



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

DATE: December 30, 2011

MEETING TIME: 9:00 -10:00 a.m. MST

HOSTED BY: Department of Health Care Policy and Financing (HCPF)

TOPIC: Coordination of Care Work Group

ATTENDEES

Moderator: Teri Bolinger, HCPF

Les Hendrickson, PCG

Participants: April Abrahamson, Colorado Access

Elisabeth Arenales, Colorado Center on Law and Policy

William (Sean) Bryan, HCPF

Matthew Elder, Colorado Health Care Association

Julie Farrar, Colorado Developmental Disabilities Counsel

Sara Gardephe, PCG

Brent Hill, Colorado Health Care Association

Beverly Hirsekorn HCPF

Drew Kasper, Colorado Access

Margot Langstaff, LifeHealth

Arlene Miles, Colorado Health Care Association

Benjamin Miller, University of Colorado

Erin O'Reilly, National Multiple Sclerosis Society

Viji Sekhar, Seniors' Resource Center

Laurie Tebo, Rocky Mountain Health Care Services

Tim Thornton, Atlantis Community, Inc

Meredith Warman, Colorado Associated Community Health

Information Enterprise

Mary Watson, Quality Life Management, LLC.

Transcript

Teri: We have about ten people on the line. More are joining us right now. My clock says 8:59, so let's wait another minute or two for folks to join us. Then we can do a group introduction and get started.

First, let me just say that I hope all of you are enjoying a very nice holiday season. As I said, this is Teri Bolinger with the Department, and who else is on the line, please?

Mary: Mary Watson, Quality Life Management.

Drew: Drew Kasper, Colorado Access.



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

Meredith: Meredith Warman, Colorado Associated Community Health Information Enterprise.

Arlene: Arlene Miles, Brent Hill, and Matt Elder from Colorado Health Care Association.

April: April Abrahamson, Colorado Access.

Erin: Erin O'Reilly, National Multiple Sclerosis Society.

Julie: Julie Farrar, Colorado Developmental Disabilities Counsel.

Margot: Margot Langstaff, LifeHealth

Beverly: Beverly Hirsekorn HCPFF.

Elisabeth: Elisabeth Arenales, Colorado Center on Law and Policy.

Benjamin: Benjamin Miller, University of Colorado

Sean: Sean Bryan, the Department.

Teri: Is that everyone? Do we have anyone from PCG, the consulting group, on the line this morning?

Sara: Yes, this is Sara Gardephe from PCG. I'll be recording for minutes.

Teri: Thank you, Sara.

Les: Les Hendrickson is on the line for the Public Consulting Group.

Teri: Les, good morning. I want to give a few opening remarks, and then I'll transition this to Les to facilitate the rest of the discussion. I'm hopeful that all of you received the materials that we sent out. We still have other materials going through the review and approval process here. We'll be getting those out to you as soon as possible.

I think all of you are aware that our next all-stakeholder meeting is on January 19th, at the Clayton Early Learning Center. At that time, we will discuss the "straw man" proposal and specific work group input and recommendations for the proposal.



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

With just a short time left until that meeting, we want to work closely with our consulting group to gather and consolidate the input that we're receiving from the work groups and from stakeholders. This will inform the proposal that we're preparing for CMS [Centers for Medicare and Medicaid Services]. Les, if you would like to begin the facilitation this morning, we can focus our ideas.

Les: Sure, thank you, Teri. I've gone over the materials that Teri sent, and I've looked at the transcript from the last Coordination of Care work group discussion. We also met with a few of the RCCOs [Regional Care Collaborative Organizations] last week and talked about what they were doing with care coordination.

I think my impression is that the Department has the task ahead of itself of preparing a proposal to CMS, and the proposal needs to address care coordination. The opportunity for a broader group of stakeholders to discuss the proposal will be coming up in mid-January, and to that end, I think the Department is hoping that we can develop some three to five points which the stakeholders could discuss.

Then those points would be put into the proposal and discussed and sent to CMS. I thought it might be useful, rather than just saying, "Okay, so what three or five points should we suggest?" to at least put some ideas out on the table. Then perhaps folks could discuss those, and then hopefully that discussion could evolve into recommendations for the stakeholder group to consider.

I'm working backwards from the proposal this morning, and I think the proposal has to address how care coordination is going to be handled in the sense of how the RCCOs will do something about care coordination in the regions where they work and with the parties they work with. It makes sense to me that it may make sense to request the RCCOs to draft a two- to three-page description of how they address care coordination and what they're doing. Then those descriptions could become incorporated into the proposal after being summarized and reviewed and digested.

In terms of what should be in these descriptions, I want to mention the points that I think might be useful. I think there are at least a couple of different care coordination levels.

One is at the service delivery level that gets into questions about embedding the behavioral health folks, psychiatric staff into FQHCs [Federally Qualified Health Centers], some psychiatric nurse practitioners that might work within doctor's offices. It's how the service delivery gets coordinated, and that's one entire level.

There's a higher level of organizational coordination, how the parties like the hospitals, the FQHCs, BHOs [Behavioral Health Organizations] communicate with each other. Are they on advisory committees? I mean, how does that broader policymaking for care get set?



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

Then there's also classic case management care coordination where you're actually at the individual level working with the client and arranging resources, talking to the care giver, and coordinating care at that level.

I think there are at least three levels of coordination that involve care and a few cross-cutting issues that are hard to pin down to a specific level, and one is the use of information technology and information sharing. How does the data get spread from health homes to hospitals or the RCCO [Regional Care Collaborative Organization]?

Then there's another item here. Who coordinates the coordinators? This is the issue of multiple care coordinators. Do you have one care coordinator for every client in the system? Do you have a team where there are multiple persons having some aspect of care coordination? How does that get organized by the RCCO?

Those are main points that I thought might be useful to facilitate a discussion around. I'd just like to hear what folks think those three or five points should be that we should address at the larger stakeholder meeting.

Elisabeth: This is Elisabeth Arenales. I have a couple questions. I appreciate the way you laid all that out. The other big piece to me seems to be, and I know there's a separate committee on this, the financing and program coordination piece that has to be integrated into care. I think all those pieces have to be integrated as well, so I hope as this process unfolds, there will be cross-pollination between the different work groups. Unless you pull all those elements together in a thoughtful and coordinated way, it's going to be hard to make as much progress as you might like.

I had a couple of questions. One, you talked about going to the RCCOs to ask what they're doing about care coordination's, so I had a question about that. They are not coordinating this kind of complex population now; they've been very intentionally left out of these early stages of the process. The question I have is, are you asking them how they're doing it now, or how they would propose to do it for a complex population?

And if so, then what parameters are you putting around what sort of RFP [request for proposal] format, or what kinds of questions would you ask them to address in terms of how they would think about doing coordination for this complex community.

Then the final question I have is there's been so much conversation in Colorado about dealing with multiple complex populations over the years. Has there been a landscape assessment done of what the gaps in the system are, and what recommendations have come forward before, so that we can build on knowledge that currently exists?

Les: I think I heard four points there.



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

Elisabeth: Sorry. I figured I'd use my question wisely.

Les: Okay. I'm not sure I can actually recall all of them, so let me start with the first one. We went to two RCCOs [Regional Care Collaborative Organizations], and one of them said that they were talking about care coordination policies among the various partners in their process. They are still developing their concepts of what they are going to do.

The second one we went to indicated that they are already well underway, that they had started enrolling their current population in the last three months. They are already having various care coordination concepts and programs that they are starting with them. We had the impression that one RCCO was getting started, and another was well underway, through the beginning stages but actually doing things.

Elisabeth: With complex populations?

Les: They hadn't enrolled any dual eligibles yet to my knowledge, but they were certainly starting with the initial populations that they had enrolled.

Teri: Les, could I just interject for a moment in response to Elisabeth's question? We do know from the RCCOs that, although they have not been actively enrolling dual eligible individuals, when they have enrolled individuals who become dual eligibles, they have not been dis-enrolling them.

Also, at the time the ACC [Accountable Care Collaborative] was proposed and when the RCCOs actually bid on the contracts, they knew that they would be called upon to develop more robust systems to handle more complex populations as integration of care and enrollment progressed. Even though the strength and capacity of the RCCOs may not be where we need it to be today for the dual eligibles, we know that they have this on their radar screen, and they are taking steps to prepare for this.

Elisabeth: I appreciate that. I'm just trying to figure out if you're trying to initiate conversations about what good care coordination looks like, are you looking at what the RCCOs are already doing as a basis of that, or are you looking at stakeholders to try to help you frame the elements that would form the basis of that? That makes a different, I think, in terms of how this conversation might unfold.

Teri: Well, it does, but we're actually looking at all of that. We're looking at what they [the RCCOs] are already doing. We're looking at active stakeholder input, and we're looking at the strength and the capacity that the RCCOs need to achieve in order to handle the more complex populations.

April: This is April from Colorado Access. I'm representing RCCO [Regional Care Collaborative Organization] Two, Three, and Five. I just wanted to let the group know that there are various levels of experience. Colorado Access has a managed population



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

for which we do care management, and that same care management team, those care management members, are part of the bigger team who also have care managers supporting RCCO care management. I think a couple of the other RCCOs have a similar situation where there is experience historically with complex populations.

Teri: Thank you, April.

April: Sure.

Sean [Bryan]: This is Sean. It's good to hear your voice again, April. I hope you've been well. I think one of the complex populations we need to be certain that we consider here, especially in the dual eligible group, is the long-term care population.

While Colorado Access had talked about a closer coordination of care management with long-term care case managers in the field supporting HCBS [Home and Community-Based Services], I don't think it's ever really successfully been developed.

I would like to suggest reviewing the information you included in the e-mail announcement, Teri, the Michigan analysis. In that report, there were some direct references made to a coordinated approach nationally known as PACE [Program for All-Inclusive Care for the Elderly]. I'm wondering if a model like that for a defined population that is certainly the medically fragile adult, our elderly population, is a complex population. That might be at least one approach we should expand upon.

Elisabeth: Well, this is Elisabeth again. We have a PACE program in Colorado. I saw they were on the last call.

Sean: No, I know we have a PACE program in Colorado, but as it specifically relates to the ACC [Accountable Care Collaborative] and the RCCO effort, then taking a model that works and expanding it across the state.

Elisabeth: No, I agree. At least it's worth looking at.

Sean: With PACE [Program for All-Inclusive Care for the Elderly], the interdisciplinary team approach has always been intriguing to me. At least in my interactions with the PACE contract managers, I found that this has been a successful endeavor. I'm wondering if it makes sense to consider vertically integrating that to include other populations that are not within the realm of long-term care.

Teri: Sean, thank you for those comments. The Department has had conversations with the PACE providers. They have been attending the stakeholder meetings, and they have been participating in the work groups. They have been discussing elements of their model of care that would be appropriate here and how they could potentially work



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

with the RCCOs [Regional Care Collaborative Organizations] in the ACC [Accountable Care Collaborative].

Sean: Thank you, Teri. I appreciate that.

Teri: You're welcome.

Laurie: Sean, this is Laurie Tebo. I just wanted to let you know that, any conversations that go on, we're really interested in being a part of as well. Teri, we're the Colorado Springs PACE provider. I think there are a lot of different possibilities in expanding the PACE concept across different populations, as Sean said.

Teri: One other thing I wanted to mention quickly are our regional and individual group meetings at the end of January, and throughout February. We will be contacting and meeting with the PACE providers as part of that effort. No one will be left out.

Laurie: That's excellent. Thank you.

Teri: You're very welcome.

Les: This is Les. Since we only have a limited time, I'd like to focus as much as I can on what we should be recommending to the larger stakeholder group in mid-January. That is what the three to five elements about care coordination are that the proposal to CMS [Centers for Medicare and Medicaid Services] really needs to address.

Elisabeth: I'm sorry. I'm going to go back. Was there a landscape assessment done, and is that available?

Les: Teri can correct me, but to the best of my knowledge, there hasn't been any assessment of the amount, kind, volume of care coordination that's currently done, and how many coordinators there are, who does them, what is coordinated. I don't think we have any landscape picture of that.

Elisabeth: Okay, thank you.

April: This is April again, and I'm going to need this group's help with what it is that meets the criteria of the dual eligibles line of thinking and the long-term care line of thinking. I agree with Sean's point that we haven't gotten to a point of extremely well-coordinated care across every single silo inside of the health care system.

Julie: This is Julie Farrar from the Colorado Developmental Disabilities Council. I have a question around enrollment and what's going on. I don't even know where this came from, but perfect timing, I did get a letter that I'm participating in an Accountable Care



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

Organization. It came from Physician Health Partners, and it looks like they're wanting to share data on how they're going to integrate and coordinate care.

If there are things that are happening already or we don't know what's happening already, how are we going to do this in any kind of organized manner? I just think that we, historically, have trouble collecting data or knowing what we're doing in an organized way because of the siloing. If things are happening right now, we should be able to track that. There's no way to measure any type of outcome if we don't even know what's going on.

Teri: Julie, I think that's a very good point. Prior to my joining the Department on this project on October 31st, I know that PCG [Public Consulting Group] and perhaps some internal personnel had done some landscape work around deficiencies. I know that for this particular project, the elements of coordinating the physical health elements with long-term care and behavioral health were identified as three of the most critical elements for this population.

Elisabeth: Is there some information available that was done as preliminary to this conversation? That would be great to see.

Teri: Elisabeth, I already made a note so that I can follow up with Marci [Eads] to see what may be in house.

Elisabeth: Thank you.

Teri: You're welcome.

Laurie: This is Laurie Tebo again, Colorado Springs. I just wanted to state that there are efforts going on right now to develop case management plans. I know that the SEPs [Single-Entry Points] are working on an intensive case management plan. Our RCCO [Regional Care Collaborative Organization] has actually contracted with an outside company to put together a comprehensive care management plan. I'm wondering if maybe our first step might be to really find out what is going on to see if we can't integrate some of those efforts. We don't have to try to reinvent the wheel.

Unfortunately, under the pressure of time, we wind up doing parallel efforts that are not necessarily consistent with things that are happening, or sometimes trying to shoehorn something that's going on that's working into a new structure. That's not always necessary. I think RCCO Seven, who is contracting with a company, would be more than happy to share some of those results that they come up with through their efforts of having the whole care management project designed by another firm. We can always check with them.



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

April: This is April again. What I was trying to say earlier is that the RCCOs have actually come together on five basic components of what looks like key requirements for management. We've attempted to start crafting definitions and metrics that tie into the RCCO contract. I'm not sure if that's in line with what you're actually asking for or not.

Teri: April, is that information available in summary?

April: It's not entirely finished yet, but I think I have something.

Teri: I think that would be extremely helpful. Again, our intent has never been to create another silo of care or to start from scratch when we know that we have many things that are working that we can utilize. I think the intent all along has been to strengthen and better coordinate existing components of this. Any information that anyone has on things that are already going on, and particularly relating to RCCO capacity, would be very helpful

Elisabeth: Well, could the contractor you're working with, Teri, help facilitate that?

Teri: Yes, and they're doing that currently.

Elisabeth: This whole issue of specialists. I'm assuming that dual eligibles need more specialists or almost rely on specialists as their primary care providers. That's something that's come up at stakeholder meetings. It seems like in coordination of care, it could be really helpful to talk about since the RCCO model right now is more focused on primary care. It seems to me that there are still issues around how the referral process works, whether they can be primary care providers, how the pay structure works with specialists. That's a pretty important conversation, and I don't know if that belongs in this work group or another one.

Julie: I think that's really important because a lot of people don't get their primary care because they only go to specialists. If you're trying to be cost-effective, then you don't want to be always going to the specialist either. I would think that our point is to coordinate primary care, make that the go-to person, and then everything flow out of there. But for a lot of folks with complex needs, it goes the other way around.

Elisabeth: Well, a lot of primary care physicians, frankly, don't understand complex conditions very well. How do we facilitate that?

Julie: Right. It definitely goes both ways.

Les: That point on special coordination of service delivery with specialists is an excellent one. Are there any other points that folks think should be discussed in coordination of care that we haven't touched on so far?



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

Drew: This is Drew Kasper with Colorado Access. Do we know how the ACOs [Accountable Care Organizations] are going to mesh into this process? We've got the RCCOs [Regional Care Collaborative Organizations], and we're talking about integrating care for the dual eligibles. Then we've got this ACO agenda moving forward in the state with the Medicare folks. Are the ACO organizations also going to be helping the dual eligibles? Are the dual eligibles going to be exclusively with RCCOs and ACOs be Medicare only? Do we know how that is going to work?

Participant: I'm sorry. I'm a dual eligible, and I just got adopted into an ACO. It may not know that, but it just got done.

Drew: Okay, so the ACOs and the RCCOs will both be working with dual eligibles? It seems like there should be some sort of an understanding perhaps with how that coordination of care will happen. I mean, is the ACO then representing just your Medicare part of care, or are they representing your Medicaid as well? Again, maybe I'm out of the loop, but I don't see how this is meshing together to know enough in terms of recommendations on coordinating care between the two systems.

Teri: No, I understand, and I think your points are very valid. I think the announcement for the ACO came out about a week ago. All of the conversations that need to occur have not yet occurred. I believe that you are exactly correct.

We need to take that into consideration and have some meetings and conversations around this. The original intent by the Department was for the dual eligible individuals to be ultimately enrolled in the RCCOs [Regional Collaborative Care Organizations]. That was before the separate ACO initiative was on the horizon.

Participant: Teri, just one quick question. How many people are proposed to be enrolled in the ACO of the Medicare population in Colorado?

Teri: That I do not know.

Participant: That would be helpful. I'm sure that's part of your thinking.

Beverly [Hirse Korn]: Teri, this is Beverly. I'm wondering if we have a definition of care coordination that is structured through the contract with the RCCOs, so we all would be on the same page. We all have different definitions of what care coordination is. We know that individuals that are dual eligibles seem to have multiple care coordinators, and they all seem to feel they do different things.

People have a bunch of case managers, and I think that's being left out with people with complex needs. They often operate in their own siloes, and I don't see how this can work if they aren't part of the process and they don't know what's going on.



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

Teri: I think that's one of the issues confronting this work group, and one of the challenges that we're facing. Go back to Les's point about their analysis of the RCCOs in their recent conversations. Look at how care coordination occurs at the organizational level, the service delivery level, and the case management or individual level.

There are some things that should be very common elements among the RCCOs; however, because we have regional differences, each RCCO may be handling some of these things in a different way. As long as we're satisfying the needs of the individuals, how that's accomplished is not as important as the outcome for the individuals.

Les: This is Les. I've looked at the definitions in the contract of the RFP [request for proposal] for the RCCOs. While it does define primary care case management, it doesn't have a concept or definition of care coordination on the list of definitions.

Participant: It does seem important to have everybody get on the same page around that.

Elisabeth: This was in the public forums that happened before the ACC [Accountable Care Collaborative] came to fruition. One of the major requests from the community across a variety of stakeholders was for the state not to be prescriptive about management or care coordination expectations. That's a large reason why the RCCO [Regional Care Collaborative Organization] leadership team got together to create the concept. We just wanted to get it out to the other people that are interested.

Les: I think there is a lot of care coordination thinking and activity going on now in the RCCOs. To one extent we need to know what that is so we can at least get a good description of it. From the other end also, we want to be sure we understand the concerns about care coordination that folks outside of the RCCOs might have and what issues they think should be discussed in care coordination. Then bring those two elements together.

Elisabeth: Absolutely.

Sean: This is Sean again. In thinking about care coordination a little more fully, I think we don't need to come up with a singular definition for care coordination. Maybe that definition varies depending upon the demographics of the specific population we're talking about.

Casey: This is Casey Ryan with LTCO [Long-Term Care Options]. I want to echo Sean's statement about we're never going to find one entity that's going to be able to do all, but my recommendation would be strong technological upgrades. Every client that is a dual eligible is not going to be with a SEP [Single-Entry Point], but we don't want to leave out the SEPs.



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

We don't want to leave out those who are on a PACE [Program of All-Inclusive Care for the Elderly] program or other programs such as that. Right now, we don't have access to any information as clients go in and out of the hospitals or as other entities are involved. If we have technology upgraded to get that information down to other care coordinators, we need to focus our efforts, as one recommendation, on how we get that information down from primary care physicians all the way to the people who are working on the ground level.

Teri: I think that's an excellent point. The SDAC [Statewide Data Analytics Contractor], Treo Solutions, as you know, provides data and reporting in the ACC model. If you remember, the ACC is a triangle. It's the SDAC, the RCCOs, and the PCMPs [Primary Care Medical Providers]. The SDAC has been incorporating data on the Medicaid clients that we're currently serving. They will be including the adults without dependent children. Then as the dual eligibles enroll, they'll be assimilating that data as well. When the Medicare data comes in, they'll be integrating that information as well. One of the constraints is that none of this happens as quickly as we need and want.

Viji: Hello, this is Viji from the Senior Resource Center. You know, we have certain projects that we do in conjunction with primary care physicians as well as the hospitals. I would agree with all that has been said. Lack of timeliness and effectiveness. One of the main causes is that we're not able to get the information or share the information in a timely fashion. Each one is working in a silo, and we don't talk to each other.

Tim: Teri, this is Tim Thornton.

Teri: Hi, Tim.

Tim: Good morning. I just wanted to make a quick comment. I think Sean hit it right on the nose. The current coordination, collaboration from the top down, is right now less than sub-par in my opinion. One of my questions is where is the Department of Human Services [DHS]? What kind of role are they playing in this?

Teri: Well, DHS and other state departments and divisions are being solicited for information and are collaborating on this as well. We actually have others involved in this initiative, not just HCPF [Department of Health Care Policy and Financing].

Tim: Okay. Thank you.

Teri: I think that's a very good point, and thank you for asking about that.

Elisabeth: This is Elisabeth. Of course, there are common threads through the overarching themes. It seems like the discussion so far has been around that. What I noticed about the notes from the last meeting that certainly came up at some of the stakeholder meetings was the particular needs of different populations. How are those



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

conversations really going to happen in a way that's sufficient to address those individualized needs?

I think about kids and the particular roles of EPSDT [Early and Periodic Screening, Diagnostic, and Treatment] and the challenges of dealing with multiple systems that deal with kids with special needs. Then you go from there all the way up to seniors. It's complicated, and I don't know, is this the group that's supposed to be talking about that?

Teri: Well, I think coordination of care for any of the dual eligible individuals is certainly a topic for this group. Elisabeth, in the latest numbers that the data section ran for us, of the almost ninety thousand [partial and full] dual eligible individuals, only about 140 of them are 21 or younger.

Elisabeth: Wow.

Teri: About a third of them are working age adults with a disability. Almost two-thirds are 65 and older. We do have some children, but that number is very small for this population.

Elisabeth: That's helpful.

Les: I think the point you raised is really a good one. It goes back to an earlier point in the conversation where someone made the observation that care coordination may differ depending on the populations. One model probably won't work for all populations. One of the concerns that stakeholders have is to what extent does the ACC [Accountable Care Collaborative], the RCCO [Regional Care Collaborative Organization], and its affiliates and partners have flexible care coordination that recognizes the needs of different people? Can they modify what they're doing to provide good care coordination for a particular population?

That's a great point to talk about in the proposal. How does the state and what it's doing take into account the needs of a particular population? Does anyone have another point that they haven't heard discussed so far that they think we should be considering?

Sean: This is Sean again, and I'll just refer to the Michigan report that I read a little while ago. There was a lot of importance about the importance of having a care coordinator "in the home." I think it is maybe an aspect of the proposal that we might want to further expand upon. There are important issues that factor into a client's overall well-being, related to their day-to-day living environments. Other basic ADL [Activities of Daily Living] support needs and important to the formulation of financial savings are the natural supports that may or may not be available to each individual client.



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

Les: Sean, could you elaborate on that? When you say in the home, do you mean in a client's home?

Sean: Yes, I mean in the client's home. There was a specific reference in the report that there was a great deal of importance placed on having a care coordinator who can visit with the client in the home. That's something that the SEPs [Single-Entry Points] and CCBs [Community-Centered Boards] currently have capacity to do; however, it may not be on the scale that we're talking about now. I do think that's an important and relevant aspect of care coordination that we need to make sure that we focus some attention to.

Teri: I think that's a good point, Sean. The other thing I might mention is that we'll be meeting with the CCBs and the SEPs when we go around the state late in January and in February. Like that PACE providers and everyone else that we can contact and meet with, those are definitely on our list. We do see they have some capacity to assist in these efforts.

Les: I'd like to take a shot at addressing some of that. Most certainly in dealing with the dual eligible population of which two-thirds are elderly, all of their service needs are not encompassed by a visit to a primary care doctor. They may need ADL [Activities of Daily Living] help or personal care. If they get that care, then they avoid visits to the hospital and the doctor or the institution.

There has to be some management of those service needs. There has to be some integration of the home and community-based services [HCBS] into the package of long-term care services. I don't know if manage is the right word, but there certainly has to be care coordination for HCBS since that's one of the major service needs for that population.

Elisabeth: Are the deliverables in their payment structure going to be based on how they manage long-term care services?

Les: I believe the care coordination fee is simply to coordinate care. It doesn't break out behavioral health specifically or long-term care needs specifically or hospital utilization specifically. It is to understand what the individual's situation is and then try to be certain that they have appropriate care. At least they're connected with providers that can provide the care package that they need.

Elisabeth: But not purely medical?

Teri: No, not purely medical.

Elisabeth: Well, that's helpful. I didn't realize that was part of the package. I'm trying to get my brain wrapped around this. Who is then ultimately responsible for managing the



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

HCBS [Home and Community-Based Services] side of things, for example? Is it the RCCOs? Are you changing that model? How do the current care management systems plan this? Do you have a diagram of what you're thinking about in terms of who has the ultimate authority? I'm thinking about everything from on the ground management to appeals and denial issues. How does all that work?

Teri: Elisabeth, I don't think all of that has been fully defined yet for this particular project.

Sean: This is Sean. I do agree with you, Teri. But I will mention that in the Money Follows the Person [MFP] initiative that we're currently developing, there is some discussion about long-term care systemic reform. I don't know what that's ultimately going to look like, but there are ongoing discussions about all sorts of things related to long-term care, including the assessment process and the ongoing care management or case management process.

Elisabeth: I'm familiar with that. Is the RCCO piece part of that conversation? If this is part of that conversation, and it's all being integrated, that's great. If it's not part of that conversation, it sounds like maybe it should be.

Sean: Well, I know Tim Cortez was going to try to be on the call this morning, but I'll follow up with him as soon as we close here and make sure that he's involved going forward.

Teri: We have already met with Tim and Nicole and with John Barry and the Long-Term Care Advisory Council. We are soliciting their assistance and their input. I think a number of coordinated conversations have been occurring. All the details for this have not been finalized yet.

Julie: This is Julie Farrar. When you guys are talking about Money Follows the Person, are you talking about people that become eligible for community-based services and then become eligible for Medicare? Money Follows the Person is Medicaid eligible only right now. Are you looking at as those people who become Medicare eligible? I'm not understanding exactly. Because at this point in time, it's straight Medicaid folks that are eligible for Money Follows the Person.

I do know that we're working really hard at trying to figure out how to incorporate implementation of the Affordable Care Act and all of that. Everything is in flux right now. I'm nervous that we do this and say that long-term care is included, but don't know how we're going to do that, how it's going to happen. Should there be more long-term care capacity questions then?

Teri: Yes.



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

Julie: Okay.

Elisabeth: I'm curious about coordination. If people on Medicare are in managed care plans themselves, or part of the Medicare Advantage Plans, if they're in a program that already manages their care to some extent, how is that going to work?

Les: This is Les Hendrickson. I'm not sure that folks who are already in a managed care plan are actually going to be enrolled to any great extent in the RCCOs.

Elisabeth: Is that correct?

Teri: Yes.

Participant: Managed care is an exclusion in the RCCO enrollment.

Elisabeth: Okay.

Les: I'd like to just go back to long-term care. I want to make one last comment on it. I don't know if manage is the right word, but I think that referral or a knowledge of HCBS [Home and Community-Based Services] is an essential part of care coordination. If folks need personal care services or need services that are available on a waiver, I think those folks can be routed to look for waiver services or help to get onto a waiver.

The actual limits of the care, the amount, the duration, the scope, those are probably set in the waiver and aren't really manageable by the RCCO. I think there's a care coordination element with HCBS, but I don't think it's a management function in the sense of setting limits on services or saying what the services are or doing prior authorization or that kind of classic management concept.

Arlene [Miles]: Okay, this is Arlene. I had a question. Can you tell me how the RCCO and the SEP [Single-Entry Point] are either going to interact or substitute what one or the other does. Is there any relationship there at all?

Participant: I don't know if this alleviates any concerns or better explains things. Based on enrollment data coming to at least Colorado Access as a RCCO, less than one percent of the population in our enrollments right now is accessing home and community-based services. Another thing to know is that the institutionalized clients are not currently being enrolled either.

Sean: Then that begs the question of how many of the ninety-nine percent who aren't would be found eligible, and then could access those services?



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

Participant: I agree.

Teri: Les, I did just want to mention that it's about two minutes until ten. We were scheduled to go until ten, and the group may need to decide when and how it wants to meet again before the stakeholder meeting on January 19th.

Les: An excellent point. We probably need to send out a survey to folks. Again, the effort is to develop a list of perhaps three to five points or issues that need to be discussed in the proposal relevant to care coordination. When we present the proposal to CMS [Centers for Medicare and Medicaid Services], CMS is going to want to hear what we are planning to propose around care coordination, what's the structure of what we're going to talk about. I mean, what are the main topic areas that we need to raise, and the issues to try to develop a draft sense of what those topics are so we can present them to a larger stakeholder group outside of the Coordination of Care Work Group and get their opinion or thoughts or changes or amplifications on that list.

That's really the task ahead, and we'll send out a survey to see who's available for another call. If you had suggestions or ideas on what you think those points should be, if you could email them to us, that would be a huge help. Does that seem like something folks feel comfortable doing?

Participant: Yes.

Les: Great. There were some really great points raised today. We need to get a list of them organized and perhaps settle on them as to what the most important ones are that we should go to the larger stakeholder group and say, "Listen, these are things about care coordination that we really need to be talking about."

So Teri, I think the process for setting up the meetings has been that we do a survey of likely times when folks are available, am I correct in that?

Teri: Yes, we'll do the survey from here. I'll ask Laura to send that out. Please feel free to e-mail me with any ideas, suggestions, or comments in addition to what's already been voiced this morning. Everything that comes in goes to the internal strategy team as well as to the consultants.

I want to thank everyone for being able to take the time this morning to participate because it's vital work that we're doing. Your efforts are greatly appreciated.

Sean: Thanks, Teri.

Teri: Thank you.



Dual Eligible Workgroup Meeting Transcript

State Demonstration to Integrate Care for Dual Eligible Individuals

[End of Audio]

Duration: 63 minutes