DREDF

June 1, 2011

Kevin Morrill, Chief **VIA Email**
Office of Medi-Cal Procurement
P.O. Box 997413, Sacramento, CA 95899-7413
omcprfp9@dhcs.ca.gov

Re: Request for Information on Pilots for Beneficiaries Dually-Eligible for Medi-Cal and Medicare

Dear Mr. Morrill:

Disability Rights Education and Defense Fund (DREDF) is a national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. We appreciate the opportunity to provide targeted comments relating to the Department's Request for Information (RFI) on pilots for beneficiaries who are dually eligible for Medi-Cal and Medicare.

As a first matter, we would like to endorse the principles advanced by our fellow advocates at the National Senior Citizens' Law Center (NSCLC) in their June 1, 2011 letter with regard to the Design and Implementation of Integration Pilots. We have reproduced NSCLC's core principles, adding some additional emphasis on specific points and one additional principle, below.

Principles to Guide Design and Implementation of Integration Pilots

Choice. Dual eligibles interacting with integration pilots must retain their right to choose how they receive care, where they receive care and from whom they receive care. The principle of choice begins with a truly voluntary, "opt in" enrollment model, but also includes: the right to choose all of one's providers, the right to choose whether and how to participate in care coordination services, the right to decide who will be part of a care coordination team, the right to self-direct care (with support necessary to do so effectively), and the right to choose, ultimately, which services to receive and where to receive them, free of discriminatory administrative, structural, and procedural barriers.

Beneficiary-centered. The integration effort must be focused, at every level, on the beneficiary. The design and implementation process must include feedback from dual eligibles. Models should be developed to provide the maximum benefit to the beneficiary. Care coordination strategies and assessment tools must place the beneficiary at the center. Monitoring and evaluation measures must start with the impact on the beneficiary experience and must include feedback directly from those individuals.

Best of both worlds. Participants in pilots that integrate Medicare and Medi-Cal should receive care that is at least as good as the care they would receive if they were not in the integrated model. When integrating Medicare and Medi-Cal, difference should be resolved to provide enrollees with the stronger consumer protection and/or more generous coverage standard of the two programs.

Increasing access to HCBS. In an environment where home and community based services are being de-funded, this initiative must be focused on increasing access to those services. Systems that are currently in place should be built upon, not dismantled.

Consumer protections. When integrating multiple funding streams and services, the importance of consumer protections is heightened. Protections include: appeals and complaint processes, network adequacy, cultural and linguistic competence, physical and programmatic disability access, transition rights, meaningful notice and information about plan benefits and changes that is effectively communicated, stakeholder input and more.

Phased approach. The level of integration proposed does not exist in any current model. DHCS and the pilot entities should continue to develop and implement plans thoughtfully and deliberately. Where possible, integration should be done in phases, starting with simple steps that build off of the current structures in place, then progressing towards more significant changes as necessary and appropriate. Every step must emphasize the building of coordination among care and financing systems that have been historically and administratively placed in separate silos.

Reinvestment of savings. Medicare dollars must not be used to replace Medi-Cal dollars. If savings eventually accrue from the integration efforts, those savings should be reinvested to expand the availability and quality of health and long term supports and services.

Monitoring, Accountability and Data Collection. The degree to which the integration pilots are serving the needs of dual eligible cannot be assessed effectively unless monitoring and accountability systems are developed and implemented from the beginning to allow for quality assessment and consumer satisfaction over time. Quality data measures, including measures specific to the accessibility needs of dual eligible, must be put into place across the full range of services that this population will require, including “non-traditional” services such as home ramps or temporary rental assistance during hospitalizations, that this population may require in order to age in place and maximize health and functioning within their communities. The implementation of quality measures and data collection will be particularly important in light of the fact that DHCS hopes to expand integrated care statewide by 2015.

In addition to the above principles, we would like to comment specifically on questions 8 and 10.

8. Which requirements should DHCS hold contractors to for this population? What standards should be met for cultural competency, sensitivity to the needs of the dual eligible population, accessibility, etc. prior to enrolling beneficiaries?

The dual eligible population will comprise younger individuals with disabilities as older individuals who will have a corresponding higher propensity to acquire a disability. According to a population report released in 2008, people aged 55 to 64 were nearly three times (30.1 percent) as likely to have a disability as people aged 15 to 24 (10.4 percent), and the likelihood of severe disability increases in successively older age groups, ranging up to 56.2 percent for the population 80 years and older. The number of people who experience deafness or who have a lot of trouble hearing increases from 0.9 percent among adults under the age of 45 to 11.1 percent among those over 65. Similarly, the number of people who experience lesser hearing loss also increases with age: 27 percent of people aged 65 and over report a lot of trouble hearing. Vision impairment and blindness rank among the top 10 most common disabilities in the U.S., and aging is associated with the leading causes of vision loss, including cataracts, macular degeneration, glaucoma, and diabetic retinopathy. More than two-thirds of adults who have vision impairments are over age 65. Moreover, income poverty will be another common factor among dual eligible, and "people with disabilities account for a larger share of those experiencing income poverty than people in any single minority or ethnic group (or, in fact, all minority ethnic and racial groups combined)."[1]

Given that many dual eligibles have chronic conditions and various disabilities, it is essential that contractors be physically and programmatically accessible and have a baseline level of disability cultural competence prior to providing services to dual eligibles. Regardless of whether a dual eligible "self-identifies" as a person with a disability, contractors and all service providers must have the capacity to recognize and appropriately respond to disability-related needs for reasonable accommodation and policy modification as required by federal and state law. All contractors should also provide public notice of a beneficiary's right to request reasonable accommodation and/or policy modification.

Physical Accessibility:

DHCS should require a provider network that is physically accessible. Full physical access includes at least the following:

- Accessible entry doors
- Accessible parking and entry pathways
- Accessible pathway signage
- Clear floor space and turning space in exam rooms and waiting areas
- Positioning and transferring space in exam rooms
- Accessible exam tables
- Patient lifts
- Accessible radiology equipment
- Accessible mammography equipment
- Accessible changing areas for medical testing
- Accessible weight scales
- Accessible health information technology.

[1] Shawn Fremstad, *Half in Ten: Why Taking Disability Into Account is Essential to Reducing Income Poverty and Expanding Economic Inclusion*. Center for Economic and Policy Research. September, 2009.

Programmatic Accessibility:

DHCS should ensure a provider network that is programmatically accessible. Programmatic access means that the policies, practices and procedures that are part of the "typical" delivery of healthcare are modified so as not to hinder the ability of patients with disabilities to receive the same quality of care as other persons. Usual office procedures often fail to take account of barriers such as untrained office staff that refuse or are unprepared to provide lift assistance or assistance with required paperwork, office emergency evacuation procedures that do not account for the needs of people with disabilities, appointment policies that do not account for patient dependence on paratransit rides that can have issues with delays or reliability, and referral procedures that fail to consider the accessibility of the specialist office. Policies and procedures that comprise programmatic access involve: methods of communicating with patients for the provision of individual medical information and general health information (see examples below); appointment scheduling procedures and time slots; patient treatment by the medical staff; awareness of and methods for selecting, purchasing, and scheduling the use of accessible equipment; staff training and knowledge (e.g., for operation of accessible equipment, assistance with transfer and dressing, conduct of the exam); standards for referral for tests or other treatment; system-wide coordination and flexibility to enable access; and disability cultural competence.

Examples of Effective Communication Access:

DHCS should require that contractors have in place systems for effective communication for individuals who are deaf or hard of hearing. These may include: qualified interpreters, note-takers, computer aided transcription services, written materials, telephone handset amplifiers, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, TTY, videotext displays, and exchange of written notes. All office staff must be both aware that these methods of communication exist, and trained to operate the equipment within the office. For example, office staff can refuse to accept California relay system calls because they do not recognize that a beneficiary is using an operator, or misunderstand how patient confidentiality is maintained within the call.

For effective communication with persons who are visually or text impaired, DHCS should require systems which may include qualified readers, taped texts, audio recordings, Brailed materials, large font print materials, and assistance in locating items.

Systems for effective communication with persons with speech or impairments should be required, which may include TTY, computer terminals, speech synthesizers, and communication boards, as well as a chosen human aide.

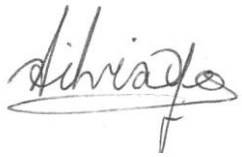
All beneficiary information and notices, as well as printed health education and informational materials should also be provided in the above formats.

10. What concerns would need to be addressed prior to implementation?

Entities undertaking the pilot projects should be prepared to undergo, and to administer to any sub-contracting providers, readiness reviews to ensure that they are physically and programmatically accessible. The information from these reviews must be made available to beneficiaries to ensure that they can make a truly informed choice regarding providers that are ready and able to provide fully accessible services.

Again, we appreciate the opportunity to submit comments on this critical subject.

Yours Truly,



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