care planning. The HRA must be reviewed and approved by the state and CMS. All participating health plans will be required to develop and implement a risk stratification approach, approved by the state and CMS, which uses available data to identify beneficiaries at highest risk of poor health and functional outcomes. For those enrollees identified as at “high-risk” per the plan’s risk stratification approach, the HRA will be completed within 45 days of enrollment. For enrollees in a nursing facility and those
identified at “lower risk” per the plan’s risk stratification approach, the plan will be required to complete the HRA within 90 days of enrollment. Reassessments will be conducted at least annually, within 12 months of the last assessment, or as often as the health of the enrollee requires. The MOU cites the state’s plan to develop a universal HCBS assessment, codified in the CCI statute, with plans to pilot test this assessment in 2015.4,8

**Network Adequacy**

Participating health plans will be required to meet Medicare and Medi-Cal standards for network adequacy. California and CMS will monitor access to care and the prevalence of needs indicated through enrollee assessments. The MOU lists the following requirements for participating plans:4

• Contract with providers and health facilities that comply with physical accessibility requirements;

• Maintain an updated listing of provider’s ability to accept new patients; and

• Maintain an appropriate provider network with an adequate number of specialists, primary care physicians, hospitals, long-term care providers and accessible facilities within each service area.

Other LTSS network adequacy specifications include the following:

• **MSSP**: Participating health plans will be required to contract with MSSP providers, providing the same level of funding those providers would have received under MSSP contracts until March 31, 2015 or 19 months after beneficiary enrollment.

• **CBAS**: Participating health plans will be required to contract with all willing, licensed, and certified CBAS centers located in the covered zip code areas and in adjacent zip codes, not more than 60 minutes driving time from the enrollee’s residence. If a CBAS center does not exist within the targeted zip codes or does not have capacity to serve enrollees, then plans must coordinate IHSS and other HCBS for eligible enrollees.

• **IHSS**: Plans are required to establish a MOU or contract with the county IHSS agency regarding the provision of IHSS for enrollees, including county eligibility assessment and authorization of hours, coordination of service delivery, provider enrollment, background checks and data sharing. Plans must also contract with the California Department of Social Services regarding IHSS provider pay wages and payroll obligations, data sharing provisions, and other processes to “promote the integration of the IHSS program into managed care” (page 84).4

• **Nursing Facility**: Plans will have the discretion to contract with licensed and certified nursing facilities in covered zip codes and adjacent zip codes. Nursing home residents will not be required to change facilities within the first 12 months of the Demonstration, as long as specified continuity of care provisions are met (see next section and Appendix 7, pages 94-96).

**Beneficiary Protections**

The MOU outlines the following beneficiary protection provisions, with further details to be specified in the three-way contract:
• **Continuity of Care:** Participating health plans will be required to provide access to necessary services and providers for a transition period of up to six months for Medicare services if certain criteria are met and a period of up to twelve months for Medi-Cal services if certain criteria are met.** Plans are required to perform an assessment within 45 or 90 days of beneficiary enrollment, depending on assessed risk level, to identify existing providers and establish a plan regarding continuity of care, if applicable.

• **Enrollment Assistance and Options Counseling:** The MOU states that individuals eligible for Cal MediConnect will be provided with independent enrollment assistance and options counseling to support their enrollment decisions. CMS and the Administration for Community Living (ACL) have set aside funds to support outreach, education, and options counseling efforts at State Health Insurance Assistance Programs (SHIPs, referred to as Health Insurance Counseling and Assistance Programs, or HICAPs in California) and Aging and Disability Resource Centers (ADRCs), and other community-based organizations.

• **Ombudsman:** The MOU states that California will establish an Ombudsman office to help resolve issues between Medi-Cal managed care members and participating health plans. As of the date of publication, no additional details are available about the development of this office.

• **Person-Centered, Appropriate Care:** All medically-necessary services must be provided to enrollees in an appropriate manner that recognizes cognitive and physical functional status, language and culture, and caregiver involvement (to the extent desired by the beneficiary). Services are to be received in an appropriate setting with emphasis on the home- and community-based environment.

• **Americans with Disabilities Act (ADA) and Civil Rights Act of 1964:** Participating health plans will be required to be in compliance with the ADA and the Civil Rights Act of 1964. Plans will be required to accommodate the communication needs of beneficiaries, including making interpreters available as needed. The MOU cites the Olmstead decision, indicating that the state and CMS will provide ongoing monitoring to ensure that those beneficiaries needing LTSS receive such services in the “care settings appropriate to their needs” (p. 16).

• **Enrollee Communications:** All communications with enrollees and prospective enrollees, such as notification regarding enrollment in Cal MediConnect, will need prior approval from CMS and the state before distribution. These communications will be available in alternate formats.

• **Beneficiary Participation on Governing and Advisory Boards:** CMS and the state will require participating health plans, as part of the three-way contract, to include beneficiary and community input on plan activities related to program management and enrollee care. This may include beneficiary participation on plan governing boards or quality review committees. Each plan must also establish at

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9The beneficiary must demonstrate an existing relationship with the provider prior to enrollment, the provider must be willing to accept payment from the participating health plan on the current Medicare fee schedule, and the plan would not have otherwise excluded that provider from its network due to quality or other concerns.

**The beneficiary must demonstrate an existing relationship with the provider prior to enrollment, the provider must be willing to accept payment from participating health plan based on the plan’s rate of service or the applicable Medi-Cal rate (whichever is higher), and the plan would not have otherwise excluded that provider from its network due to quality or other concerns. This policy does not apply to IHSS providers, durable medical equipment, medical supplies, transportation, or other ancillary services.
least one consumer advisory committee, with monthly meetings, to provide input to the governing board. The advisory committee must reflect the diversity of the enrollee population in the plan, including people with disabilities.

• **Additional Beneficiary Protections:** Other beneficiary protections detailed in the MOU include the requirement that participating health plans hire sufficient numbers of customer service representatives to respond to enrollee inquiries and complaints within a period of time as defined by CMS and the state. CMS and the state will staff call centers in sufficient numbers to respond to beneficiary inquiries and complaints. All plans must ensure the privacy and security of enrollee health records. The MOU details some cost-sharing provisions; plans are not permitted to charge Medicare Part C or D premiums or any cost-sharing for Medi-Cal services, and copays charged for pharmacy must not exceed that established by CMS under the Part D low-income subsidy or Medi-Cal cost-sharing rules. Lastly, no enrollee may be balance billed (charged the difference between the provider’s billed rate and the rate reimbursed by the plan) by any provider for covered services.

**Integrated Appeals and Grievances**

The MOU indicates that through Cal MediConnect, CMS and the state will work to develop an integrated appeals process to support beneficiaries. Plan grievances and internal appeals procedures will be reviewed and approved by CMS and the state. CMS will continue to manage Part D appeals and grievances. The IHSS fair hearing process will continue as it exists today.

In Year 1 of Cal MediConnect, no changes will be made to the appeals process. Medicare and Medi-Cal appeals processes will remain intact until a new system of integrated appeals is developed and approved (see page 99 in Appendix 7 for more detail on the appeals process). The state will work with stakeholders and CMS to produce a more integrated appeals process.

**Payments, Rate Setting Methodology, and Savings Calculations**

CMS and the state have been engaged in a process to establish rates for the participating health plans. Plans will be paid a “blended” capitated monthly amount for each enrolled beneficiary that combines the Medicare and Medi-Cal capitated rates. Appendix 6 of the MOU describes the various steps that CMS and the state will engage in to establish the final rates. While the methodology to establish the rates has been made public, the rates themselves have not been released as of the date of publication of this fact sheet.

The rates will be established based on baseline Medicare and Medi-Cal spending and estimates of what would have been spent each year if Cal MediConnect did not exist. The rates consist of Medicare Parts A, B, and D costs, as well as Medi-Cal costs. The state and CMS will share in savings for Medicare Parts A and B and Medi-Cal costs equivalent to a minimum of one percent in Year 1, two percent in Year 2, and four percent in Year 3. Savings will not come from Medicare Part D. The total estimated spending will be projected for each year and the savings will be calculated based on this aggregated dollar amount. As noted in Appendix 6 of the MOU, changes to the minimum savings percentages “would only occur if and when CMS and the State jointly determine the change is necessary to calculate reasonable, appropriate, and attainable payment rates for the Demonstration” (page 48).
The risk adjustment approach for the Medi-Cal portion of the rate consists of four population categories:

- Institutionalized individuals (those residing in a long-term care facility for 90 or more days);
- HCBS High: individuals who are high-utilizers of home- and community-based services including those enrolled in CBAS, MSSP, or IHSS with the classification of “severely impaired”;
- HCBS Low: individuals who are considered low-utilizers of home- and community-based services, including those enrolled in IHSS classified as “not severely impaired”; and
- “Community Well”: all other individuals with no Medi-Cal covered HCBS services.

The Medi-Cal risk-adjusted rate will not include behavioral health services paid for and provided by county behavioral health agencies. It will also not include the administrative costs borne by the county-based IHSS programs, including eligibility determination, assessment of authorized hours, and maintaining the provider registry.

The Medicare risk adjustment approach will be based on standard methodologies used by CMS currently (Medicare Parts A and B will use hierarchical condition categories or HCCs; Medicare Part D will use RxHCCs).

**Quality Monitoring and Quality Withholds**

Participating health plans will be subject to monitoring and evaluation as part of their participation in Cal MediConnect. CMS and the state will jointly monitor the plans’ performance on a broad set of metrics. Each plan will be required to report data for quality metrics selected by CMS and the state for ongoing monitoring during the demonstration period. There are 85 metrics in total listed in the MOU that will form the quality monitoring efforts of Cal MediConnect. These metrics are similar to those for other states that have approved MOUs for dual eligible integration efforts. The quality metrics selected are derived largely from standard measurement sets including the Healthcare Effectiveness Data and Information Set (HEDIS), the Health Outcomes Survey (HOS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) as well as measure sets used to evaluate quality in Special Needs Plans (SNPs). In addition, the state identified a selected set of metrics to evaluate LTSS quality. However, these have not been finalized and the state will continue to develop these measures with stakeholder input for eventual inclusion. Figure 7-1 beginning on page 108 of the MOU lists the core quality metrics for Cal MediConnect.

The Medicare and Medi-Cal programs will withhold a certain percentage of estimated capitation rates for each Demonstration plan (1, 2, and 3 percent in years 1, 2 and 3, respectively). If the plan meets specified performance targets, they will receive quality payments equal to the percentage deducted from the rates for enrolled beneficiaries. Most of the metrics selected for the quality withhold are part of the larger set of metrics to be used for ongoing health plan monitoring.

In Year 1, the quality withhold will be equal to one percentage point based on ten performance measures. These measures focus on key structure and process measures including submission of complete encounter data for enrolled beneficiaries, the proportion of initial health assessments completed within the specified timeframe, evidence of the establishment of a beneficiary governance board, evidence of appropriate access to services, among others (see Figure 6-3 on page 52 of the MOU for more detail).
In Year 2, the quality withhold will increase to two percentage points and in Year 3, to three percentage points, and are based on an additional ten quality measures. These measures are focused more on process and outcomes with a clinical focus (see Figure 6-4 on page 54 of the MOU for more detail). The three-way contract will include more detail about the quality withhold measures, including performance standards. Part D payments will not be subject to a quality withhold.

The MOU states that plans meeting quality withhold requirements will be reported for each year and the quality scores for each plan will be publicly reported in Years 2 and 3 of the Demonstration. CMS has also implemented a contract with RTI International as the independent evaluator for the national Financial Alignment Demonstration, of which California is a part, as well as the state-specific activities under this Demonstration.

**Next Steps and Timeline**

**Readiness Review:** As a condition of participation in Cal MediConnect, health plans must undergo a readiness review process. CMS and state officials are conducting this review jointly, which applies to both the participating health plans and their sub-contracted plans. The purpose of the readiness review is to evaluate each plan's capacity to meet all program requirements, such as having an adequate provider network for the full range of services (e.g., primary, acute, rehabilitative, LTSS) and capacity to ensure consumer protections. CMS has posted the California specific readiness tool that will guide the readiness review process. The tool includes criteria related to continuity of care, assessment, care coordination, individualized care plan, coordination of services, transitions between care settings, confidentiality, beneficiary protections, communications with enrollees, and others.

**Three-Way Contracts:** California and CMS will develop a three-way contract for each participating health plan, including a contracting process that ensures a coordinated program operation, enforcement, monitoring, and oversight. The three-way contract will include provisions for CMS and California to evaluate the performance of the primary-contracted plans and sub-contracted plans. Plans will be held accountable for ensuring that sub-contracted plans meet all applicable laws and requirements.

**Stakeholder Process:** The state will continue to engage with stakeholders during the implementation and operational phases of Cal MediConnect. This will include ongoing public meetings, and monitoring individual and provider experiences. Participating health plans will be required to develop processes for beneficiary input as well as systems for measuring and monitoring the quality of services.

**Conclusion**

The MOU establishes the general framework and parameters of the Cal MediConnect program, with additional policy and program requirements to be further specified in the three-way contracts. Over the next several months, stakeholders at the state and local levels will have a critical role to play in highlighting key policy and program issues, educating providers and beneficiaries, and working with the state and Legislature to ensure that Cal MediConnect meets its intention of providing a more coordinated, higher quality service delivery system.

††The readiness review tool can be found at the following link: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf.
References


8. CCI Trailer Bill SB 1036.


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APPENDIX M:

Quality Managed Care for People with Dementia

The Issues:

- Alzheimer’s disease currently affects 5.4 million Americans and with the aging of the baby boomers, this number will double in less than twenty years and triple by mid-century. Alzheimer’s and other dementias have enormous health and economic consequences for patients, their family caregivers, and society.
- These individuals cost Medicare three times more than other beneficiaries in the same age group; this difference is driven primarily by hospitalizations.
- They cost Medicaid nineteen times more than other beneficiaries of the same age, largely due to nursing home utilization.
- Over 50% of people with Alzheimer’s disease never receive a diagnosis. No accommodations are made to help them manage their care.
- Dementia often coexists with other conditions: 60% of people with dementia also have hypertension; 26% have coronary heart disease; 25% have stroke; and 23% have diabetes.
- People with serious medical conditions and Alzheimer’s disease or other dementias are more likely to be hospitalized and to stay in the hospital longer than people with the same serious medical conditions but no dementia.

Solutions: There are now three randomized controlled studies that have examined ways to improve care for this vulnerable population while controlling costs. They each recommend:

- The training of physicians and other staff in dementia care
- Assigning a specialized dementia care manager to patients with this condition
- Coordination of care with community-based providers of long-term care services

Key Components of Quality Managed Care for People with Dementia

- Screening. Most people with Alzheimer’s never receive a diagnosis. Therefore they are not given appropriate treatment, nor are they managed well. The managed care plan needs to put in place screening procedures to identify members with cognitive impairment. This could be part of the annual wellness visit.
• **Provider Training:** Physicians, advanced practice nurses, pharmacists and care managers who are employed by or under contract to the managed care plan should be knowledgeable about Alzheimer’s disease and dementia and how to care for people with these conditions. Training should include the non-pharmacologic management of behavioral symptoms.

• **Diagnosis, Treatment and Management.** Evidence-based guidelines need to be put in place to assure quality care over the course of the disease. California has developed a practice guideline for primary care providers ([www.caalz.org](http://www.caalz.org) or [www.alz.org/socal](http://www.alz.org/socal)).

• **Family Caregivers.** Procedures for identification, engagement and assessment of the needs of family and other caregivers are essential. These individuals help to keep patients safe and in their own homes. They are partners in the provision of quality care.

• **Dementia Care Management.** Three randomized controlled studies have demonstrated that trained dementia care managers (social workers or nurses), can improve quality of care and care processes, and may reduce use of more expensive care options. Dementia care management should be provided to all patients with dementia. The care manager’s role should include:
  - assessment of patient and caregiver needs
  - creation of a problem list and care plan
  - disease education
  - patient and caregiver counseling and support
  - referral to community-based resources such as:
    - The Alzheimer’s Association for:
      - Dementia care management
      - MedicAlert™+SafeReturn™ Wanderers program
      - Evidence-based caregiver education & family counseling
      - Early stage and caregiver support groups
    - Adult day services or community based adult services (CBAS)
    - In-Home Supportive Services
    - California Alzheimer’s Disease Centers for evaluation of complex cases and access to clinical trials
APPENDIX N:
Innovations in Integration: State Approaches to Improving Care
For Medicare-Medicaid Enrollees

See next 14 pages
The passage of the Affordable Care Act (ACA) in 2010 created the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS), establishing unparalleled potential to improve care for individuals who are dually eligible for Medicare and Medicaid. MMCO has since released two opportunities, the State Demonstrations to Integrate Care for Dual Eligible Individuals and the Financial Alignment Demonstration, for states and the federal government to work together to improve coordination and alignment of care for Medicare-Medicaid enrollees. These demonstrations provide states with new vehicles to test innovative financing and delivery models that better integrate Medicare and Medicaid services, improve care delivery, and beneficiary experience, and reduce unnecessary spending for this population.

Through support from The SCAN Foundation and The Commonwealth Fund, the Center for Health Care Strategies (CHCS) is providing targeted technical assistance to many of the states that received an award through the State Demonstrations to Integrate Care for Dual Eligible Individuals. During the design phase of their demonstrations, states have changed operational and programmatic elements of their original proposals to respond to federal guidance, meet Medicare standards, or address operational issues that arose in designing these complex programs. Many states have decided to pursue a financial alignment model; some of those states have expanded or revised the scope of their original demonstration proposals, while others have reduced their scope or delayed implementation. A few states determined that the financial alignment model was not a viable option for their state and decided to explore alternative approaches to improve integration of Medicare and Medicaid.

This brief provides a snapshot of participating states’ plans for financial alignment and examines some of the states’ innovative design approaches. Sharing this information can help other states in developing similar programs for this high-need, high-cost population. Providing insight into the states’ experiences may also help stakeholders understand the intricacies and effort involved in building these programs, and how they can support states’ efforts to advance what works in improving Medicare-Medicaid integration and alignment.

Overview of Medicare-Medicaid Alignment Opportunities

There are more than nine million individuals in the United States who are dually eligible for both Medicare and Medicaid. They are a high-need, high-cost population and account for a disproportionate share of spending in both programs. These dually eligible enrollees and their providers face several challenges in navigating the two programs including: uncoordinated and fragmented services; separate policies regarding provider reimbursement, beneficiary protections, benefits, and enrollment; and conflicting financial incentives.

In April 2011, CMS awarded design grants of up to $1 million each to 15 states for State Demonstrations to Integrate Care for Dual Eligible Individuals to develop approaches to coordinate care for Medicare-Medicaid enrollees across primary, acute, behavioral health services, and long-term services and supports (LTSS). Three months later, CMS announced related guidance for the Financial Alignment Demonstration program for states that outlined two new...
integrated care models: a capitated model and a managed fee-for-service (MFFS) model. The capitated model is based on a three-way contract signed by states, CMS, and health plans that will provide comprehensive, integrated Medicare and Medicaid services and align administrative functions between the two programs. Under the MFFS model, states sign an agreement with CMS to manage an enhanced FFS program that integrates primary, acute, behavioral health and LTSS for Medicare-Medicaid enrollees and may incorporate other care coordination models introduced in the ACA, such as health homes or accountable care organizations (ACOs).

Current State Plans for Financial Alignment Demonstrations

Within certain federally-mandated parameters, states have the flexibility to design demonstrations that work effectively with their current Medicaid programs. Several factors have affected the directions states have taken to pursue a financial alignment model or another strategy, including:

- Current program infrastructure and experience, including with enrolling disabled and/or elderly populations into managed care arrangements;
- Medicare Advantage market capacity;
- Wide-ranging stakeholder input; and
- Related Medicaid payment and delivery reforms already underway, such as the state plan option for health homes (established by §2703 of the ACA).

As of February 2013, 23 states are working on proposals to implement a Financial Alignment Demonstration or improve integration through another vehicle. In addition, a few states that determined that neither of the financial alignment models would work in their states are pursuing alternative options to improve integration, with some similarities to the financial alignment model framework.

In the 18 months since the Financial Alignment Demonstration was announced, states have made tremendous progress in the design of their demonstration programs. CHCS, as a provider of targeted technical assistance to many of the participating states, has observed the evolution of their plans for enrollment processes, rate setting, oversight, targeted geographic regions, and other administrative provisions of the proposed demonstration programs. The following section shares highlights from CHCS’ observations of states’ innovative approaches to integration for Medicare-Medicaid enrollees.

Innovative Approaches to Integrated Program Design

State efforts over the last several years to design innovative approaches to better align Medicare and Medicaid provide a foundation to continue to address the longstanding issues related to misaligned systems and prepare for the implementation and operation of integrated care programs. This section details how select states approached several program design elements, including: (1) building upon existing reforms; (2) developing payment and financing methodologies and data analytic systems; (3) designing targeted interventions to identify high-risk individuals; (4) coordinating care across various service sectors; and (5) engaging key stakeholders throughout the proposal process. These examples describe only a subset of states’ creative and resourceful program design activities to advance these initiatives.

Colorado Leverages its Recent Medicaid Reform Initiative

Colorado is using its MFFS Financial Alignment Demonstration to advance a major Medicaid delivery reform initiative it implemented in 2011: the Accountable Care Collaborative (ACC) Program. The demonstration will be implemented statewide for approximately 45,000 full benefit Medicare-Medicaid enrollees.
Organized in seven geographic regions, the ACC Program is comprised of three elements that work together to improve care for Medicaid beneficiaries and better support Medicaid providers. First, Regional Care Collaborative Organizations (RCCOs) connect Medicaid beneficiaries to providers, provide medical management and care coordination services, and identify appropriate community and social services and supports. RCCOs support providers with clinical tools, client materials, data, and analytics. Second, beneficiaries are assigned to a medical home with a Primary Care Medical Provider (PCMP), who also helps to identify appropriate specialty service providers and other supports. Third, the Statewide Data and Analytics Contractor collects and analyzes client utilization and program performance data for the RCCOs, PCMPs, and the state.

Colorado intends to maintain existing provider relationships for Medicare-Medicaid enrollees who participate in the demonstration. RCCOs are recruiting primary care Medicare-Medicaid providers who currently serve those eligible for the demonstration to be PCMPs in the ACC Program. In addition, the state will improve coordination of physical and behavioral health and acute care and LTSS in the demonstration. Improvements will include:

- **Strengthening collaboration** between RCCOs and behavioral health organizations (BHOs) through new RCCO contract requirements and written protocols outlining BHO obligations for meeting the care needs of Medicare-Medicaid enrollees;

- **Enhancing care coordination** between providers and/or care coordinators by expanding exchange of data to include BHO encounter data along with the already available physical health information and substance abuse claims, and by developing platforms for RCCOs and BHOs to exchange this data;

- **Reducing potentially-preventable readmissions** and improving discharge planning for Medicare-Medicaid enrollees by including them in the current ACC Program that encourages hospitals to work closely with RCCOs and PCMPs;

- **Improving communication and capacity** to develop interventions between hospitals, nursing facilities and post-acute care settings with LTSS providers, Single Entry Point agencies, Community Centered Boards, Area Agencies on Aging, and home health providers; and

- **Increasing timely identification of decline** in Medicare-Medicaid enrollee functional status or quality of life and needs for LTSS by incorporating functional assessment data into those collected by the Statewide Data and Analytics Contractor.

**Washington Designs a Multi-Faceted Effort Using Early Stakeholder Input**

All states pursuing a demonstration must maintain a robust, public, and transparent stakeholder engagement process during program design and implementation phases. All states highlighted in this brief have made concerted efforts to involve a broad range of stakeholders including providers, beneficiaries and their families, advocacy groups, health plans and other state or county-based entities and officials. Many states sought extensive feedback from stakeholders before deciding to move forward with submitting a proposal, and have emphasized the importance of rigorous stakeholder involvement.

Washington is one of the few states pursuing both a capitated and MFFS model. Washington was the first state to sign a Memorandum of Understanding (MOU) with CMS to implement a MFFS Financial Alignment Demonstration, to be phased in by seven geographic regions in 2013. The MFFS demonstration will build upon Medicaid health homes; the state is working with CMS to finalize a State Plan Amendment to establish these health homes statewide for all Medicaid beneficiaries.
Washington plans to pursue its capitated model in select counties in 2014. The state's decision to pursue both approaches was driven considerably by stakeholder input that the state collected prior to submitting their proposal.

Along with the influence of stakeholder input, Washington State's experiences with prior initiatives influenced the evolution of the proposed models. The capitated managed care model takes advantage of lessons learned in the implementation of the Washington Medicaid Integration Project, and the more recent addition of persons with disabilities into its statewide managed care program. The MFFS approach builds on Washington's successful Chronic Care Management Initiative and will be based in part on its §2703 Health Home State Plan Amendment submitted to CMS in 2012, which will target high-need, high-cost Medicaid enrollees in the state.

It is challenging enough to implement one new model for Medicare-Medicaid enrollees, let alone two. As outlined below, many voices contributed to Washington's decision to implement both models.
**Internal Cross-Agency Team:**
Washington’s integration project included leadership from both the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA). While HCA and DSHS’ Aging and Disabilities Services provided day-to-day planning, DSHS also contributed critical resources from its Research and Data Analysis division. The Project Steering Committee also included representatives from the governor’s office, who remained involved as key stakeholders through the end of the governor’s term.

**External Stakeholders:** The cross-agency team gathered input from stakeholders around the state, well before any design elements were finalized. For example, in Fall 2011 the state staff led a series of statewide meetings in which they presented Medicare-Medicaid enrollees’ utilization data, information about which services are covered by Medicare and Medicaid, and the requirements of the integration model. Break-out sessions sought stakeholder input about the core elements and consumer protections necessary. Other focus groups were held to get stakeholder input on contract language for the capitated model. The stakeholders – including beneficiaries, providers, advocacy organizations, managed care organizations, and county government representatives – were emphatic in their desire to test multiple options. Based on their input, Washington’s proposal called for three models: the two outlined in the Financial Alignment Demonstration opportunity (a health home model and a capitated managed care model), and a third model of three-way contracting and performance incentive payments, which was eventually dropped.

**Authorizing Entities – CMS and the Washington State Legislature:** Although Washington requested that beneficiaries have the option of two or three different models, CMS determined that the evaluation would not accommodate multiple models within a single county. The Washington State legislature required that county legislative authorities take action to accept the implementation of the capitated model. To date, two counties have partnered with the state to move forward with implementation planning, procurement, plan selection, and readiness review.

**California’s Process for Ongoing Stakeholder Communication**
As part of its statewide Coordinated Care Initiative (CCI), California plans to implement a capitated model in eight counties in 2013. Most full benefit Medicare-Medicaid enrollees in these counties will be eligible to participate. The health plans will cover all services except for specialty mental health and substance use disorder services that are currently provided through a county-administered system. California has executed a multi-faceted plan to maintain continuous communication between the state and several stakeholder groups, including advocates, providers, health plans, lawmakers, county governments, beneficiaries and their family members throughout the design and implementation of its demonstration.

California sought input on its policy goals and framework for the demonstration from several key stakeholder groups across the state during early design phases. The state kicked-off this process with four large public meetings of more than 250 participants each to discuss concerns, barriers, and opportunities. California also produced a communications toolkit to describe information about the initiative for the public on its Section 508-compliant “CalDuals” webpage (www.calduals.org). In addition to public content, the state uses the website for internal, non-public activities, such as managing its 3,300-person
Massachusetts developed a risk mitigation strategy including risk corridors and high-risk pools for its Financial Alignment Demonstration to protect all entities from significant over- or under-estimates in reimbursement rates.

Massachusetts developed a risk mitigation strategy including risk corridors and high-risk pools for its Financial Alignment Demonstration to protect all entities from significant over- or under-estimates in reimbursement rates.

stakeholder list, planning meetings, conducting surveys, and hosting conference calls.

California held several public meetings to explain and solicit comments on its Request for Solutions (RFS), a document the state released in January 2012 to procure health plans. California revised the RFS several times to incorporate stakeholder input and added new requirements that meet the Special Needs Plan (SNP) Model of Care guidelines. To promote full transparency, California published a version of the final RFS that included comments in redline so that all interested parties could see what comments were offered and what changed in the final version. The state selected 11 health plans for participation, pending successful completion of the readiness review.15,16

Throughout 2012, California collected targeted input to refine the proposal and develop implementation strategies. Several stakeholder work groups were established to help the state develop policies on specific topics, each of which held public meetings and published information on www.calduals.org. Work groups include Long-Term Services and Supports and In-Home Supportive Services Integration; Behavioral Health Integration; Beneficiary Notices and Protections; Quality and Evaluation; Fiscal and Rate Setting; and Provider Outreach.

California’s legislature also required that the state collect public feedback on specific topics before submitting official procurement documents, proposals, contracts, or policies. In turn, the state held public meetings to address issues including:

- A programmatic transition plan;
- Demonstration evaluation scope and structure;
- Quality and fiscal measures;
- Enrollment process and timelines;
- Beneficiary notices and communication plan;
- Quality assurance indicators for LTSS;
- Scope, duration, and intensity of home- and community-based services (HCBS) plan benefits;
- Any changes to population eligibility; and
- Development of a universal assessment process.

Stakeholders continue to provide feedback on important documents through early 2013, including quality measures and key policies and procedures. The state incorporated this feedback into its readiness review, set to be posted on www.calduals.org in mid-2013.

California is focusing its efforts now on education and outreach campaigns to help prepare beneficiaries and providers for implementation, recognizing that clear information is critical to the early success. The state is working with several stakeholder partners to develop and implement this campaign, including consumer advocacy organizations; community-based organizations that serve the target population; low-income housing providers; County Behavioral Health Offices; regional offices of state and national legislators; medical societies and professional organizations, including those representing specific ethnic groups; and health plans, when appropriate.

Massachusetts’ Risk Mitigation Strategy

Setting appropriate rates across two programs that encompass primary, acute, behavioral health and LTSS is extremely challenging. Few existing models offer states and CMS guidance on building a comprehensive, prospective payment rate that blends Medicare and Medicaid funding streams. The most pressing challenges are coordinating medical and LTSS needs and ensuring that capitation payment rates account for the different risk levels of beneficiaries.17 Medicare-Medicaid enrollees are a very heterogeneous population with a wide range of health needs; however, only a small number of these beneficiaries are heavy users of services in both programs, underscoring the importance of developing
targeted approaches to capture the highest-need, highest-cost subset within a state. In addition to calculating adequate payment rates for covered services, other factors for consideration in developing a payment methodology include apportioning shared risk and savings between the states, CMS, and health plans; incorporating performance targets for health plans and providers; and promoting the use of HCBS for Medicare-Medicaid enrollees through savings achieved from decreased use of Medicare services.

Innovations in Integration: State Approaches to Improving Care for Medicare-Medicaid Enrollees

Taking into consideration the uncertainty of developing new, complex payment rates, the MOU that Massachusetts signed with CMS to implement a capitated financial alignment model provides insight into how states might approach risk-sharing. The demonstration will serve most full benefit Medicare-Medicaid enrollees ages 21 to 64, excluding those residing in intermediate care facilities for individuals with intellectual disabilities and those enrolled in an HCBS 1915(c) waiver program. The state issued a competitive procurement and has identified six organizations currently undergoing readiness reviews and contract negotiations to serve as Integrated Care Organizations (ICOs) to coordinate all current Medicare and Medicaid services, and suplemental services to enhance community behavioral health and LTSS benefits. Massachusetts developed two risk mitigation strategies for the first year of its demonstration (which is actually 18 months) to protect all entities from significant over- or under- estimates. Sharing risk – and profit – may reduce the effects of enrollment bias and attract higher health plan participation at the outset, as well as manage federal and state government costs more effectively.

In the first part of its strategy, the state established three risk corridor tiers for the first year of the demonstration to help mitigate potential ICO losses or profits. If ICOs gain or lose:

- **Zero to 5 percent**, the ICOs bear all of

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### Calculating the Demonstration Payment Rate Baseline

CMS established a prospective methodology to set a baseline payment rate for health plans in the capitated model, which is made up of separate Medicare, Medicaid, and Part D components. The Medicare component will be set at a county-level, blending:

- An amount that represents what Medicare Advantage payments would be expected to be in the absence of the demonstration, reflecting historical bid amounts trended forward to the current year;
- The star ratings of plans serving beneficiaries who are expected to enroll; and
- Current Medicare Advantage benchmarks with Medicare fee-for-service spending data for beneficiaries in each county at the beginning of the calendar year.

CMS also includes a Part D component in this rate to account for prescription drug utilization and spending. The Medicaid component of the blended rate is based on historic spending data trended forward to the payment year for Medicare-Medicaid enrollees in that state enrolled in both Medicaid managed care and FFS arrangements.

The payment rates will be risk-adjusted to capture the diverse needs of the populations expected to enroll. For example, the Medicare rates will be risk-adjusted based on the Medicare hierarchical condition categories model, while Medicaid rates could be risk-adjusted based on variables such as the rate of facility-based care, HCBS needs, behavioral health utilization, among others.

The blended capitation methodology has a mechanism to hold health plans to high performance standings while operating efficiently. The rate will be prospectively lowered from the baseline rate to reflect savings assumptions that the health plans must meet, which will increase annually in the first three years. For example, in Massachusetts and Ohio, the savings assumptions that represent what would have been spent in absence of the demonstration are one, two and four percent in years one, two and three, respectively. Also, a percentage of the capitation rate will be withheld (one, two and three percent in years one, two and three, respectively) that plans may earn back if they meet established performance thresholds for core quality measures consistent across all demonstrations, as well as state-specific quality measures.
In the second part of its strategy, the state will create high-cost risk pools for ICOs that enroll Medicare-Medicaid enrollees meeting an established risk level that is based on reaching an amount of LTSS spending. The risk pools will be financed through a portion of the state’s Medicaid capitation rate contribution that will be withheld from all ICOs in the risk pool. The risk pool funds will then be divided among all ICOs based on their percentage of total enrollee costs for beneficiaries who meet that risk level.¹⁹

Minnesota’s Efforts to Further Alignment Opportunities

Minnesota launched the nation’s first integrated Medicare-Medicaid demonstration in 1995. In developing a capitated Financial Alignment Demonstration proposal, the state sought to build on Minnesota Senior Health Options (MSHO), an existing integrated managed care program that serves almost 80 percent of the state’s Medicare-Medicaid enrollees over age 65. Most MSHO members are enrolled in fully-integrated Dual Eligible Special Needs Plans (FIDE-SNPs), which have achieved high clinical outcomes and consumer satisfaction ratings for several years, as well as a high Medicare Advantage Star Rating average of four stars.

However, after working with actuarial and other external organizations, Minnesota decided not to pursue a Financial Alignment Demonstration proposal in June 2012. (For additional details about Minnesota’s decision, see sidebar, “Assessing the Feasibility of the Financial Alignment Demonstration Model in Individual States.”) Instead, Minnesota is designing a new administrative alignment proposal, “Demonstration to Align Administrative Systems for Improvements in Beneficiary Experience,” that will build on the current MSHO model and other statewide Medicaid purchasing and delivery reform initiatives. Under this demonstration, Minnesota is working with CMS to revise Medicare and Medicaid contract requirements for existing SNPs to assure continued administrative alignment across several areas such as enrollment, provider networks, grievances and appeals, member premium protections, and marketing, among others for senior Medicare-Medicaid enrollees enrolled in MSHO.

A key feature of Minnesota’s redesigned demonstration is to promote payment and delivery reform in Minnesota’s managed care programs for dually eligible seniors and people with disabilities. Minnesota is developing Integrated Care System Partnerships (ICSPs) designed especially for dually eligible seniors and people with disabilities enrolled in managed care. ICSPs align with other provider-level payment delivery reform efforts such as the state’s all-payer Health Care Homes and new Medicaid Health Care Delivery System Demonstrations.
The ICSP models support SNP and Medicaid managed care organizations’ contracting arrangements with Minnesota’s Health Care Homes (medical homes) and primary, acute, LTSS and behavioral health providers. For example, contracting arrangements may include performance and financial metrics under a range of pay-for-performance or risk- and gain-sharing models, and focus on improvements in administrative alignment, seamless care delivery and accountability between Medicare and Medicaid providers. Minnesota has amended its contracts with SNPs to outline requirements for submitting proposals to the state for ICSPs in 2013, planning for ICSPs to be in place by 2014.

Minnesota is also working to adopt policies to improve integration between Health Care Homes, LTSS, and behavioral health providers through a “Virtual Care System” approach that coordinates care in areas where more fully-integrated ICSP approaches are not possible.

Lastly, Minnesota is considering options for expanding the administrative alignment improvements underway to Medicare-Medicaid enrollees under age 65 with

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**Assessing the Feasibility of the Financial Alignment Demonstration Model in Individual States**

Minnesota, Oregon, and Tennessee submitted proposals for a capitated demonstration, but subsequently determined that the demonstration was not a viable option for their state. One major factor in each state’s decision was that demonstration payment rates were projected to be lower than what Medicare Advantage plans are currently paid.

In Minnesota, offering current MSHO plans a lower rate in the demonstration could create barriers to plan retention. Given its robust SNP market and enrollment in high-performing plans, and the fact that the state had already achieved many of the quality outcomes in its MSHO program that are goals of the Financial Alignment Demonstration, Minnesota determined that the capitated model was not a financially viable option. Tennessee has a robust Medicare Advantage and managed Medicaid LTSS market as well, and faced similar constraints.

Oregon described two key reasons why the demonstration rates would likely be lower than the state’s current rates. In Oregon, average Medicare FFS expenditures are lower than both the national average and current payment rates for Medicare Advantage plans in the state, or the regional Medicare Advantage benchmark. As described above in Calculating the Demonstration Payment Rate Baseline, Medicare FFS spending is one of the weighted components required under the demonstration, and would thus lower the capitation payment calculation. In addition, Oregon has many high-performing Medicare Advantage plans that have earned financial bonuses under the Medicare Star Rating system. Under the demonstration model, plans exceeding specified performance levels would be eligible for a county-averaged bonus payment that would likely be a lower amount than under the Star Rating system.

Similar to Minnesota, Oregon and Tennessee plan to examine alternatives to improve Medicare-Medicaid integration. In 2012, Oregon passed a health reform law to establish Medicaid “coordinated care organizations” (CCOs), based on a patient-centered medical home model. CCOs provide comprehensive services, including care coordination for those with chronic physical and behavioral health needs. Oregon is examining how to integrate Medicare services for Medicare-Medicaid enrollees in this model. Tennessee, a state leader in delivering managed acute, LTSS, and behavioral health services through one coordinated Medicaid system, continues to examine alternatives to integrate Medicare services within its current system.

Of note, Wisconsin designed a financial data analytic resource that may serve as a valuable template to other states. The state developed a comprehensive financial model to assess key areas of cost and savings estimates for their proposed capitated demonstration. This model, to be updated with new data as program design planning proceeds:

- Develops assumptions on upfront costs on both the Medicare and Medicaid sides, such as administrative and care coordination costs;
- Analyzes trends in spending, enrollment and service utilization to calculate baseline estimates as well as the cost of the population had they continued to remain in FFS; and
- Projects the savings likely to be realized over time based on initial assumptions, such as savings through managed care and integration of various clinical services.
disabilities in 2014. This would build on current efforts to manage and integrate mental and physical health services for Medicaid-only and Medicare-Medicaid enrollees ages 18 to 64 diagnosed with cognitive and/or behavioral health impairments, including co-occurring substance abuse, brain injury, and other cognitive impairments.

**Michigan Focuses on Physical and Behavioral Health Integration**

Although most states are designing demonstrations to include all or most service categories under one contract, many state Medicaid programs provide services through separate managed entities, carve-outs, and waivers for certain services. Recognizing the value of maintaining the current delivery system to prevent destabilization of current, effective practices, some states have proposed to keep these structures in place in their demonstrations. In turn, these states will incorporate shared accountability and new coordination requirements between participating health plans, behavioral health and other providers as necessary.

Michigan has decided to retain its separate managed physical and behavioral systems in its capitated model, but will use this demonstration as an opportunity to improve care coordination and alignment in the current system between behavioral and physical health providers. All full-benefit Medicare-Medicaid enrollees residing in select geographic regions, excluding PACE enrollees and categorically medially needy beneficiaries, will be eligible for the demonstration. The decision in Michigan to keep the current behavioral health system intact was the result of strong stakeholder support for the current program and concern that major changes to the delivery model would disrupt care for vulnerable beneficiaries.20 Local, county-based Prepaid Inpatient Health Plans (PIHPs) have provided managed behavioral health specialty services in Michigan for 15 years, and have established provider networks, contracts and other infrastructure to serve all Medicaid beneficiaries who have a behavioral health condition.21 Michigan will contract with Integrated Care Organizations (ICOs) to provide physical health and LTSS, covering both institutional and HCBS. In turn, the ICOs will subcontract with regional PIHPs, which will continue to provide all behavioral health services, including specialty services for beneficiaries who have a serious mental illness, intellectual/developmental disability (I/DD), and/or a substance abuse disorder. The state plans to create incentives for ICOs to contract with primary care providers who partner with PIHPs for the physical co-location of primary care services at community mental health centers (CMHCs) or in Federal Qualified Health Centers (FQHCs) to improve care for beneficiaries with serious mental illness, substance use disorder and I/DD.

To ensure integration and coordination of services across each delivery system, Michigan is working through operational details for developing and implementing a protected web-based platform, a “care bridge,” between ICOs, PHIPs, care managers and all other providers to share beneficiary data, reports, care plans, medications and other documents critical to managing care. The care bridge will advance shared accountability among providers, care coordination, and seamless access to services. The state will determine roles and responsibilities between the state, ICOs and PIHPs for building and maintaining the platform; creating communication tools; and collecting, analyzing, and reporting data.

**Washington Adds Medicare Data to Enhance Predictive Modeling**

Integrating Medicare and Medicaid data to compile complete information on service utilization and expenditures is critical to establishing an aligned care model. Without access to Medicare data, state Medicaid agencies and providers have only a limited picture of individuals’ care and support needs. CMS and states have undertaken efforts to improve access to and the quality of linked Medicare and Medicaid data, which create significant new opportunities to improve care, target appropriate care interventions, and reduce avoidable

**Stakeholder input spurred Michigan’s decision to keep its behavioral health system carved out of its Financial Alignment Demonstration, but it will use the demonstration to improve coordination and alignment between physical and behavioral health providers.**
expenditures. In 2011, CMS released guidance to inform state Medicaid agencies about the opportunity to and process for requesting Medicare Parts A, B and D claims/event data for Medicare-Medicaid enrollees to support care coordination, and offered federal support to help states use, link and analyze this data. Using merged data is a critical step toward supporting both program planning for care coordination and actual care coordination efforts provided to improve care at the individual beneficiary level.

Washington State has had considerable success in integrating data from several state systems to identify Medicaid beneficiaries with complex health needs, and in building upon its existing technology to expand this system to target Medicare-Medicaid enrollees. Using its predictive modeling capabilities, the Department of Social and Health Services (DSHS) has been able to identify high-cost, high-risk Medicaid beneficiaries in its chronic care management programs since 2009. The predictive model identifies individuals most in need of comprehensive care coordination based on risk scores calculated on demographics, diagnoses, and filled prescriptions drawn from integrated claims data. The risk scores and contributing risk factors are provided to care coordinators through a web-based clinical decision support tool called PRISM (Predictive Risk Intelligence System). PRISM also allows the user to view integrated information from primary, acute, social services, behavioral health, and long-term care payment and assessment data systems. The system includes health and demographic information from administrative data sources to display complete patient profiles for providers.

Leveraging its innovative modeling system, the state recently added Medicare data to its integrated data warehouse that includes Medicaid claims, encounter data and assessment information. The state will use linked Medicare and Medicaid data to identify Medicare-Medicaid enrollees with the highest prospective risk scores for enrollment into the demonstration health homes. The availability of linked Medicare and Medicaid data provides complete information about a beneficiary’s care experience and will improve Washington’s ability to better target Medicare-Medicaid enrollees who would most benefit from additional care management services or specific service interventions.

Massachusetts Incorporates Behavioral Health and LTSS Standards into its Readiness Review

Before a state implements a capitated model or allows a health plan to enroll Medicare-Medicaid enrollees, CMS and the state will conduct a readiness review to assess and ensure that every selected plan is ready to accept enrollment, provide the necessary continuity of care, ensure access to the full spectrum of Medicare, Medicaid, and pharmacy services, adhere to all federal and state requirements, and fully protect and meet the diverse needs of the Medicare-Medicaid population. The readiness review will also help CMS and states refine a monitoring strategy after implementation by identifying areas in which they should focus oversight efforts and where ongoing monitoring may be required.

Massachusetts was the first state to make its readiness review document publicly available on November 28, 2012. Before enrolling any beneficiaries, selected ICOs must provide sufficient evidence to pass the readiness review. The readiness reviews of the ICOs will be a combination of desk audits, a network validation review and site visits, and will be conducted by CMS and state staff, or their contractors.

The detailed readiness review includes several domains and requirements, many of which will be reflected in the readiness reviews of other states proposing a capitated model. The criteria that will be used to evaluate whether ICOs have the operational capacity to provide high-quality services to Medicare-Medicaid enrollees fall into categories set by Massachusetts and CMS; for example, Assessment Processes, Care Coordination, Enrollee Protection,
Organizational Structure and Staffing, Performance and Quality Measurement, and Provider Network. Massachusetts and CMS took into account the unique needs of Medicare-Medicaid enrollees in arriving at the readiness review criteria. In addition, all readiness reviews will include criteria to evaluate the plans’ ability to provide appropriate care management and support for the complex and heterogeneous Medicare-Medicaid enrollee population. The criteria will also focus on whether health plans have policies in place that:

- Provide beneficiary protections related to the Americans with Disabilities Act;
- Use person-centered language and reinforce beneficiary roles and empowerment;
- Reflect independent living philosophies; and
- Promote recovery-oriented models of behavioral health services.  

Examples of the criteria used to gauge readiness of ICOs are shown in Exhibit 1, along with summaries of specific evidence needed for each criterion.

**Exhibit 1: Massachusetts Readiness Review Criteria**

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<th>Category</th>
<th>Sample Criteria</th>
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| **Assessment**                    | - For enrollees identified in their initial assessments as needing intensive behavioral health services or LTSS, during the comprehensive assessment, the ICO will determine (for example):  
  - The enrollee’s understanding of available services; the enrollee’s desire to self-manage all or part of his/her care plan regardless of the severity of disability, and understanding of his or her self-management responsibilities;  
  - The enrollee’s preferences regarding privacy, services, caregivers, and daily routine;  
  - The enrollee’s understanding of and engagement in recovery-oriented activities;  
  - The enrollee’s preferred living situation and a risk assessment for the stability of housing; and  
  - The enrollee’s understanding of his/her rights.                                                                                                                                 |
| **Care Coordination**             | ICO has a process to ensure every enrollee who wants an Individualized Care Team to coordinate the delivery of care and services will have access to one. |
| **Enrollment**                    | Member services staff have cultural and disability competencies based on the target populations and must be knowledgeable in effective communication with individuals with disabilities. |
| **Enrollee Projections**          | Emergency services (for example): ICO has a back-up plan in case an LTSS provider does not arrive to provide assistance with activities of daily living. |
| **Organizational Structure and Staffing** | The training program for Care Coordinators includes (for example):  
  - Needs assessment and care planning;  
  - Service monitoring;  
  - Long term services and support;  
  - Self-direction of personal care attendant services;  
  - Behavioral health and the recovery model;  
  - Care transitions; and  
  - Independent living philosophy. |
| **Utilization Management**        | The ICO shall develop and maintain behavioral health inpatient services and diversionary services authorization policies and procedures (for example):  
  - A plan and a system in place to direct enrollees to the least intensive but clinically appropriate service;  
  - Verification and authorization of all adjustments to behavioral health inpatient services treatment plans and diversionary services treatment plans; and  
  - Processes to ensure that treatment and discharge needs are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the primary care physician and other providers, such as community based mental health services providers, as appropriate. |
Conclusion

Several states intend to hit the ground running in 2013 and 2014 with newly-launched integrated models, seizing unprecedented federal support, state innovation and the vast potential for states to advance alignment of Medicare and Medicaid services. Stakeholders and policymakers alike can learn from the experiences of pioneering states that have taken significant steps toward implementing financial alignment models. Much of the progress achieved to date is the result of partnerships between states, the federal government and a wide range of stakeholders committed to improve clinical outcomes and performance measurement, expand person-centered, coordinated care, reduce fragmentation across delivery systems, and eliminate incentives for either program to shift costs to the other. There are still many programmatic and policy details to tackle; designing programs that attempt to address long-standing, systemic misalignments for a complex population is a daunting task. However, states are actively working with CMS and stakeholders to resolve outstanding issues and achieve the ultimate goal of improving the beneficiaries' care experience and aligning programs.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

This brief is part of CHCS’ Technical Assistance for Dual Eligible Integrated Care Demonstrations program, made possible through The SCAN Foundation and The Commonwealth Fund. Through this program, CHCS is helping demonstration states develop and implement integrated-care models for individuals eligible for both Medicare and Medicaid services. For more information, visit www.chcs.org.

Endnotes

1. Referred to in statute as the Federal Coordinated Health Care Office.
3. CHCS is also providing technical assistance to states participating in the Financial Alignment Demonstration through the CMS-funded Integrated Care Resource Center.
7. Groups excluded from Colorado’s demonstration include: 1) Denver Health Medicaid Choice plan enrollees; 2) Rocky Mountain Health Plan enrollees; 3) PACE enrollees; 4) Medicare Advantage/Special Needs Plan (SNP) enrollees; 5) beneficiaries who reside in an ICF-ID; or 6) other Medicare-Medicaid beneficiaries already participating in another recognized program that provides care coordination.
8. Summary of participants’ discussion at CHCS-facilitated multi-state meetings; July 6-7, 2011; November 16-17, 2011; March 8-9, 2012; and July 19-20, 2012.
9. Ibid.
10. All information, including the protocol, standards, instructions and certification process results for the first phase, are posted online at http://www.dhs.wisconsin.gov/virtualPACE/icos/index.htm.
12. Populations excluded from California’s demonstration include: Partial-benefit dual eligible beneficiaries; Beneficiaries with other health coverage; Children under age 21; Current ESRD beneficiaries; Developmentally disabled; 1915 (c) waiver enrollees; and Beneficiaries not in areas covered by managed care.
14. Section 508 is a part of the Rehabilitation Act of 1973, which requires that electronic and information technology developed, procured, maintained or used by the Federal government be accessible to people with disabilities.
15. California CCI health plans include: Alameda Alliance for Health, CareMore (Anthem Blue Cross), CalOptima (OneCare), Care 1st, Community Health Group, Health Net of California, Health Plan of San Mateo, Inland Empire Health Plan, L.A. Care Health Plan, Molina Health Care of California, and Santa Clara Family Health Plan.


Medicare Part A includes care provided by hospital inpatient and outpatient units, skilled nursing facilities, clinics, ambulatory surgical centers, home health providers, and hospice. Medicare Part B includes physician services, diagnostic tests, laboratory, ambulance, durable medical equipment, Part B drugs (administered by or under close supervision of a physician), Medicare Part D covers prescription drugs.

Refer to the Medicare-Medicaid Integration Toolkit for resources to help states to request and use Medicare data from the Medicare-Medicaid Coordination Office (MMCO), http://www.integratedcareresourcecenter.com/icmdatatoolkit.aspx.


Ibid.

Massachusetts Readiness review, MMCO, op. cit