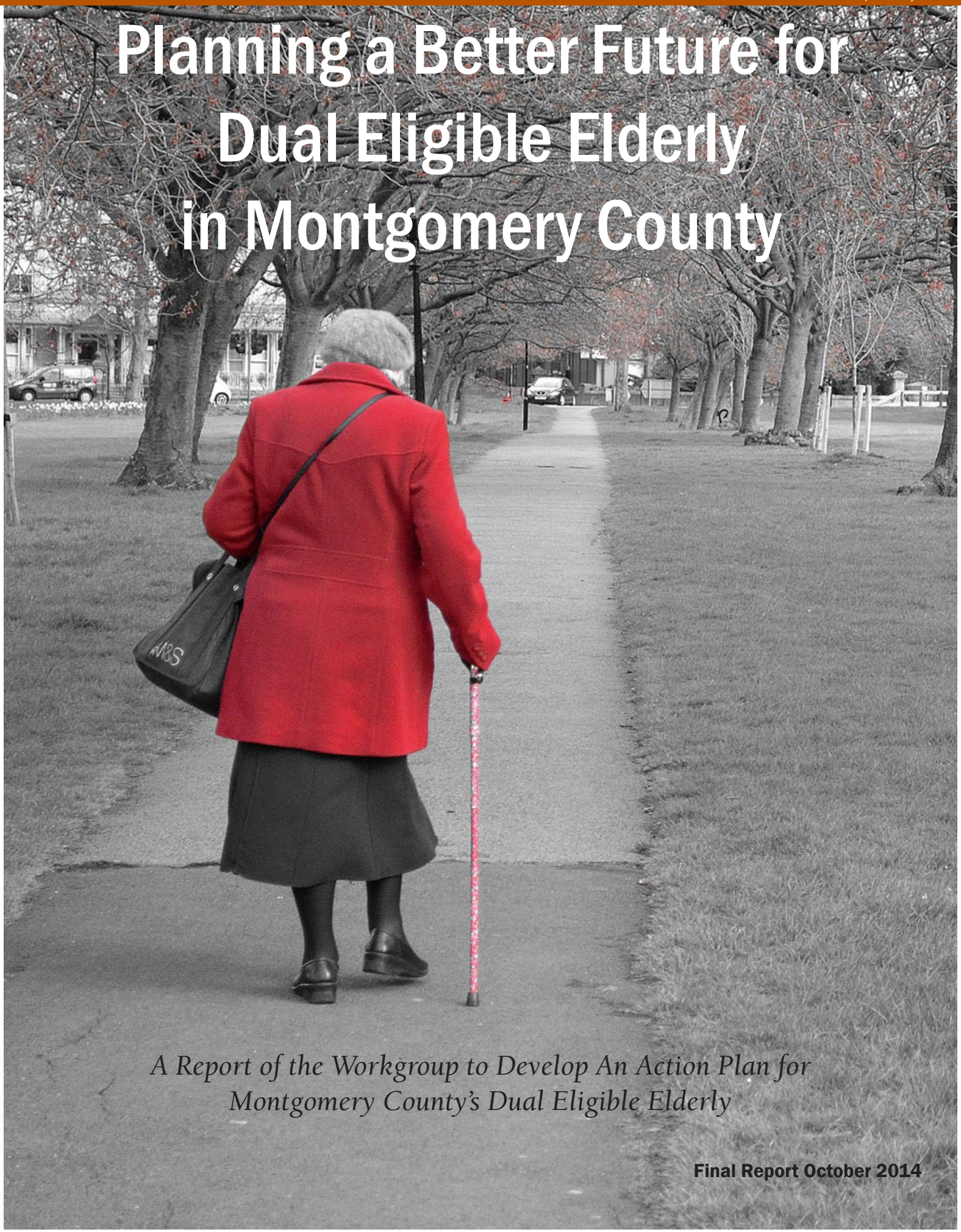
Planning a Better Future for Dual Eligible Elderly in Montgomery County



A Report of the Workgroup to Develop An Action Plan for Montgomery County's Dual Eligible Elderly

Final Report October 2014

This report was made possible through a planning grant by the North Penn Community Health Foundation to the Polisher Research Institute of the Madlyn and Leonard Abramson Center for Jewish Life.

Prepared by the Montgomery County Planning Commission.

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EXECUTIVE SUMMARY

In June 2013, the North Penn Community Foundation awarded the Polisher Research Institute of the Madlyn and Leonard Abramson Center for Jewish Life a $50,000 planning grant to convene a workgroup of knowledgeable stakeholders to explore the problems, and potential solutions, for dual eligible elderly in Montgomery County. The six months of funding ran from July 1, 2013 – December 31, 2013. The Polisher Research Institute brought in two consultants and convened the Workgroup, which met monthly from July to December, with phone calls, emails, and subcommittee meetings occurring in between the monthly meetings. The Workgroup assembled a list of potential opportunities and efforts underway to address dual eligible elderly's needs in Montgomery County and developed this report with nine primary recommendations for how to better meet the needs of dual eligible elderly in Montgomery County.

Older adults who are dual eligible (who qualify for both Medicare and Medicaid) face a daunting gauntlet of challenges in healthcare. Despite comprehensive coverage through Medicare and Medicaid, the lack of coordination between the two systems creates often insurmountable problems of access and delivery. Federally-funded Medicare lacks coordination and integration with federal-state funded Medicaid.

Ironically, it is these dual eligible individuals who so desperately need healthcare since they have a higher incidence of cognitive impairment (including Alzheimer's Disease), mental disorders, diabetes, pulmonary disease and strokes. Further, they are more vulnerable and frail, have lower incomes, and are more isolated than are non-dual eligible elderly. These problems, in turn, contribute to significant challenges with housing, food and transportation. The challenges with access to care are tragic, expensive and avoidable.

The high care needs of dual eligible individuals and the associated costs have driven states and the federal government to seek ways to better integrate and coordinate their care. The Affordable Care Act (2010) is teeming with initiatives, demonstrations, and new opportunities premised on finding a way to better meet dual eligible individuals' healthcare needs at a cost-effective rate. While little has yet been done at the state level, local providers are starting to test innovative approaches to delivering better care to dual eligible individuals.

This report summarizes state and federal initiatives and opportunities for delivering better care to dual eligible elderly. It also presents the efforts underway at the County level and by local providers. Following the informational section of the report, the Workgroup presents nine systems change recommendations to better improve the care provided to Montgomery County's dual eligible elderly. The recommendations may stand alone, each reflecting their own systems change, or may be combined in a more encompassing effort at service delivery system overhaul.

There are numerous federal opportunities for delivering better care to frail populations. Some of them are specifically targeted towards the dual eligible population and others are targeted towards other populations, but include a considerable number of dual eligible individuals. In the report, we describe five different types of approaches and describe examples of each, including information on where they are already in play in Montgomery County. The five types of approaches are:

1. **Insurance-Based Approaches:** Managed Care through Special Needs Plans, Managed Long-Term Supports and Services Programs, and Program of All-Inclusive Care For the Elderly
2. **Provider-Based Approaches:** Medical Homes, Accountable Care Organizations, Independence at Home
3. **Place-Based Approaches:** Housing with Services and NORCs
4. **Systems Navigation-Based Approaches:** HCBS Waiver Supports Coordination and Targeted Case Management
5. **Episode-Based Approaches:** Bundled Payment Initiatives and Care Transitions Efforts.

The following is a list of approaches the Workgroup viewed as potentially feasible approaches to improving access to care for Montgomery County's dual eligible elderly. It should be noted that this is not exhaustive list of every approach that could be included in efforts to better coordinate care.

RECOMMENDATION #1: MANAGED LONG-TERM SUPPORTS AND SERVICES PILOT PROGRAM

Type of Approach: Insurance-Based Approach

Background: Many states have moved or are moving part or all of their long-term supports and services (LTSS) delivery system to a managed care system. As LTSS are extremely costly to state Medicaid budgets, MLTSS has become an appealing way to control LTSS costs. States can adopt programs in which they implement managed care for only their home and community based LTSS, for both their home and community LTSS and facility-based LTSS, for all LTSS plus all other state Medicaid services, or for all state Medicaid services plus all Medicare services. With the likelihood of MLTSS for Pennsylvania increasing, it is important that the providers and community be prepared for the implementation of Managed Long-Term Supports and Services

Recommendation: It is important that the providers and community be prepared for the implementation of Managed Long-Term Supports and Services. It would also be fruitful for the state to pilot-test voluntary Managed LTSS before full-scale adoption and implementation. Any pilot should incorporate all Medicaid physical health care, behavioral health care, and LTSS. With dual eligible elderly as the target population, the state should test program design elements that could ease a subsequent expansion to full integration. The workgroup, in its community conversations, should talk to stakeholders about whether Montgomery County would be good site for an MLTSS pilot. This approach could potentially test additional systems changes, such as Medicaid funding of assisted living through the inclusion of assisted living in the MLTSS benefit package. We believe Montgomery County would be a good pilot site.

RECOMMENDATION #2: PACE IMPLEMENTATION

Type of Approach: Insurance-Based Approach

Background: The federal Program for All-Inclusive Care for the Elderly (known as the Living Independently for Elders in Pennsylvania) gives Providers a per capita payment from Medicare and Medicaid to deliver all covered healthcare and LTSS through a highly integrated, intensive model of care management and service delivery. Most services are delivered in an enhanced adult day setting where doctors and specialists are on

staff or under contract. Additional services including hospitalization, homecare, meals, home modifications and other measures that support life in the community are provided up to and including services in a long term care facility. The PACE model has long been considered one of the most fully integrated Medicare and Medicaid programs available.

Recommendation: Establish a collaboration effort of providers to revisit and reinitiate efforts to implement a PACE program for Montgomery County, reinvigorating the County-wide effort that had been collaboratively developed in 2009. In the alternative, the County and Providers could build up additional models of enhanced medical day care, using bundled care and bundled payment strategies outside of PACE, positioning for future opportunities to implement PACE

RECOMMENDATION #3: Dual Eligible ACO Providers

Type of Approach: Provider-Based Approach

Background: Accountable Care Organizations (ACOs) are partnerships of groups of doctors, hospitals, and other health care providers operating with the goal of meeting the health and LTSS needs of a defined group of patients for a pre-determined budgeted amount.

Recommendation: Conduct a feasibility study on Accountable Care Organizations and dual eligible elderly, incorporating a full array of LTSS. The goal of this feasibility study would determine if a Medicare ACO, focusing on long-term supports and services and meeting the needs of dual eligible elderly is possible. An ACO specifically for dual eligibles does not yet exist, thus, prompting the need for a feasibility study. One potential funding source of the feasibility study would be a CMS Innovation Grant and the unique approach of a dual eligible ACO might be ideal for an Innovation Grant.

RECOMMENDATION #4: PCMH Development and Facilitation

Type of Approach: Provider-Based Approach

Background: In recent years, Primary Care Medical Homes (PCMHs) have evolved as a new approach to better coordinate care for all patients. Medical homes emphasize prevention, health information technology, care coordination and shared decision making among patients and their providers.

Recommendation: Convene county providers, payers, philanthropy, and other stakeholders in an effort to incentivize all providers and practices in the County to obtain their PCMH certifications from the National Committee for Quality Assurance (NCQA). Target those practices that serve dual eligible elderly and facilitate their advancement toward PCMH certification. This will help position them for increased reimbursement from payers who pay more to NCQA certified providers and practices and for delivering better care to dual eligible elderly.

RECOMMENDATION #5: PCMH-SMI Integration

Type of Approach: Blended Provider-Based and Systems Navigation

Background: The Primary Care Medical Home (PCMH) is an enhanced primary care delivery model that endeavors to provide better access, coordination of care, prevention, quality, and safety within the primary care practice. In 2009, the County participated in a PCMH demonstration focused on integrated physical health and behavioral healthcare for persons with severe mental illness (SMI). The County had applied for but did not, in the end, receive a federal Innovation Grant to expand the demonstration to a broader population, include dual eligible older adults.

Recommendation: 1) Continue the county's blended PCMH-Systems Navigation work that was conducted through the Severe Mental Illness integration demonstration.
2) Resubmit the county's Innovation Grant request with specific focus on the dual eligible elderly population or, alternatively, pursue other funding to permit it to expand and enhance the concepts tested in this very successful demonstration.

RECOMMENDATION #6: NORC Plus or NORC as Anchor

Type of Approach: Blended Place-Based, Systems-Navigation, and PCMH Approach

Background: Naturally Occurring Retirement Communities (NORCs) are neighborhoods or buildings in which a large segment of the residents are older adults. NORCs are not usually purpose-built senior housing or retirement communities. NORCs are not intended to meet the particular health and social services needs and wants of the elderly. Studies reflect a strong belief within the Aging Services Network that NORCs provide an invaluable opportunity to deliver targeted health and supportive services cost-effectively; increase service availability; organize cooperative health promotion, crises prevention, and community improvement initiatives; and develop new human, financial, and neighborhood resources for the benefit of older residents. NORCs provide an excellent opportunity to improve quality of care where older dual eligible individuals live.

Recommendation: Utilize existing NORCs to develop a multi-faceted approach to providing services including: 1) a paid System-Navigator whose role it is to connect dual eligible elderly to services and 2) an array of primary care providers that have been incentivized to become PCMHs for all residents. In addition, the PACE program and the Independence at Home initiative for the higher acuity residents would support dual eligible elderly in remaining in the community and avoiding institutionalization.

RECOMMENDATION #7: IAH - HCBS Waiver

Type of Approach: Place-Based Approach

Background: The Independence at Home (IAH) Demonstration Program tests the use of designated medical practices comprised of primary care teams of physicians, nurse practitioners, and others to deliver care to high needs populations in their own homes and to coordinate care across all treatment settings. Home-based primary care provided to the highest cost, most chronically ill Medicare beneficiaries will significantly reduce costs, allowing

the participants to remain independent in their homes and avoid high cost unnecessary hospitalizations, emergency room visits, nursing home stays, medications and laboratory tests.

Recommendation Integrate HCBS Waivers with IAH, which will enable primary care and other medical services to be provided in the home. This will serve those dual eligible older adults who are too frail to seek medical services in the community. It will also provide a PCMH for those who are less frail able to see health care providers in their offices.

RECOMMENDATION #8:
Dual Eligible Targeted Case Management

Type of Approach: Systems-Navigation Approach

Background: Targeted case management (TCM) is a service which provides selected Medicaid participants with access to comprehensive medical and social services to encourage the cost-effective use of medical care and community resources, while ensuring the client's freedom of choice and promoting the well-being of the individual. TCM is currently provided to individuals who fall into the AIDS target group.

Recommendation: Establish a demonstration project to test intensive care navigation similar to the TCM available through Medicaid and Ryan White Block Grant funding for the HIV/AIDS population. A "System Navigator" would coordinate insurance coverage for duals eligible older adults. This single-individual system navigator would be an expert in both Medicare and Medicaid, and have access to key contact people in both systems. This approach would ensure adequate coverage of required and preventative services.

RECOMMENDATION #9:
Dual Eligible Care Transitions

Type of Approach: Episode-Based Approach

Background: Episode-based approaches are care coordination models built around a single episode of care, such as a hospitalization. Payments may be linked for multiple services during an episode of care, as in the Bundled Payment Initiative created under the Affordable Care Act of 2010, or payment penalties might be linked to a hospital readmission prompting an incentive to ensure the smooth transition back to the community, as in the care transitions initiative. These approaches are not limited or targeting dual eligible individuals, although they could be designed to do so.

Recommendation: Establish a pilot program, funded by local or foundation dollars, to test the impact of care transition efforts with longer-term needs of dual eligible older adults. Through this effort, the County or a local philanthropy would fund a navigator that would be assigned solely to dual eligible elderly during care transitions from the hospital back to the community. The care transition role would serve as a starting point for providing additional services and referrals. The effort could be one initially focused on the immediate transition and then on providing needs assessment, care navigation, and study of outcomes for a year following the initial discharge. This could be a mechanism to test Montgomery County's rapid response capability (i.e.,the ability to meet sudden LTSS needs, improve LTSS and ensure that hospital discharge planners are aware of these services.)

The Workgroup also provides additional stakeholder and system support recommendations – addressing community engagement, identifying needed services, workforce, education and awareness and improving the gathering and maintaining of data. Finally, the Workgroup identifies some related topics for future study.

"It is estimated that 7,833 dual eligible individuals age 65 and older live in Montgomery County."

In the report, the Workgroup outlines multiple immediate steps that could be implemented independently or jointly that each could better improve the access to care and the quality of care for the County's dual eligible elderly. Work could begin in 2014 on implementing any of the nine primary recommendations. Notwithstanding, the Workgroup strongly recommends that the first and next step should be to spend the first 4-6 months of 2014 engaging the local community in a community conversation about the Workgroup's report and recommendations. While the Workgroup contained a broad representation of stakeholders, the conclusions of the group were reached without input or buy-in from the individuals that would be assisted or the providers that would be impacted. These steps, the Workgroup agrees, are critical precursors to implementation of our systems change recommendations.

May 2014 note: In February 2014, the North Penn Community Health Foundation provided supplemental funding to the Workgroup so that the Workgroup could conduct community conversations. These were conducted and a summary of the conversations is provided in Appendix E of the Final Report.

THE DUAL ELIGIBLE WORKGROUP: PLANNING A BETTER FUTURE FOR DUAL ELIGIBLE ELDERLY IN MONTGOMERY COUNTY

I. INTRODUCTION

Older adults who are dual eligible (who qualify for both Medicare and Medicaid) face a daunting gauntlet of challenges in healthcare. Despite comprehensive coverage through Medicare and Medicaid, the lack of coordination between the two systems creates often insurmountable problems of access and delivery. Federally funded Medicare lacks coordination and integration with federal-state funded Medicaid.

Ironically, it is these dual eligible individuals who so desperately need healthcare since they have a higher incidence of cognitive impairment (including Alzheimer's Disease), mental disorders, diabetes, pulmonary disease and strokes. Further, they are more vulnerable, frailer, have lower incomes, and are more isolated than are non-dual eligible elderly. These problems, in turn, contribute to significant challenges with housing, food and transportation. It is estimated that 7,833 dual eligible individuals age 65 and older live in Montgomery County. The challenges with access to care are tragic, expensive and avoidable.

The high care needs of dual eligible individuals and the associated costs have driven states and the federal government to seek ways to better integrate and coordinate their care. The Affordable Care Act (2010) is teeming with initiatives, demonstrations, and new opportunities premised on finding a way to better meet dual eligible individuals' health care needs at a cost effective rate. While little has yet been done at the state level, local providers are starting to test innovative approaches to deliver better care to dual eligible individuals.

A. The Grant

The North Penn Community Health Foundation awarded the Polisher Research Institute of the Madlyn and Leonard Abramson Center for Jewish Life a $50,000 planning grant to convene a workgroup of knowledgeable stakeholders to explore the problems, and potential solutions, for dual eligible elderly in Montgomery County. The six months of funding ran from July 1, 2013 – December 31, 2013. The grant was funded under the "systems change" initiative of the foundation. Systems change is typically defined as the process of altering or transforming how a major system operates. The Workgroup was funded to make recommendations about potential systems change for future consideration and action.

B. The Workgroup Goal

The Polisher Research Institute of the Madlyn and Leonard Abramson Center for Jewish Life convened the dual eligible stakeholder Workgroup with a two-fold goal:

1) Assemble a list of efforts underway to address dual eligible elderly's needs in Montgomery County and

2) Outline a plan to strategically address the gaps in the system for access and service delivery for elderly Montgomery County dual eligibles that is achievable.

C. The Workgroup Participants

Carol Irvine, CEO of the Polisher Research Institute of the Madlyn and Leonard Abramson Center for Jewish Life, served as the Principle Investigator leading the initiative. Alissa Halperin, JD, led and provided substantive expertise to the Workgroup. Jenny Campbell, Ph.D. provided strategic planning expertise and facilitated Workgroup meetings.

The following agencies and people served on the Workgroup:

- **Linda Abram, North Penn United Way**
- **Jennifer C. Barnhart, United Way of Greater Philadelphia & Southern New Jersey**
- **Tricia Bradly, Your Way Home, Montgomery County Department of Housing and Community Development**
- **Joanne Kline, Montgomery County Aging and Adult Services**
- **Mark Lieberman, Family Services of Montgomery County**
- **Sarah Maus, Muller Institute for Senior Health (Abington Hospital)**
- **Diane Menio, Center for Advocacy for the Rights and Interests of the Elderly (CARIE)**
- **Barbara O'Malley, Montgomery County Health Department**
- **Ouida Williams Simpson, Benefits Advisor and Caregiver**
- **Mary Beth Snyder, Montgomery County Assistance Office**
- **Ann Torregrossa, JD, author of the recent, "Future of Medicaid Long-Term Care Services in PA: A Wake Up Call"**

The County Commissioners' Office agreed to serve as a resource and to allow Joanne Kline to represent it on the Workgroup.

D. The Process:

The Workgroup met monthly from July to December 2013. Each of the early meetings included a substantive presentation by Alissa Halperin, who provided background about best practices in meeting dual eligible individuals' needs, national trends, and Pennsylvania's efforts to-date. During each monthly Workgroup meeting, questions were raised that were researched and answered at the following meeting. Detailed minutes were kept and distributed within two weeks of the meeting. Every effort was made to keep this fast-paced Workgroup on schedule. If members could not attend in person, they attended by conference call. When members of the Workgroup missed a meeting, one of the facilitators contacted them to bring them up-to-date.

At the July 2013 meeting, the Workgroup formed a data subcommittee, seeking relevant data to understanding the population's demographics and service needs. The Workgroup felt that it was imperative to get a handle on the number of dual eligible elderly living in Montgomery County, where they were living within the County, what type of setting they reside in, what their age distribution is, and where they are receiving services. The data subcommittee sought information on the numbers of dual eligible elderly and where they reside from the County Assistance Office, information on the providers who are serving dual eligible elderly from the Office of Medical Assistance Programs and the Medical Assistance Transportation program, information on the services being provided by the Area Agency on Aging (AAA), and the number of dual eligible elderly receiving behavioral health services from the County Office of Behavioral Health. The data subcommittee also reviewed County data contained on the Montgomery County Planning

Commission website and contacted Governor Corbett's office as to whether they had any County-specific information that might be helpful. All of this data would be critical to understanding the potential impact of any recommendations. The data subcommittee met numerous times via conference call through October 2013, at which point, it determined that it could not obtain any additional data.

"Dual eligible individuals represent the most costly segment of the Medicaid recipient population."

By October 2013, the Workgroup transitioned toward a preliminary discussion of recommendations. Recommendations were also gathered by email correspondence following the October meeting. Alissa Halperin began drafting the report to present the research conducted and the information gathered by the Workgroup and to frame the recommendations arising from the research and information gathered. A draft of the report was distributed a week before our scheduled meeting, and reviewed at the November 2013 meeting. The report was then revised and provided to the Workgroup members. Final comments were received and incorporated into the draft in time for the December meeting.

E. The Report Organization:

This report summarizes state and federal initiatives and opportunities for delivering better care to dual eligible elderly. It also presents the current efforts underway at the County level and by local providers. Following the informational section of the report, the Workgroup presents recommendations to better improve the care provided to Montgomery County's dual eligible elderly.

While there can be no doubt that state and national attention is acutely focused on this issue, there are a myriad of opinions about the solutions. Dual eligible individuals represent the most costly segment of the Medicaid recipient population. Thus, states are desperate to find solutions to better serve this population while also reducing costs. The recommendations contained herein recognize the urgency of meeting both objectives. States are rapidly moving towards significant systems changes of their own, with efforts to reform their service delivery systems through managed long-term care and similar objectives. The recommendations offered each stand alone, reflecting their own systems change. The recommendations may also be combined in a more encompassing effort at service delivery system overhaul.

II. BACKGROUND

A. General Information on Dual Eligible Individuals

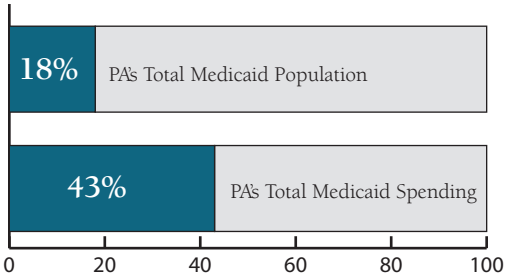
Dual eligible individuals qualify for both Medicare and Medicaid. For purposes of this paper, dual eligible elderly are persons sixty-five years old or older and qualify for both Medicare and Medicaid. They are low income and have limited resources. Pennsylvania has over 333,096 full dual eligible individuals[i] enrolled in its Medicaid program. Approximately 7,833 dual eligible elderly live in Montgomery County.

According to the Medicare Payment Advisory Committee's June 2012 Data Book[ii], dual eligible individuals are poorer and sicker than the rest of the Medicare population. Fifty-eight percent have incomes under the poverty level, as compared to ten percent of non-dual eligible Medicare participants. Eighteen percent of dual eligible individuals report being in poor health as compared to seven percent of non-dual eligible Medicare participants who report the same. Twenty percent of dual eligible individuals are institutionalized as compared to only two percent of non-dual eligible Medicare participants. Dual eligible individuals have a greater incidence of cognitive impairments, mental disorders, diabetes, pulmonary disease, stroke

and Alzheimer's disease than do non-dual Medicare participants. And, dual eligible individuals account for 17% of the Medicare population but 29% of Medicare spending; they account for 18% of PA's total Medicaid population but 43% of PA's total Medicaid spending.[iii]

"Dual eligible individuals are poorer and sicker than the rest of the Medicare population."

Dual Eligible Individuals Account for



Dual eligible individuals represent the most chronically ill segments of both the Medicare and Medicaid population, requiring a complex array of services from a variety of providers. They are three times as likely to have disabilities as compared to a Medicare beneficiary without Medicaid and have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease. Nearly 94% live below 200% of the federal poverty level – which for 2013 is $22,980/year for a single person. They have lower education, lower income, and higher care needs. [iv]

B. Services Covered for Dual Eligible Individuals and How Services are Accessed

Medicare and Medicaid each offer a broad array of covered benefits and services. Medicaid coverage tends to be broader, and the criteria applied to whether a service will be covered for a given participant is broader under Medicaid's medical necessity definition. However, Medicare is primary, meaning the person must try to obtain coverage through Medicare first.

Medicare Part A covers: Hospitalization, Skilled Nursing Facility Care, Home Health Care, and Hospice.

Medicare Part B covers annual wellness visit, physician services, outpatient hospital services, durable medical equipment/supplies, ambulance services, dialysis services, home health services, x-rays, lab tests, outpatient physical therapy, vaccines, some preventive services, some behavioral health services, and drugs administered in a physician's office.

Medicare Part D covers: outpatient prescription medications. Medicare does not cover: most vision care, hearing services, long-term supports and services (LTSS), medical transportation, and dental care. Medicare requires cost-sharing for services, including premiums, deductibles, and copayments.

Medicaid coverage for dual eligible individuals includes everything that Medicare covers plus vision services, hearing services, dental services, medical transportation, prescription and non-prescription medications not covered by Part D, LTSS either in facilities or at home, a broader array of behavioral health services, and the cost-sharing associated with Medicare. Medicaid also applies a far less strict Medical Necessity Definition such that if a service covered by Medicare is denied for a particular person as not Medically Necessary under Medicare's rules, it is often covered for that same consumer under Medicaid's Medical Necessity rules.

The majority of Pennsylvania's full dual eligible individuals access their services through multiple sources. For most dual eligible individuals, this means navigating and negotiating their way through many different programs or insurers, and that is just on the Medicaid side. The following are some of the different sources of coverage a typical dual eligible individual could have:

Medicaid:

- **Physical Health Services:** With the exception of those dual eligible individuals over 55 who participate in the Commonwealth's LIFE Program (Pennsylvania's Program of All-Inclusive Care for the Elderly), all of Pennsylvania's dual eligible adults receive their Medicaid physical health (PH) benefits from the Medicaid Fee-For-Service program.
- **Behavioral Health Services:** Pennsylvania's dual eligible adults receive their Medicaid behavioral health (BH) benefits from a mandatory, County-based BH Managed Care Organization (MCO).
- **Transportation:** Medical Assistance Transportation Program (MATP) services are provided through County-based transportation contractors.
- **Home and Community Based Services and Supports (HCBS):** Dual eligible adults may qualify to participate in one of the Commonwealth's 1915(c) HCBS Waiver Programs.

Medicare

- **Physical and Behavioral Health Services:** Dual eligible adults may receive their Medicare healthcare services through Traditional Medicare or through Medicare Advantage.
- **Prescription Coverage:** They may receive their Medicare Part D through a Medicare Prescription Drug Plan or through a Medicare Advantage plan.
- **Supplemental Coverage:** Some dual eligible older adults with traditional Medicare may retain a Medigap policy, which means they are paying for duplicate coverage that they do not need, since their Medicaid coverage covers those things covered by a Medigap policy.

Note: Some dual eligible individuals are also eligible for healthcare or long-term care through the Veterans Health Administration.

C. Overview of Access Issues that Dual Eligible Individuals Encounter

"Any given full dual eligible individual may have half a dozen separate sources of coverage."

The number and nature of programs or plans each individual dual eligible may have is staggering and provides strong support for the need for service delivery integration or service coordination. Under the status quo, any given full dual eligible individual may have half a dozen separate sources of coverage. This highly fragmented array of different coverages leads to access challenges for dual eligible individuals, some of which are:

- Care is not coordinated;
- Coverage rules and procedures differ under each program;
- Written information comes from multiple sources with no single comprehensive description of the sum total of benefits, procedures, or rights and responsibilities applicable to dual eligible individuals;
- Processes for grievances and appeals differ, as do notices relating to both coverage determinations and grievances and appeals;
- Responsibility for delivering necessary services is divided between different programs, making it hard to know where to go when problems present;

- Providers are challenged to understand how the different coverages interact and how to proceed when they conflict; and
- Providers across programs have little or no established mechanisms through which to communicate.

At present, dual eligible individuals must navigate this patchwork of a system without the benefit of person-centered care planning or care coordination around the entire array of physical health, behavioral health, LTSS, and supplemental services they might need or wish to access.

When dual eligible individuals struggle to access their care needs through the fragmented elements of the existing system, they are likely to go without some portion of their care. This lack of care often leads to a decline in health status that can eventually result in more costly interventions. Because improved access to care can mean early intervention and better quality of care, it also leads to a better quality of life. Because better coordinated care can also improve efficiencies to the state, great attention is being turned to determining strategies that produce streamlined, seamless access to services.

III. DATA ON MONTGOMERY COUNTY'S DUAL ELIGIBLE ELDERLY

As of 2010, there were 799,874 individuals living in Montgomery County.[v] Approximately 15% of these individuals were age 65 or older (120,727 individuals).[vi] In 2010, 3.6% of the total population in the County was living below the federal poverty level ($11,490/yr or $957.50/mo for 2013). Absent data on the specific number of individuals age 65 or older who live below the federal poverty level, we used the percentage of total individuals under the federal poverty level to estimate that 4,405 individuals age 65 or older in Montgomery County live below the federal poverty level.

Approximately 15% of Montgomery County residents are age 65 or older (as of 2010).

According to the Montgomery County Assistance Office, in July 2013, there were 7,833 full dual eligible individuals age 65 and older in the County. This is the number that Workgroup utilized throughout its work. The information provided by the CAO is presented in Appendix C and is broken down by age group and by civil subdivision within the County. The information provided by the CAO has been validated twice and the Workgroup relied upon this information through its work.

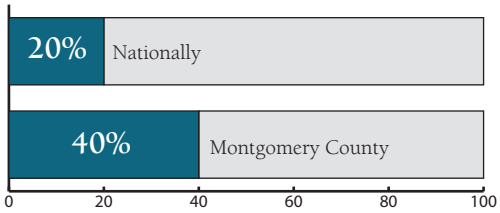
However, the lack of clearly available data was a concern for the Workgroup and figured in its recommendations. In March 2013, before the Workgroup was formed, the state Office of Income Maintenance indicated to the Workgroup leadership that there were over 16,500 full dual eligible individuals in the County. Based on this information the Workgroup leadership had estimated that 14,253 dual eligible individuals were over 65[1] – significantly more than the figure subsequently received from the Montgomery County Assistance Office. The Workgroup was unable to determine why there was such a significant disparity between the number of full dual eligible elderly provided by the state Office of Income Maintenance and the number provided by the local County Assistance Office (CAO), despite extensive efforts to clarify. The lack of clarity resulted in a Workgroup recommendation to make data on dual eligible more available (Recommendation #11).

Of the 7,833 dual eligible elderly the CAO shows residing in the County, the CAO reports that 3,055 reside in nursing homes, 29 reside in Personal Care Homes and receive the Personal Care Home Supplement from the state, and 3 reside in Domiciliary Care Homes and receive the Domiciliary Care Home Supplement from the state. The Workgroup was not able to determine the total number of dual eligible elderly residing in Personal Care Homes, Assisted Living Facilities, or Domiciliary Care Homes. We were only able to confirm the number of dual eligible elderly who receive the state supplement, as both of these supplements for low-income individuals are processed through the County Assistance Office (CAO). This information is also on Appendix C, divided by civil subdivision.

1 We estimated based on the knowledge the percentage of dual eligible adults with disabilities is 14% for Pennsylvania

According to national figures, only 20% of dual eligible elderly reside in nursing homes. The data from the CAO indicates that 40% of Montgomery County's dual eligible elderly reside in nursing homes. Again, the Workgroup is not confident in the total numbers of dual eligible elderly residing in the County. If the total is, in fact, 7,833, the Workgroup has serious concerns about the high percentage of dual eligible elderly residing in nursing homes. These numbers raise several concerns, including but not limited to the possibility that: 1) the only way lower-income elderly are able to the access the services they need is by entering a nursing home; 2) the potential for care coordination for dual eligible elderly could significantly reduce the number of people living in long-term nursing home beds; and, 3) more is being spent on caring for dual eligible elderly than is necessary.

Dual Eligible Elderly Residing in Nursing Homes



Approximately 233 dual eligible elderly are receiving behavioral health services through the Medicaid Health Choices Program. Additionally, Suburban Transit's Medicaid Transportation program made more than 5,500 trips in the last fiscal year to transport dual eligible elderly to more than 135 separate providers. While this number only reflects the visits for which the Medicaid Transportation provider was responsible, it provides a sense of the number of visits and the breadth of providers serving dual eligible elderly from Montgomery County.

Many dual eligible elderly are receiving services through the Area Agency on Aging (AAA). In Montgomery County, 1,643 dual eligible elderly are receiving some service(s) from the AAA. According to these figures, only 21% of the County's dual eligible elderly are receiving services through AAA, as compared to 40% receiving services through nursing facilities. The following table reflects the findings, by age group and by whether the dual eligible elderly are participating in the Options or Waiver program:

Dual Eligible Elderly in Montgomery County

AGE	RECEIVING PERSONAL CARE SERVICES AND ARE IN WAIVER OR OPTIONS PROGRAM	RECEIVING AAA SERVICES OTHER THAN PERSONAL CARE SERVICES AND ARE NOT IN WAIVER OR OPTIONS PROGRAM
65 – 69	115	52
70 – 74	142	77
75 – 79	150	98
80 – 84	168	129
85 – 89	141	139
90 – 94	106	125
95 – 99	113	65
100 – 104	6	15
105 – 109	1	1
TOTAL:	**942**	**701**

IV. STATEMENT OF THE NEED FOR BETTER COORDINATED CARE FOR DUAL ELIGIBLE INDIVIDUALS

Dual eligible individuals have high needs, and are also a high cost population for both the Medicare and Medicaid programs. Dual eligible individuals have long struggled to access the full array of services they need from Medicare and Medicaid. Problems with accessing routine or preventive care can increase the need for acute care, driving up the care costs for this population.

"Better coordinated care and better access to care improves overall health outcomes and reduces costs to the system."

Better coordinated care and better access to care improves overall health outcomes and reduces costs to the system. It also prevents decline and the need for nursing facility care. These facts have propelled the issue of better care for dual eligible individuals to the top of healthcare priorities at the state and federal levels. In growing numbers each year, providers, states and the federal government have been actively and intensively seeking and testing new ways to better integrate and coordinate dual eligible individuals' care. It is in search of this goal that the Affordable Care Act (2010) contains many initiatives, demonstrations, and new opportunities premised on finding a way to better meet dual eligible individuals' health care needs at a cost effective rate.

The Workgroup is well aware that better coordinated health care and LTSS are not the only needs of Montgomery County's dual eligible elderly. Low-income housing, food support, transportation, and energy assistance are additional areas of concern. The Workgroup focused its attention on improving access to physical health care, behavioral health care, and long-term supports and services for Montgomery County's dual eligible elderly. Challenges accessing care have been shown to impact whether care is ever obtained.

V. APPROACHES TO DELIVERING BETTER CARE AND OPPORTUNITIES IN MONTGOMERY COUNTY

There are numerous federal opportunities for delivering better care to frail populations. Some of these opportunities are specifically targeted towards the dual eligible population and others are targeted towards other populations, but all include a considerable number of dual eligible individuals. The following is a list of approaches the Workgroup viewed as potentially feasible approaches to improving access to care for Montgomery County's dual eligible elderly. It should be noted that this is not exhaustive list of every approach that could be included in efforts to better coordinate care.

"The Affordable Care Act of 2010 (ACA) includes many opportunities to improve care and services for dual eligible individuals."

The Affordable Care Act of 2010 (ACA) includes many opportunities to improve care and services for dual eligible individuals. The ACA contains significant infrastructure changes as well as pilots, demonstrations or new state plan options through which states may seek to participate. The ACA initiatives all strive to accomplish better overall health outcomes for dual eligible individuals or chronically ill individuals. Among the many provisions that involve some element of delivery system redesign, are provisions that: 1) create an Innovation Center at the Centers for Medicare and Medicaid Services to test, evaluate, and expand different Medicare and Medicaid payment structures to foster patient-centered care and care coordination across treatment settings and to slow cost growth[vii] and 2) create a Federal Coordinated Health Care Office tasked with improving coordination of care for individuals who are dual eligible and enrolled in both Medicare and Medicaid. [viii] These initiatives provide some evidence of the considerable import given to the need to better coordinate care for dual eligible individuals.

A. Insurance-Based Approaches: Managed Care

There are several managed care approaches to improving care for dual eligible individuals.

1. Medicare Advantage Special Needs Plans

The Medicare Modernization Act of 2003 (MMA) created a new subset of Medicare Advantage plans that focus on Medicare beneficiaries with special needs. These Special Needs Plans (SNP) serve beneficiaries who are 1) institutionalized (I-SNP) or meet the institutional level of care and live at home, 2) dual eligible for both Medicare and Medicaid (D-SNP), or 3) have severe or disabling chronic conditions (C-SNP).

SNPs for Dual Eligibles (or D-SNPs) are open to beneficiaries in all Medicaid eligibility categories but some may restrict enrollment to dual eligible individuals that belong to certain Medicaid eligibility categories. CMS divides D-SNPs into the following five categories, according to the types of beneficiaries that the SNP enrolls: 1) All-Dual D-SNPs; 2) Full-Benefit D-SNPs; 3) Medicare Zero-Cost-sharing D-SNPs; 4) Fully Integrated Dual Eligible (FIDE) SNPs; and, 5) Dual eligible subset D-SNPs.

Despite being targeted to individuals with Medicare and Medicaid, D-SNPs are Medicare plans that cover all Medicare healthcare services. Federal law contains care management requirements for D-SNPs. These include the requirement to conduct an initial assessment and annual reassessment of the enrollee; develop an individualized care plan for each enrollee; use an interdisciplinary care management team; and, have an evidence-based model of care with appropriate networks of providers and specialists.

i. Recent Developments in D-SNPs – New Federal Opportunities

The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 (as amended by the Patient Protection and Affordable Care Act (Affordable Care Act) of 2010) included new opportunities to improve the integration of Medicare and Medicaid benefits for dual eligible individuals by requiring all D-SNPs, starting in 2013, to have contracts with State Medicaid Agencies.

To comply with federal requirements, the state-D-SNP contract must, at a minimum, describe the D-SNPs responsibility to integrate and/or coordinate Medicare and Medicaid benefits. CMS will not accept an administrative services agreement (i.e., an agreement in which the contracted MA organization provides solely administrative functions such as claims processing) as meeting MIPPA requirements. States and D-SNPs must share sufficient data with each other to allow for the coordination and/or integration of Medicare and Medicaid benefits. This must include data on the providers contracted with the State Medicaid Agency as well as information for verifying enrollees' Medicaid eligibility.

States are free to choose the scope of that contract, whether to simply agree to data sharing or whether to contract for a full package of Medicaid benefits from the D-SNPs. Pennsylvania does not have an expansive contract (also called a MIPPA agreement) with D-SNPs through which D-SNPs provide Medicaid covered services. MIPPA agreements may be revisited for any year of a plan's Medicare contract.

2. Managed Long-Term Supports and Services

Many states have moved their long-term supports and services (LTSS) delivery system (or a subsection of their long-term supports and services delivery) to a managed care system. As LTSS are extremely costly to state Medicaid budgets, many more states have been considering this as well.

There are varying degrees of managed care that states can adopt in an MLTSS program. States can adopt programs in which they implement managed care for only their home and community based LTSS, for both their home and community LTSS and facility-based LTSS, for all LTSS plus all other state Medicaid services, or for all state Medicaid services plus all Medicare services.

While MLTSS programs are not necessarily limited to dual eligible individuals, some states have implemented programs specifically targeting dual eligible individuals.

i. Recent Developments in MLTSS – New Federal Opportunities

The Financial Alignment Initiative made available new opportunities for states to contract with CMS in an effort to provide dual eligible individuals with better coordinated care. There were two approaches through which states could pursue these opportunities: 1) a capitated managed care approach or 2) a managed fee-for-service approach to integration of all Medicare and Medicaid physical health, behavioral health, or LTSS care. States submitted proposals in 2012 and are still in the process of negotiating with the Centers for Medicare and Medicaid Services. In both instances, CMS is an active participant in developing the specific program design elements around rights, appeals, enrollment processes, and other details. While this program is closed to new states CMS has expressed its willingness to explore similar projects with states not involved in the demonstration.

ii. Examples of Managed LTSS

Pennsylvania has one program active in four counties that is considered to be MLTSS. The Adult Community Autism Program, ACAP, is a program that provides physical, behavioral, and community services to adults with an autism spectrum disorder. The Adult Community Autism Program, ACAP, is like a managed care program in Pennsylvania that provides physical, behavioral, and community services to adults with an autism spectrum disorder. The ACAP program contractor, Keystone Autism Services is the participant's health plan and participants generally must see providers in Keystone Autism Services' network of providers. ACAP provides or coordinates all Medicaid physical, behavioral and community support services. Additionally, support coordinators are expected to help coordinate and assist participants with access to Medicare services. ACAP uses a team approach to developing each participant's Individual Service Plans (ISP). The ISP team includes the Supports Coordinator, a Behavioral Health Specialist, the participant, the participant's legal guardian (if applicable), and anyone else the individual or legal guardian chooses to have involved. The ISP specifies the services a participant will receive, the reason(s) those services are needed, and the goals and objectives of the services.

This program is currently available in four counties only (Cumberland, Dauphin, Chester, and Lancaster).

3. PACE

The federal Program for All-Inclusive Care for the Elderly (known as the Living Independently for Elders in Pennsylvania) gives Providers a per capita payment from Medicare and Medicaid to deliver all covered healthcare and LTSS through a highly integrated, intensive model of care management and service delivery. Most services are delivered in an enhanced adult day setting where doctors and specialists are on staff or under contract. Additional services including hospitalization, homecare, meals, home modifications and other measures that support life in the community are provided up to and including services in a long term care facility. PACE programs have defined geographic service areas which are selected with the goal that PACE be a local, community-based service to which participants travel three or more days per week for services and socialization. The PACE model has long been considered one of the most fully integrated Medicare and Medicaid programs available.

"The PACE model has long been considered one of the most fully integrated Medicare and Medicaid programs available."

In the PACE model, care planning and care coordination are conducted by an interdisciplinary team (IDT) which must, at least, include: 1) Primary Care Physician; 2) Registered nurse; 3) Master's Level Social worker, 4) Physical therapist; 5) Occupational therapist; 6) Recreational therapist or activity coordinator; 7) Dietitian; 8) PACE Center manager; 9) Home care coordinator; 10) Personal care attendant or his or her representative; and 11) Driver or his or her representative. Additional medical and physical or behavioral health-related professionals may be included as well.

The IDT approach is comprehensive with care planning meetings occurring weekly and sometime like medical grand rounds occurring daily. The IDT is responsible for: 1) Conducting assessments and reassessments; 2) Developing participants' care plan; 3) Coordinating the 24-hour care delivery to participants; and 4) Continuous oversight of service delivery and monitoring of care plan. The IDT is also responsible for reaching Coverage Determinations on Participant coverage requests.

There are no new developments around PACE. The program continues to grow nationally. Some states have incorporated PACE expansion into their overall LTSS reform, including MLTSS implementation.

i. PACE in Pennsylvania

In 2009, the state PACE program, LIFE (Living Independently for Elders) issued a Request for Proposals to develop a LIFE Program in Montgomery County. The state received six applications from six bidders. The state was constrained with budget issues, and did not pursue its initial plan to create new service areas. There have been no additional service areas developed for the LIFE Program.

Despite the state's refusal to create a new PACE site at that time, there was great interest in the program from within Montgomery County. One of the applications was from a collaboration of providers and County government agencies. The proposal included a hub-and-spokes model that would make LIFE available throughout the County, using multiple LIFE Centers.

B. Provider- Based Models – Medical Homes and Accountable Care Organizations

1. Medical Homes

The medical home model is an enhanced primary care delivery model that endeavors to provide better access, coordination of care, prevention, quality, and safety within the primary care practice. A secondary goal is to create a strong partnership between the patient and primary care provider. Frequently, payers reward providers with a per member per month "bonus" for improving primary care services for each patient through the medical home model. The medical home model is referenced many times in current health reform efforts as one way to improve health outcomes through care coordination.

"Medical homes emphasize prevention, health information technology, care coordination and shared decision making among patients and their providers."

In recent years, medical homes have evolved as a new approach to better coordinated care for all patients. Medical homes emphasize prevention, health information technology, care coordination and shared decision making among patients and their providers. Medical homes go by multiple names: primary care medical homes, patient-centered medical homes, or health homes.

i. Recent Developments in Medical Homes – New Federal Opportunities

There are a few specific ACA provisions geared towards developing primary care medical homes (PCMHs) or Health Homes, a few of which are described here.

The Affordable Care Act created a new Medicaid state plan option under which Medicaid enrollees with chronic conditions can designate a provider, team of health care professionals, or a health team as their "health home".[ix] States adopting this state plan option receive a 90% FMAP or federal match for the first two years of implementation of this option. There are no deadlines for states to adopt this option. Pennsylvania has not pursued this option to date but still could, as the opportunity remains open to states to pursue.[x]

Another recent PCMH development is the Multi-payer Advance Primary Care Practice Demonstration (MAPCP). Under this demonstration program, Medicare began participating in existing State multi-payer health reform initiatives that includes participation from both Medicaid and private health plans. The goal of the demonstration is to improve the quality and coordination of health care services. Through MAPCP, a care management fee is paid to participating PCMHs to pay for the care coordination, improved access, patient education and other services to support chronically ill patients.

ii. Medical Home Examples

Medical Homes have rapidly emerged as a valuable service delivery model. There were an estimated 10,000 medical homes in operation by 2012.[xi] In fact, in Pennsylvania there are 721 doctors and 1,774 practices that have received National Committee for Quality Assurance's (NCQA's) PCMH recognition.[xii]

A medical home approach has been adopted in many health systems, including the US Air Force and the Veterans Health Administration. In 2010 the Veterans Health Administration[xiii] changed its service delivery model to a primary care medical home model. It has adopted a PCMH model

for all of its 978 primary care sites through the "Patient Aligned Care Teams (PACT) initiative". In PACT, each patient is assigned to a "teamlet," which consists of a primary care physician, a registered nurse (RN) care manager, a licensed practical nurse (LPN) or medical assistant, and administrative clerk. PACT strategies for improving patient care include: introducing advanced-access scheduling with more same-day appointments, conducting more appointments via phone, offering shared medical appointments, increasing patients' internet-based access to health information and care providers, and devoting substantial new VA resources towards supporting patients' healthy lifestyle changes, mental health, and preventive care. The VHA is still studying changes in health outcomes resulting from the transition to a PCMH model.

The Medical Home approach is also a central tenet of the Pennsylvania Chronic Care Initiative. The Chronic Care Initiative started in 2008 as an effort to transform the organization and delivery of primary care, with particular focus on individuals with two chronic conditions: diabetes and pediatric asthma. The program combined the Wagner chronic care model[xiv] with the PCMH model. The initiative was a multi-payer initiative through which providers/practices received increasing incentive payments for reaching each of three levels of nationally established certification towards being a PCMH. At each level of NCQA certification, a provider/practice is determined to be providing better care along the elements including: communication with patients, supporting patients in self-management of chronic conditions, managing care and ongoing needs for services, tracking how they managed care through tracking of referrals and prescribed tests, tracking patients health status and ongoing fluctuations in test results, and anticipating care and service needs prior to medical appointments such that they are more proactive than the traditional reactive model.

Early analysis indicates that the PCMH model of the Pennsylvania Chronic Care Initiative is improving the health status of the participants at reduced cost. In 2012, the following information was released about the CCI efforts in Southeastern Pennsylvania for Independence Blue Cross: 49% improvement in HbA1c levels, 25% increase in blood pressure control, 27% increase in cholesterol control, 56% increase in patients with self-management goals, and increased diabetes screenings from 40% to 92%.[xv]

In 2012, Pennsylvania became one of 8 states participating in the three-year Multi-payer Advanced Primary Care Practice Demonstration, as described above. A full evaluation of the initiative will be conducted as the Demonstration concludes.

Another PCMH initiative in Montgomery County was the Severe Mental Illness Care Integrated Demonstration.[xvi] In 2009, the Montgomery County Behavioral Health Department began participating in an effort to integrate physical healthcare and behavioral healthcare for individuals who have severe mental illness. Through this Center for Health Care Strategies funded initiative, the Behavioral Health Department tested a multipronged approach to delivering better care to this high need population. Specifically, the demonstration tested the notion of using an integrated patient profile to facilitate information sharing between behavioral health and physical health providers. It also tested the notion of providing care teams and care navigators. The outcomes produced considerable improvements in the physical health of individuals with severe mental illness.

One interesting component of this initiative is the way in which it reflects a marriage of two of the approaches described in this report. It incorporates the Primary Care Medical Home model along with the systems-navigation model discussed below. The Key Elements of this effort included provider engagement; designating a primary care medical home (physical or behavioral health) for each participant; consumer engagement; data management and information exchange; coordination of hospital discharge and follow-up; pharmacy management; appropriate emergency

department use for behavioral health treatment; and coordination with alcohol and substance use treatment providers; and co-location of services. The program used care navigators. Through regular contact with members, navigators played a key function within the multidisciplinary team, bridging the gap between their own agency, physical health providers, and other behavioral health providers. Navigators engaged both members and their providers to share information on recent hospitalizations and emergency department visits and developed individualized care plans. Interventions emphasized early recognition of symptoms that could lead to a decline in a physical or mental health condition.

Mathematica Policy Research evaluated the demonstration and found that the effort was successful at reducing the rate of mental health hospitalizations, all-cause readmissions, and emergency department visits. The rate of emergency department use was an estimated 9% lower. The shared, electronic, physical and behavioral health profile that provided real time information on prescriptions filled, doctor's appointments kept, etc. was a huge step in facilitating the collaboration and success of the initiative.

This demonstration ended in 2011. Montgomery County's results were very positive all around and, Montgomery County pursued a federal Innovation Grant to expand and enhance the initiative. CMS was very impressed with the Grant application, however, the County had to eventually withdraw its application due to turnover at the State office preventing it from completing the final requirement of obtaining final state sign-off.

2. Accountable Care Organizations

Accountable Care Organizations (ACOs) are partnerships of groups of doctors, hospitals, and other health care providers operating with the goal of meeting the health and LTSS needs of a defined group of patients for a pre-determined budgeted amount. Often, an ACO is comprised of medical homes, and thus the PCMH model (above) and the ACO model are complementary. ACOs are accountable for the cost and quality of care both within and outside of the primary care environment. As such, ACOs must include providers such as specialists and hospitals so as to control costs and improve health outcomes across the entire care continuum. If costs fall below the pre-determined budgeted amount, the ACO shares in the profits. If not, the ACO may share in the losses, depending on the ACO.

"Accountable Care Organizations are accountable for the cost and quality of care both within and outside of the primary care environment."

The payment structure is such that ACOs are rewarded for getting chronic conditions under control but also for preventing the onset of disease by promoting health and lifestyle changes. The idea is that healthcare providers can be enticed to work together to provide better care and to take financial responsibility for the outcomes of that care.

i. Recent Developments in ACOs

The Affordable Care Act created Medicare ACOs and, thus, only addressed incentives for Medicare. Some states have begun to establish state requirements for Medicaid ACOs and some state Medicaid programs have begun to adopt the ACO model for their Medicaid programs in the hopes of providing better coordinated care at lower cost. Medicare ACOs can only be operated as a voluntary option for patients. By contrast, states are permitted to require enrollment into Medicaid ACOs. A Medicare ACO shares in the savings it achieves for the Medicare program under the Medicare Shared Savings Program. As of August 2013, about four million Medicare beneficiaries were in an ACO.

The Pioneer ACO Model is an initiative launched by the Centers for Medicare & Medicaid Services (CMS) Innovation Center that is designed 1) to show how particular ACO payment arrangements can best improve care and generate savings for Medicare; and 2) to test alternative program designs to inform future rulemaking for the Medicare Shared Savings Program. Pioneer ACOs are ACOs that were so far along the path towards being an ACO that they were given an opportunity to participate in a special shared savings program the first two years of the demonstration and the opportunity to move into a population-based payment in year three. The Pioneer Model also requires participating ACOs to engage in similar arrangements with commercial and other payers. There are only 32 Pioneer ACOs in the country, one of which is in Montgomery County, Pennsylvania.

ii. Examples of ACOs

There is only one ACO in Montgomery County. It is a Pioneer ACO, one of only 32 Pioneer ACOs in the country.[xvii] It is Renaissance Health Network. The Pioneer ACOs have achieved the following results: slower rate of growth in costs for care, 13 of the 32 participating Pioneer ACOs achieved shared savings, 25 of 32 Pioneer ACOs generated lower risk-adjusted readmission rates for their aligned beneficiaries than the benchmark rate for all Medicare fee-for-service beneficiaries, median rate among Pioneer ACOs on blood pressure control among beneficiaries with diabetes was 68 percent compared to the comparison value of 55 percent, and median rate among Pioneer ACOs for LDO control among beneficiaries with diabetes was 57 percent compared to 48 percent.[xviii]

3. Independence At Home

The Independence at Home (IAH) Demonstration Program tests the use of designated medical practices comprised of primary care teams of physicians, nurse practitioners, and others to deliver care to high needs populations in their own homes and to coordinate care across all treatment settings.[xix] The thinking is that home-based primary care provided to the highest cost, most chronically ill Medicare beneficiaries will significantly reduce costs, allowing the participants to remain independent in their homes and avoid high cost unnecessary hospitalizations, emergency room visits, nursing home stays, medications and laboratory tests. This model contains an incentive payment methodology under which IAH programs must generate a minimum of 5% savings to Medicare each year in order to be paid for their coordination services and receive a share of the savings. There is one IAH program in Philadelphia, at the University of Pennsylvania. There are none in Montgomery County.

C. Place-Based Approaches

The concept behind place-based approaches is one of bringing services to a location where older adults lives or congregates. These are natural and potentially easier settings in which to capture the attention of individuals who could benefit from the service(s). There are no federal healthcare demonstrations geared towards testing or using place-based approaches.

1. Examples of Place-Based Services Happening in Montgomery County

i. Housing with Services

Through the Montgomery County program Your Way Home, the County is focusing on providing housing along with additional services to homeless in the County's shelters. The program breaks from traditional programs that address exclusively housing needs and instead provide a wide array of services intended to address the underlying conditions that caused or contributed to the individual's homelessness.

While targeting housing needs, the program incorporates other critical services from health care to employment, and more. Through this program, there are individualized goals set and housing is connected to the goals and contingent upon the individuals making progress on their goals. The program intends to add more services over time.

2. NORCs[xx]

Naturally Occurring Retirement Communities (NORCs) are neighborhoods or buildings in which a large segment of the residents are older adults. NORCs are not usually purpose-built senior housing or retirement communities. NORCs are not intended to meet the particular health and social services needs and wants of the elderly.

"Studies reflect a strong belief that Naturally Occurring Retirement Communities provide an invaluable opportunity to deliver targeted health and supportive services cost-effectively."

Since the 1990s, studies reflect a strong belief within the Aging Services Network that NORCs provide an invaluable opportunity to deliver targeted health and supportive services cost-effectively; increase service availability; organize cooperative health promotion, crises prevention, and community improvement initiatives; and develop new human, financial, and neighborhood resources for the benefit of older residents.

The NORC Supportive Service Programs (SSP) initiative tests an innovative approach designed to capitalize on the NORCs demographic phenomenon to advance health and social services to seniors living in NORCs.

United Way of Greater Philadelphia and Southern New Jersey recently funded the Eastern Montgomery County Visiting Nurses Association to create a naturally occurring retirement community and build in services.

D. Systems Navigation-Based Approaches

1. Home and Community Based Services Waiver Program Supports Coordination

Through Home and Community Based Services (HCBS) Waivers, eligible individuals who require LTSS may receive an array of necessary LTSS geared towards the two-part aim of supporting them in their homes and communities and preventing them from being unnecessarily institutionalized. A critical component of each HCBS program is care management or service coordination. For years, the Commonwealth's home and community based services waiver programs have been coordinated care for individuals with a varying array of intense service needs.

Care management or service coordination involves the location, coordination, and monitoring of needed services and supports. The care manager assists participants in obtaining and coordinating needed waiver and other State plan services, as well as housing, medical, social, vocational, and other community services, regardless of funding source. They do not typically provide extensive coordination of healthcare services through the Medicare or Medicaid programs.

In HCBS Waiver programs, care management includes the needs assessment and development of care plan (also called an Individual Support Plan (ISP)) through a person-centered approach to care planning.

i. Targeted Case Management Services[xxi]

Targeted case management (TCM) is a service which provides selected Medicaid participants with access to comprehensive medical and social services to encourage the cost effective use of medical care and community resources, while ensuring the client's freedom of choice and promoting the well-being of the individual.

Targeted case management is provided to individuals who fall into the AIDS target group. In this program, a case manager serves as a coordinator and facilitator of necessary medical and social services. It is the case manager's role to locate appropriate resources and assist the client in gaining access to needed services. Some of the services provided in the TCM program include screening (evaluating to determine if the recipient is an appropriate candidate for case management services), assessing (identifying the recipient's medical and social needs and the appropriate services to meet those needs. Based on the medical treatment plan established by the client's physician, the client and case manager to develop realistic goals), developing and Implementing a Service Coordination Plan (SCP).

The case manager, with the cooperation of the client and the client's family, will develop an action plan that specifies concrete activities to be completed in order to achieve the client's goals, linking and coordinating services (locating resources and making referrals or arrangements for treatment and support services related to the SCP), facilitating (acting as a resource person to resolve access problems that may arise while implementing the SCP), monitoring (insuring the appropriate quantity, quality, and effectiveness of services in accordance with the SCP), and reassessing (conferring with the client and physician and reviewing the SCP periodically, as required by the Department, to ensure that services provided are consistent with the needs and goals of the client).

Family Services provides care coordination for the HIV/AIDS population in Montgomery County. They have multiple sources of funding, including Ryan White Care Act funds and Medicaid Targeted Case Management funds. They provide coordination around an extremely broad array of services and needs. Using case managers, the program offers assistance in accessing the full array of medical and social services including healthcare, food, housing, and employment. Although the program does not deliver the services, it provides the care manager or individual responsible for ensuring that the consumer has access to the services.

E. Episode-Based Approaches

Episode-based approaches are care coordination models built around a single episode of care, such as a hospitalization. Payments may be linked for multiple services during an episode of care, as in the Bundled Payment Initiative created under the Affordable Care Act of 2010, or payment penalties might be linked to a hospital readmission prompting an incentive to ensure the smooth transition back to the community, as in the care transitions initiative. These approaches are not limited or targeting dual eligible individuals, although they could be designed to do so.

1. Recent Developments in Episode-Based Care – Bundled Payments Initiative and Care Transitions Demonstration

"The federal Bundled Payments initiative links payments for multiple services that beneficiaries receive during an episode of care."

The federal Bundled Payments initiative[xxii] links payments for multiple services that beneficiaries receive during an episode of care. It is comprised of four broadly defined models of care. Model 1 includes an episode of care focused on the acute care inpatient hospitalization. Awardees agree to provide a standard discount to Medicare from the usual Part A hospital inpatient payments. Models 2 and 3 involve a retrospective bundled payment arrangement where actual expenditures are reconciled against a target price for an episode of care. Model 4 involves a prospective bundled payment arrangement, where a lump sum payment is made to a provider for the entire episode of care. Over the course of the three-year initiative which began in January 2013, CMS is working with participating organizations to assess whether the models being tested result in improved patient care and lower costs to Medicare.

Another Affordable Care Act opportunity is a demonstration program around Community-based Care Transitions. Through this demonstration program, several Pennsylvania counties were funded to provide transition services (which exceed typical hospital discharge planning steps) to beneficiaries at high risk of either re-hospitalization or a substandard transition to post-acute care.[xxiii] There are five Transitions Demonstration sites in Pennsylvania and the opportunity is closed to new applicants. The Demonstration sites include 1) Delaware, 2) Philadelphia, 3) York, 4) Allegheny, and 5) Fayette, Greene, Washington, and Westmoreland.

i. Examples of Bundled Payment Initiatives and Care Transitions Initiatives in Montgomery County

"In Montgomery County, there is currently no single source or entity from which a person can obtain all of their physical health, behavioral health, and long-term supports and services."

In Montgomery County, there are six entities that are participating in a Model 2 Bundled Payment Initiative, also known as the model testing Retrospective Acute Care Hospital Stay plus Post-Acute Care. In Model 2, the episode of care will include the inpatient stay in the acute care hospital and all related services during the episode. In Montgomery County, there are seven entities that are participating in Model 3 Bundled Payment Initiatives, also known as the model testing Retrospective Post-Acute Care Only. For Model 3, the episode of care will be triggered by an acute care hospital stay and will begin at initiation of post-acute care services with a participating skilled nursing facility, inpatient rehabilitation facility, long-term care hospital or home health agency.

Several providers in Montgomery County are engaged in care transitions efforts. The Abington Hospital and other hospitals are undertaking care transition programs to improve the way they handle care transitions. This is partially motivated by new readmission penalties that are being levied. As one example hospital, Abington has recently hired staff to focus on care transitions and reducing readmissions with the largest 7-8 practices. Care Transitions efforts are general efforts to better coordinate care after a hospitalization and do not exclusively target Dually Eligible Elders. They are also typically short term efforts and are not focusing on care needs over the long term.

VI. RECOMMENDATIONS

In Montgomery County, there is currently no single source or entity from which a person can obtain all of their physical health, behavioral health, and long-term supports and services. There is currently no system-wide care management or care coordination to help a dual eligible person to navigate and negotiate his/her way through these different entities for purposes of obtaining his services. There is no one single recommendation that would be the panacea to this problem. Instead, multiple approaches can and should be pursued simultaneously. None of these initiatives will interfere with the other suggestions.

We propose nine (9) different, potential strategies for better coordinating care for dually eligible elderly, none of which are mutually exclusive. Some of the approaches outlined provide excellent models for delivering better coordinated and, potentially, higher quality care for dual eligible individuals. Not all, however, are approaches that the County or providers within the County can undertake independently. Integrating Medicare and Medicaid, including LTSS, is an approach that the Workgroup supports. It is not, however, an approach that the County can undertake independently because of the required involvement of the state Medicaid and federal Medicare programs.

Additionally, it is the opinion of the Workgroup that many of the suggested strategies complement each other and, thus, the Workgroup has chosen to integrate these successful strategies into recommendations that reflect multi-faceted approaches to delivering better care to dual eligible individuals.

Lastly, we provide supplemental recommendations aimed toward improving the ability for stakeholders to become and remain informed about the needs of dual eligible individuals and the opportunities available to help in meeting those needs.

REC #	RECOMMENDATION	TYPE OF APPROACH
1	**Managed Long-Term Supports and Services Pilot Program:** It is important that the providers and community be prepared for the implementation of Managed Long-Term Supports and Services. It would also be fruitful for the state to pilot-test voluntary Managed LTSS before full-scale adoption and implementation. Any pilot should incorporate all Medicaid physical health care, behavioral health care, and LTSS. With dual eligible elderly as the target population, the state should test program design elements that could ease a subsequent expansion to full integration. The workgroup, in its community conversations, should talk to stakeholders about whether Montgomery County would be good site for an MLTSS pilot. This approach could potentially test additional systems changes, such as Medicaid funding of assisted living through the inclusion of assisted living in the MLTSS benefit package. We believe Montgomery County would be a good pilot site. **(pages 15-16)**	Insurance-Based Approach
2	**PACE Implementation:** The Workgroup recommends that a coalition of providers collaborate to revisit and reinitiate efforts to implement a PACE program for the County, reinvigorating the countywide effort that had been collaboratively developed in 2009. In the alternative, the County and Providers could build up additional models of enhanced medical day care, using bundled care and bundled payment strategies outside of PACE, positioning for future opportunities to implement PACE. **(pages 16-17)**	Insurance-Based Approach

REC #	RECOMMENDATION	TYPE OF APPROACH
3	**Dual Eligible ACO Providers:** Obtain funding to conduct a feasibility study on Accountable Care Organizations and dual eligible elderly, incorporating a full array of LTSS. This would be funded by local foundation and state buy-in. There are no Medicare ACOs in the County, other than the one Pioneer ACO. There are no Medicaid ACOs yet either. There are no duals only ACOs and, thus, a feasibility study would be essential. The goal of this feasibility study would determine if a Medicare ACO, focusing on the needs of dual eligible elderly is possible. This is a new and untested concept making it an ideal idea for a CMS Innovation grant. The purpose of the innovation grant would be to bring providers together to explore interest in forming an ACO with a specific focus on LTSS and on serving the dual eligible population. **Note: Writing the Innovation Grant proposal is extremely complicated and time consuming and funding support from an outside source would be essential. (pages 13-14)**	Provider-Based Approach
4	**PCMH Development and Facilitation:** Convene providers, payers, philanthropy, and other stakeholders in an effort to incentivize all providers and practices in the County to obtain their PCMH certifications from NCQA. Several payers provide increased reimbursement to providers and practices that have obtained PCMH certification. Target those practices that serve dual eligible elderly and facilitate their advancement toward PCMH certification. This will help position them for increased reimbursement and for delivering better care to dual eligible elderly. **(page 12)**	Provider-Based Approach
5	**PCMH-SMI Integration:** Continue the blended PCMH-Systems Navigation work that was conducted through the Severe Mental Illness integration demonstration. Resubmit the Innovation Grant request with specific focus on the dual eligible elderly population or, alternatively, pursue other funding to permit it to expand and enhance the concepts tested in this very successful demonstration. **(page 10)**	Blended Provider-Based and Systems Navigation
6	**NORC Plus or NORC as Anchor:** A placed-based initiative focusing on NORCs and Villages provides a useful framework in addressing the needs of dual eligible older adults in Montgomery County. NORCs provide an excellent opportunity to improve quality of care where older dual eligible live. A multi-faceted approach to providing services in a NORC would include providing: 1) a paid System-Navigator whose role it is to connect dual eligible elderly to services and 2) an array of primary care providers that have been incentivized to become PCMHs for all residents. In addition, the PACE program and the Independence at Home initiative for the higher acuity residents would support older adult dual eligible remaining in the community and avoiding institutionalization. **(pages 17-18)**	Blended Place-Based, Systems-Navigation, and PCMH Approach
7	**IAH - HCBS Waiver:** Integrate HCBS Waivers with IAH which would enable primary care and other medical services to be provided in the home. This will serve those dual eligible older adults who are too frail to seek medical services in the community. It will also provide a PCMH for those who are less frail able to see health care providers in their offices. **(pages 14, 18)**	Place-Based Approach
8	**Dual Eligible Targeted Case Management:** Fund a demonstration project to test an intensive care navigation similar to the Targeted Case Management available through Medicaid and Ryan White Block Grant funding for the HIV/AIDS population. A "system navigator" would coordinate insurance coverage for duals eligible older adults. This single-individual system navigator would be an expert in both Medicare and Medicaid, and have access to key contact people in both systems. This approach would ensure adequate coverage of required and preventative services. **(pages 18-20)**	Systems-Navigation Approach
9	**Dual Eligible Care Transitions:** Initiate a pilot program, funded by local or foundation dollars, to test the impact of care transition efforts with longer-term needs of dual eligible older adults. Through this effort, the County or a local philanthropy would fund a navigator that would be assigned solely to dual eligible elderly during care transitions from the hospital back to the community. The care transition role would serve as a starting point for providing additional services and referrals. The effort could be one initially focused on the immediate transition and then on providing needs assessment, care navigation, and study of outcomes for a year following the initial discharge. This could be a mechanism to test Montgomery County's rapid response capability (i.e., The ability to meet sudden LTSS needs, improve LTSS and ensure that hospital discharge planners are aware of these services. **(pages 20-21)**	Episode-Based Approach

Additional Stakeholder and Systems Support Recommendations

REC #	RECOMMENDATIONS
10	**Community Engagement, Education and Awareness:** In order to garner support for addressing the needs of the dual eligible older adults in Montgomery County, it will be important to educate the community about the needs and challenges of this population and why additional support is needed. It will also be important to include education/outreach about why systems change is needed. This will help ensure that decisions regarding public investments in the dual eligible elderly population will be well understood by both community members and local leaders
11	**Data Recommendations:** The County needs a plan for gathering and maintaining data on dual eligible individuals. A single entity that serves as the warehouse for data related to this high needs population will be crucial for long term planning. Although the County Planning Commission has a tremendous amount of data, it is not specific to dual eligible elderly and their needs. Any data plan that is developed will need involvement from key stakeholders to ensure long term viability of the data collection and reporting.

VII. RELATED TOPICS FOR FUTURE CONSIDERATION

There were three areas that were not explored at great depth but were raised by the Workgroup as needed future consideration. They are:

i. **Near Dual Eligible Individuals:** There is an unknown population of "near" dual eligible older adults that face similar problems and have the potential for costly and unnecessary institutionalization in a nursing home. All of the recommendations about dual eligible older adults also hold for the "near" dual eligible.

ii. **Identifying Needed Community Supports:** Isolation is a problem for persons with LTSS needs who remain at home. A survey of dual eligible elderly, their caregivers, and the service system will be key in identifying the needed supports and services, including those for socialization, meals, transportation, entertainment, etc. This survey should determine the supports needed to help families and friends maximize the care and supports they can provide to keep those needing LTSS in their own homes.

iii. **Workforce:** It will be essential to foster partnerships to help create the long-term services and work force that Montgomery County will need in the future. It is important that the County provide leadership in determining workforce needs (year-by-year) for the next decade and plan for the training and supports that will be needed. It is suggested that Montgomery County could also convene LTSS providers to provide feedback on needs assessments for workforce. Linkages with the community college and other educational institutions will ensure that there is a continuous feedback loop between education and workforce needs.

VIII. CONCLUSION

The Workgroup to Develop An Action Plan for Montgomery County's Dual Eligible Elderly spent six months reviewing Montgomery County's efforts to better serve dual eligible elderly alongside national initiatives and opportunities. The Workgroup's work has been completed, with the suggestion of multiple initiatives that can be implemented independently or jointly with the goal of improving access to care and the quality of care for the County's dual eligible elderly.

At this point, we believe work could begin on implementing any of the recommendations 1-9. The Workgroup strongly recommends that the first and next step should be to spend the first 4-6 months of 2014 engaging the local community in a community conversation about the Workgroup's report and recommendation. While the Workgroup contained a broad representation of stakeholders, the conclusions of the group were reached without input or buy-in from the individuals that would be assisted or the providers that would be impacted. These steps, the Workgroup agrees, are critical precursors to implementation of our systems change recommendations.

May 2014 note: In February 2014, the North Penn Community Health Foundation provided supplemental funding to the Workgroup so that the Workgroup could conduct community conversations. These were conducted and a summary of the conversations is provided in Appendix E of the Final Report.

APPENDIX A - ACRONYM LIST

AAA – Area Agency on Aging

ACA – Affordable Care Act of 2010

ACO – Accountable Care Organization (service delivery model)

BH – Behavioral Health

BPI – Bundled Payment Initiative (federal demonstration)

CAO – County Assistance Office (makes Medicaid eligibility determinations)

CMS – Centers for Medicare and Medicaid Services (part of Federal government)

DCH – Domiciliary Care Home (residential setting)

DPW – Department of Public Welfare (part of State government)

D-SNP – Dual Eligible Special Needs Plan (service delivery model)

FMAP – Federal Medicaid Assistance Percentages

IAH – Independence At Home (federal demonstration) (service delivery model)

LIFE – Living Independently for Elders (PA's federal-state PACE Program) (service delivery model)

LTSS – Long-Term Supports and Services

MAPCP - Multi-payer Advance Primary Care Practice

MATP – Medical Assistance Transportation (Medicaid transportation program)

MLTSS – Managed Long-Term Supports and Services (service delivery model)

NCQA – National Committee for Quality Assurance

NORC – Naturally Occurring Retirement Community

NPCHF – North Penn Community Health Foundation

OMAP – Office of Medical Assistance Programs at DPW (part of state government)

PACE – Program of All-Inclusive Care for the Elderly (service delivery model)

PCH – Personal Care Home (residential setting)

PIHP - Pre-Paid Inpatient Health Plan (service delivery model)

PCMH – Primary Care Medicare Home (service delivery model)

SNP – Medicare Advantage Special Needs Plan (service delivery model)

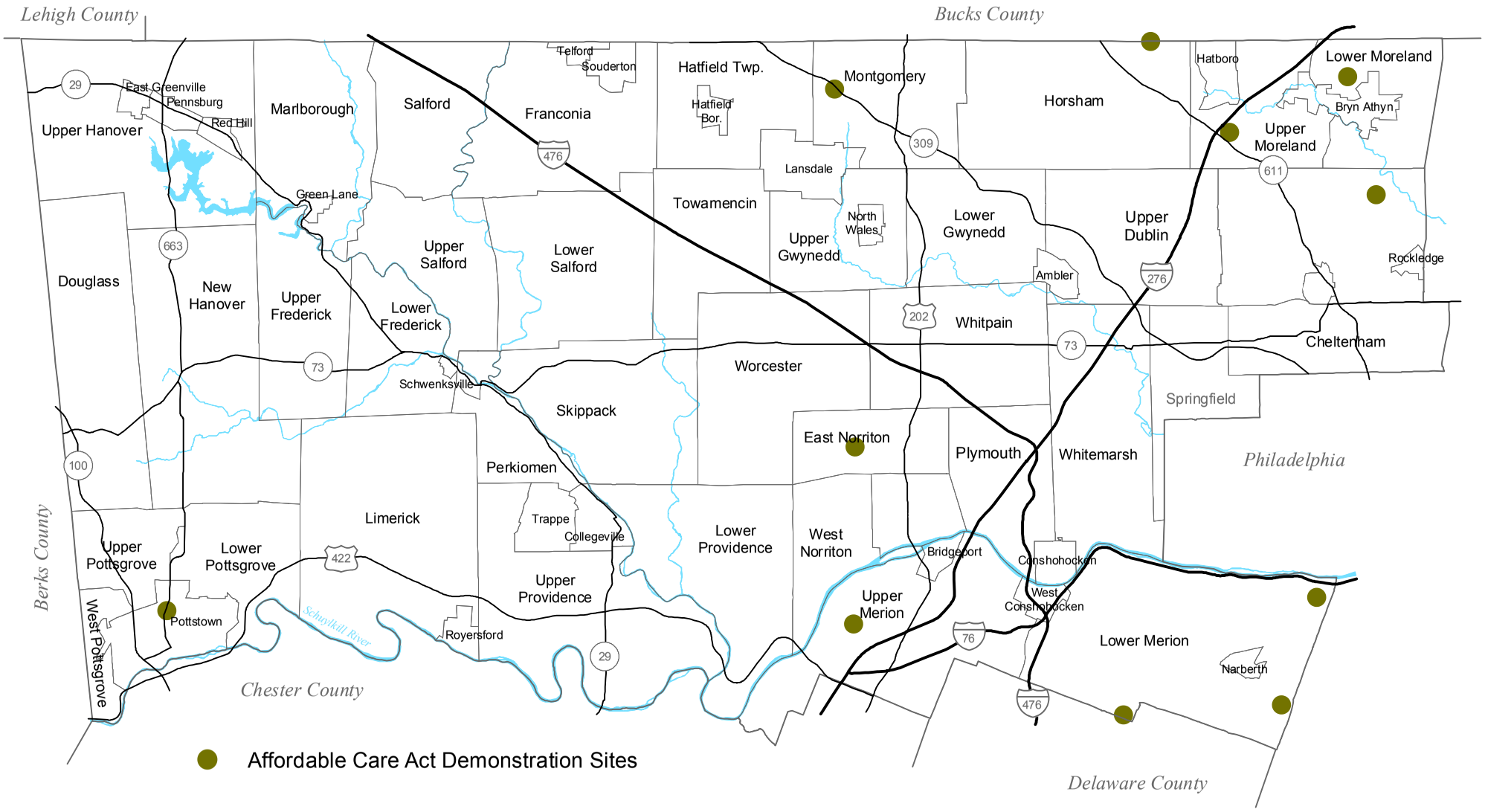
VA – Veterans Administration

VHA – Veterans Health Administration

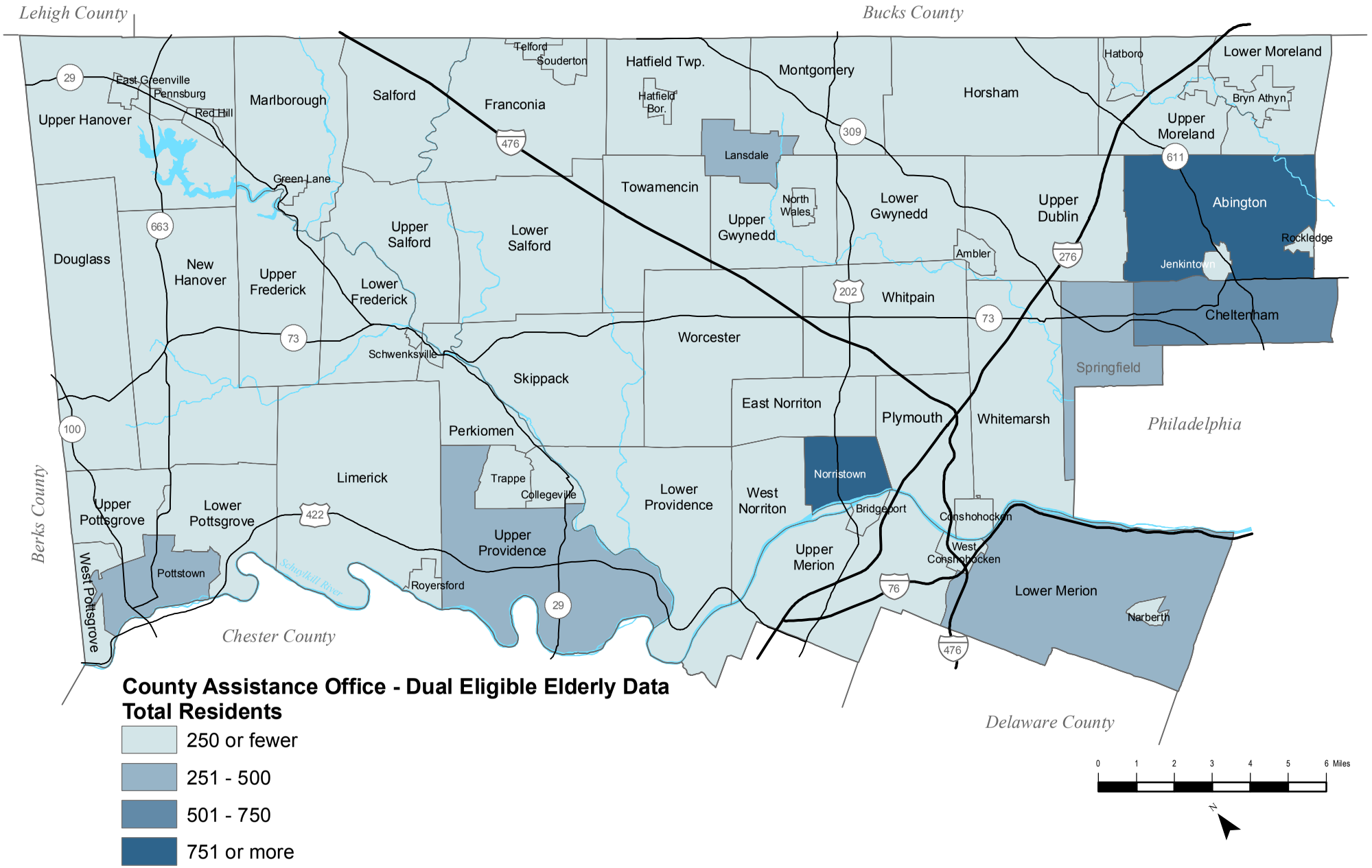
APPENDIX B – CHART OF ACA DEMONSTRATION SITES IN MONTGOMERY COUNTY

BPCI Initiative: Model 2	Bryn Mawr Hospital	130 S. Bryn Mawr Ave.	Bryn Mawr	PA	Number of Episodes: 4 // Convening Organization(s): Geisinger Clinic and Main Line Health
BPCI Initiative: Model 2	Einstein Medical Center Montgomery	559 W. Germantown Pike	E Norriton	PA	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc
BPCI Initiative: Model 2	Einstein Medical Center Montgomery	559 W. Germantown Pike	E Norriton	PA	Number of Episodes: 48 // Convening Organization(s): Association of American Medical Colleges and Albert Einstein Healthcare Network
BPCI Initiative: Model 2	Holy Redeemer	1648 Huntingdon Pike	Meadowbrook	PA	Number of Episodes: 2 // Convening Organization(s): Geisinger Clinic
BPCI Initiative: Model 2	Lankenau Medical Center	100 E. Lancaster	Wynnewood	PA	Number of Episodes: 4 // Convening Organization(s): Geisinger Clinic and Main Line Health
BPCI Initiative: Model 2	St. Luke's Hospital	801 Ostrum St.	Bethlehem	PA	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc
BPCI Initiative: Model 3	ManorCare Health Services-Huntingdon Vly	3430 Huntingdon Pike	Huntingdon Valley	PA	Number of Episodes: 48 // Convening Organization(s): Optum
BPCI Initiative: Model 3	ManorCare Health Services-King of Prussia	600 W. Valley Forge Rd.	King of Prussia	PA	Number of Episodes: 48 // Convening Organization(s): Optum
BPCI Initiative: Model 3	ManorCare Health Services-Lansdale	640 Bethlehem Pike	Montgomeryville	PA	Number of Episodes: 48 // Convening Organization(s): Optum
BPCI Initiative: Model 3	ManorCare Health Services-Pottstown	724 N. Charlotte St.	Pottstown	PA	Number of Episodes: 48 // Convening Organization(s): Optum
BPCI Initiative: Model 3	Bayada Home Health Care, Inc.	319 W. County Line Rd.	Hatboro	PA	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc
BPCI Initiative: Model 3	Bayada Home Health Care, Inc.	630 Fitzwatertown Rd.	Willow Grove	PA	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc
BPCI Initiative: Model 3	PennCare at Home	150 Monument Rd.	Bala Cynwyd	PA	Number of Episodes: 48 // Convening Organization(s): Remedy Partners, Inc
Independence at Home Demonstration	Schnabel In-Home Care Program, Division of Geriatric Medicine, UPHS	3615 Chestnut Street	Philadelphia	PA	Operating in the Mid-Atlantic Consortium

DEMONSTRATION MAP



APPENDIX C
DUAL ELIGIBLE MAP



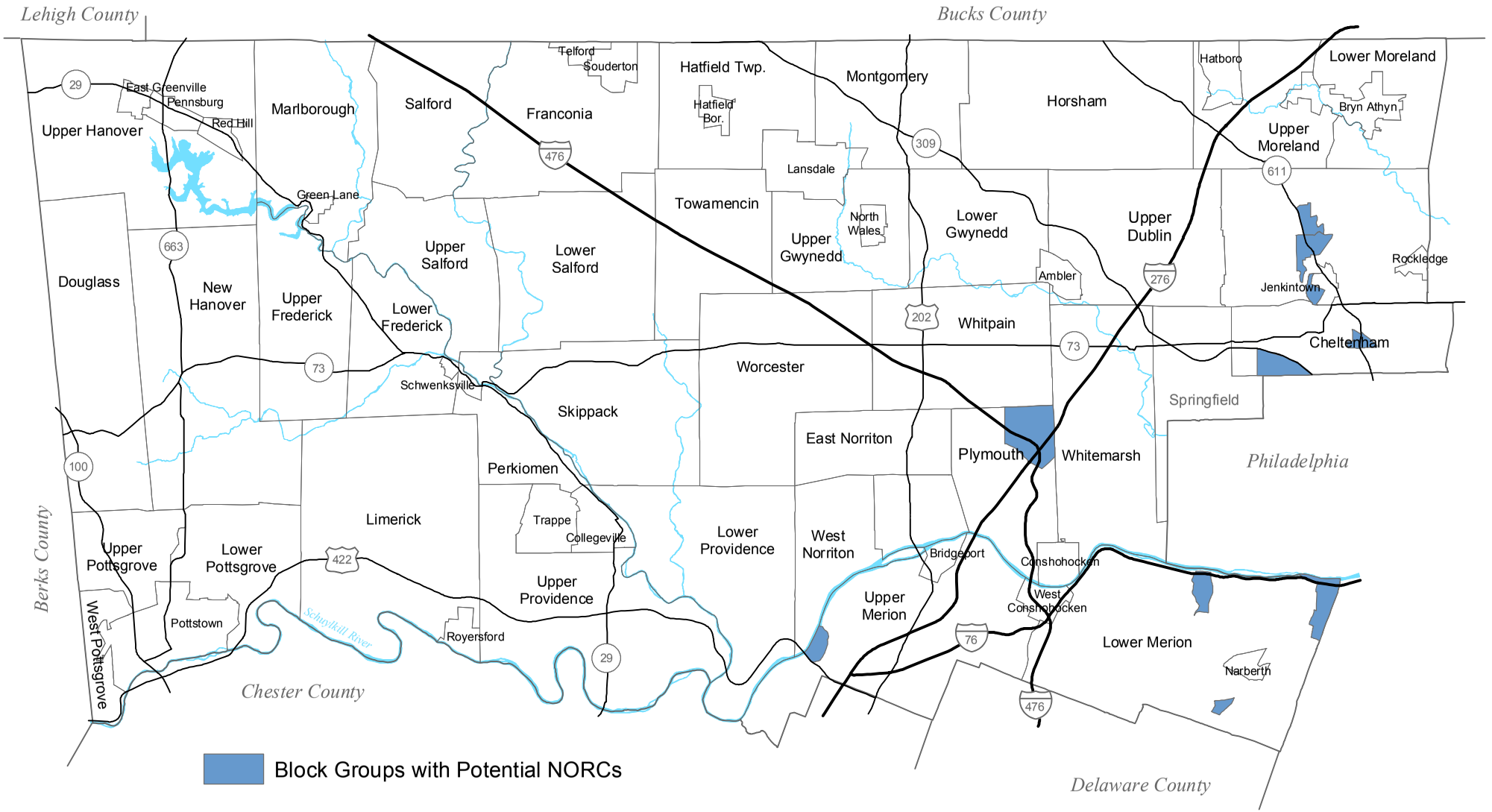
CAO DUAL ELIGIBLE ELDERLY DATA

NAME	RESIDING IN THE COMMUNITY	RESIDING IN THE A NURSING FACILITY	TOTAL LIVING IN THE COMMUNITY OR IN A NURSING HOME	65-74	75-84	85-94	95+
Abington Twp	565	263	828	300	267	222	39
Ambler Boro	59	74	133	47	46	34	6
Bridgeport Boro	30		30	21	7	2	
Bryn Athyn Boro	2	3	5	2		1	2
Cheltenham Twp	235	290	525	205	166	126	28
Collegevile Boro	18	2	20	10	6	4	
Conshohocken Boro	88	4	92	49	25	15	3
Douglass Twp	43	1	44	19	17	8	
E Greenville Boro	11		11	7	3		1
E Norriton Twp	74	33	107	55	36	12	4
Franconia Twp	31	23	54	24	9	16	5
Green Lane Boro	1	1	2	2			
Hatboro Boro	74	60	134	28	55	37	14
Hatfield Boro	48	1	49	28	14	6	1
Hatfield Twp	127		127	69	39	19	
Horsham Twp	61	158	219	39	52	88	40
Jenkintown Boro	34	3	37	17	16	3	1
Lansdale Boro	192	271	463	120	135	160	48
Limerick Twp	42	1	43	24	12	6	1
Lower Frederick Twp	12	1	13	8	4		1
Lower Gwynedd Twp	30	56	86	26	39	16	5
Lower Merion Twp	189	110	299	98	96	83	22
Lower Moreland Twp	152	69	221	84	89	42	6
Lower Pottsgrove Twp	58	6	64	39	16	6	3
Lower Providence Twp	75	2	77	36	32	9	
Lower Salford Twp	68	5	73	33	24	15	1
Marlborough Twp	10	7	17	10	3	2	2
Montgomery Twp	145	68	213	94	77	33	9
Narberth Boro	11		11	7	4		
New Hanover Twp	23		23	12	6	2	3
Norristown Mun	623	304	927	457	280	157	33
North Wales Boro	42	9	51	25	14	9	3
Pennsburg Boro	16	68	84	22	23	32	7
Perkiomen Twp	24		24	15	7	2	
Plymouth Twp	74	21	95	43	29	22	1
Pottstown Boro	306	128	434	217	142	69	6
Red Hill Boro	43		43	14	20	9	
Rockledge Boro	13		13	4	6	3	

NAME	RESIDING IN THE COMMUNITY	RESIDING IN THE A NURSING FACILITY	TOTAL LIVING IN THE COMMUNITY OR IN A NURSING HOME	65-74	75-84	85-94	95+
Royersford Boro	43	4	47	27	10	7	3
Salford Twp	2		2	1	1		
Schwenksville Boro	26		26	10	14	2	
Skippack Twp	18		18	12	3	3	
Souderton Boro	68	18	86	32	33	17	4
Springfield Twp	145	352	497	134	173	150	40
Telford Boro	30		30	19	7	3	1
Towamencin Twp	173	11	184	79	66	31	8
Trappe Boro	7		7	5	1	1	
Upper Dublin Twp	79	48	127	46	49	27	5
Upper Frederick Twp	2	11	13	1	2	6	4
Upper Gwynedd Twp	49	14	63	36	14	11	2
Upper Hanover Twp	17		17	9	6	2	
Upper Merion Twp	110	60	170	66	64	34	6
Upper Moreland Twp	62	50	112	56	29	26	1
Upper Pottsgrove Twp	31		31	17	7	6	1
Upper Providence Twp	48	311	359	66	102	163	28
Upper Salford Twp	5		5	2	2	1	
W. Conshohocken Boro	2		2	1			1
W. Norriton Twp	78		78	36	34	7	1
W. Pottsgrove Twp	33	2	35	19	11	5	
Whitemarsh Twp	35	131	166	60	60	37	9
Whitpain Twp	48	1	49	25	12	11	1
Worcester Twp	18		18	11	5	2	
	4778	**3055**	**7833**	**3080**	**2521**	**1822**	**410**

APPENDIX D

POSSIBLE SITES FOR NATURALLY OCCURRING RETIREMENT COMMUNITIES (NORCS)



These areas with the potential for NORCs were identified by selecting Census block groups with 1) higher numbers of single person households where the householder is 65 and over. 2) no age restricted communities, and 3) large apartment and/or condo development(s).

APPENDIX E: COMMUNITY CONVERSATION SUMMARY

Overview:

After drafting our preliminary report in December, the Workgroup to Develop An Action Plan for Montgomery County's Dual Eligible Elderly developed a plan for conducting community conversations about the report for the purposes of obtaining feedback on the report and the recommendations.

Between February 2014 and May 2014, the Workgroup discussed the report and/or met with:

- Members of County government,
- Members of State government,
- Managed care plans,
- Healthcare and long-term care providers,
- A long-term care provider association,
- State legislators,
- Dual eligible consumers, and
- Caregivers for dual eligibles.

Generally, the feedback on the report was positive or neutral. The workgroup did not receive any negative feedback about its recommendations.

Meetings:

Here is a summary of the community conversation meetings that we had, organized by the group or type of group with which we met.

Members of County Government

In February 2014, the Workgroup presented its report to County Commissioner Joshua Shapiro. After reviewing the report, the Commissioner supported the Workgroup's recommendations in his comments to CEOs of Healthcare Facilities. On April 28, 2014, the Workgroup met with the county Human Services Cabinet. The Cabinet consists of the leaders of the Departments of Health, Commerce, Children and Youth, Veterans, Aging & Adult Services, Behavioral Health/ Developmental Disabilities, Child Care Information Services, and Housing.

- **Feedback:** The Healthcare Cabinet was pleased with and supportive of all nine of the recommendations contained in the Workgroup report. The Director of the Department of Health indicated his intention that the recommendations be incorporated, in their entirety, into the Strategic Health Plan that the county is developing.

Members of State Government

On May 5, 2014, the Workgroup met with officials from the Department of Public Welfare including Bonnie Rose, Deputy Secretary for the Department of Public Welfare Office of Long-Term Living; Virginia Brown, Policy Director for the DPW Office of Long-Term Living; Cheryl Martin, Chief of Staff for the DPW Office of Long-Term Living; and Heather Hallman, Legislative Assistant to Secretary Mackereth.

- **Feedback:** The Department of Public Welfare was not opposed to any of the recommendations and thought they were reasonable and interesting. They asked if the Workgroup has any priority recommendations, which it does not. They asked if the Workgroup has specifics about the program design elements of an MLTSS pilot, which it does not.

On May 21, 2014, the Workgroup met with Secretary Brian Duke of the Department of Aging.

- **Feedback:** Secretary Duke was generally interested in all of the recommendations. He thought they were reasonable and that many were feasible. He asked how he could help the Workgroup and suggested that he could write letters of support for any funding requests (to CMS or otherwise) and that he could share the report with the Long Term Care Commission.

Managed Care Plans

On April 11, 2014, the Workgroup met with AmeriHealth Caritas to discuss the report and its recommendations. We discussed the opportunity of creating an MLTSS demonstration for Montgomery County and she felt there may be interest from Keystone VIP. On April 25, 2014, the Workgroup hosted a meeting with AmeriHealth Caritas/Keystone VIP Choice Plans, Aetna Better Health, and Health Partners Plans. The Workgroup reviewed the report and recommendations.

- **Feedback:** Overall, the managed care plans were not opposed to any of the recommendations and

seemed hesitant to affirmatively support any of the recommendations without more information on exactly how the recommendations would be implemented in the managed care context. The recommendations that the group felt were best suited to fit with managed care were the MLTSS, ACO, PCMH, and Case Management recommendations, although the group was open to the possibility that any of the recommendations could be implemented within the managed care context or alongside of it.

Healthcare Facilities:

On March 12, 2014, the Workgroup attended a meeting of all of the CEOs of Healthcare Facilities in Montgomery County. The meeting was hosted by Commissioner Josh Shapiro. Commissioner Shapiro and staff had previously reviewed the Workgroup report and had incorporated several of the recommendations into his presentation to the group as action items for the county to pursue. The Workgroup briefly presented the report and the recommendations.

- **Feedback:** When asked, no one in the group felt that the recommendations were far-fetched or unattainable. No one expressed disapproval for any of the nine recommendations. Generally, the attendees were supportive with specific interest being expressed in the PACE Development recommendation. These was also specific interest in several attendees that the Workgroup's report should be incorporated into Montgomery County's Health Service Planning efforts.

A Long-Term Care Provider Association:

On April 7, 2014, the Workgroup had a preliminary meeting with Leading Age, the association that represents non-profit long-term care facilities in Pennsylvania. The Workgroup met again with Leading Age on May 7, 2014. The Workgroup discussed the report and all of its recommendations.

- **Feedback:** The Leading Age provided a written letter of support for five of the Workgroup's nine recommendations. Specifically, they support Recommendation 1: MLTSS Demonstration, Recommendation 2: PACE Implementation, Recommendation 7: HCBS Waiver and IAH Demonstration, Recommendation 8: Dual Eligible Case Management, and Recommendation 9: Care Transitions. While the Leading Age provided affirmative support only for these five recommendations, they conveyed no objections to or disapprovals for the other four.

State Legislators:

On April 7, 2014, the Workgroup joined with a similar workgroup from SW PA and met with State Senator Robert Mensch. The Workgroup shared the report and the group jointly discussed the MLTSS pilot recommendation, which the SW PA workgroup is also recommending. The Workgroup also dropped off a copy of its draft report to State Senator Randy Vulakovich, the new chair of the Senate committee on Aging.

- **Feedback:** Senator Mensch was interested in hearing about the recommendation of an MLTSS pilot in Montgomery County and Allegheny County. There was no negative feedback provided on any of the Workgroup's recommendations.

Dual eligible consumers and Caregivers for dual eligibles:

On May 2, 2014, the Workgroup met with consumers and caregivers of consumers at Family Services office in Eagleville. This was focus group during which the Workgroup presented the recommendations at a high level. Participants were incentivized to attend with gift cards and transportation was provided.

- **Feedback:** There was a lot of positive feedback. The group particularly like the Dual Eligible Case Management recommendation as the idea of a systems navigator who could help coordinate care was appealing.

Conclusion:

The Workgroup received a great deal of positive support of the recommendations contained in its report "**Planning a Better Future for Dual Eligible Elderly in Montgomery County:** A Report of the Workgroup to Develop An Action Plan for Montgomery County's Dual Eligible Elderly". The Workgroup received some neutral feedback as well. The Workgroup is extremely pleased with the outcome of its community conversations and will be finalizing the report without any additional changes.

ENDNOTES

[i] Kaiser Family Foundation, "State Health Facts, Number of Dual Eligible Beneficiaries", 2009 data for Pennsylvania reported at: *http://www.statehealthfacts.org/profileind.jsp?ind=303&cat=6&rgn=40&cmprgn=1* (Last viewed on 12/13/13).

[ii] MedPAC, "A Data Book: Health Care Spending and the Medicare Program", June 2012. Available at *http://www.medpac.gov/chapters/Jun12DataBookSec3.pdf* (Last viewed on 12/13/13)

[iii] Kaiser Family Foundation, "Medicaid's Role for Dual Eligible Beneficiaries", April 2012, *http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7846-03.pdf* (Last viewed on 12/13/13)

[iv] AARP Public Policy Institute, by Edwards, Tucker, Klutz, and Flowers, "Integrating Medicare and Medicaid: State Experience with Dual Eligible Medicare Advantage Special Needs Plans" September 2009, *http://assets.aarp.org/rgcenter/ppi/health-care/2009_14_maplans.pdf* (Last viewed on 12/13/13)

[v] Montgomery County Planning Commission Website at *http://webapp.montcopa.org/planning/dataportal/PopulationNational.asp* (Last reviewed 12.13.13)

[vi] Montgomery County Planning Commission Website at: *http://webapp.montcopa.org/planning/dataportal/AgeCharacteristics.asp* (Last reviewed 12.13.13)

[vii] Affordable Care Act, Pub. L. No. 111-148, §3021.

[viii] Affordable Care Act, Pub. L. No. 111-148, §2602.

[ix] Affordable Care Act, Pub. L. No. 111-148, §2703.

[x] "Health Homes (Section 2703) Frequently Asked Questions" available at *http://www.chcs.org/usr_doc/Health_Homes_FAQ.pdf* (Last reviewed 12.13.13)

[xii] Patient-Centered Primary Care Collaborative, "Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, 2012." Available at *http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home* (Last Reviewed 12.13.13)

[xiii] As of August 2013 review of NCQA website at *www.NCQA.org*.

[xiiii] University of Michigan Health System, "Care model linked to improved veteran care; more access, use of e-records, post hospital follow-up", August 7, 2013, Available at: *http://www.uofmhealth.org/news/archive/201308/care-model-linked-improved-veteran-care-more-access-use-e;*

United States Department of Veterans Affairs, "Patient Aligned Care Team", Available at: *http://www.va.gov/PRIMARYCARE/PACT/index.asp*. (Last visited 12.13.13)

[xiv] The model was designed and tested by Edward H. Wagner, MD, MPH, and his colleagues at the MacColl Institute for Healthcare Innovation. The Wagner Chronic Care Model is based on research and evidence for delivery of effective chronic illness care. The model recognizes that formal health care settings are only a part of what is needed to improve chronic care. Patient self-management, information systems, decision support and community resources are all critical components. The Chronic Care Model is a comprehensive approach to improving the management of chronic illness. Its elements touch the provider practice, insurers, state agencies, employers, communities and community organizations, and, of course, consumers.

[xv] Patient-Centered Primary Care Collaborative, "Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, 2012." Available at *http://www.pcpcc.org/guide/benefits-implementing-primary-care-medical-home* (Last Reviewed 12.13.13).

[xvi] Center for Health Care Strategies reports on SMI Demonstration Available at *http://www.chcs.org/usr_doc/PA-RCP_Early_Lessons_Brief051412.pdf, http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261427&inactive=1, and http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261431.* The Lewin Group report on the SMI Demonstration Available at: *https://www.resourcesforintegratedcare.com/sites/default/files/Navigation%20Guide.pdf.*

[xvii] Centers for Medicare and Medicaid Services Website on Pioneer ACOs available at: *http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/* (Last visited 12.13.13).

[xviii] July 16, 2013 press release from CMS on the Pioneer ACOs available at *http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html*.

[xix] Affordable Care Act, Pub. L. No. 111-148, §3024.

[xx] NORCS - *http://www.norcblueprint.org/*

[xxi] Pennsylvania Regulations on Targeted Case Management, *55 PA Code 1247*

[xxii] CMS Informational Website on BPI available at: *http://innovation.cms.gov/initiatives/bundled-payments/index.html and* http://innovation.cms.gov/Files/x/Bundled-Payments-FAQ.pdf.

[xxiii] Affordable Care Act, Pub. L. No. 111-148, §3026.

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