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Via email: info@calduals.org

RE: Duals Integration Demonstrations – Comments on Duals Demonstration Background and Process Overview

The California State Association of Counties (CSAC) and the County Welfare Directors Association of California (CWDA) appreciate this opportunity to comment on the Duals Demonstration Background and Process overview. California's 58 counties administer local mental health, alcohol and drug and the In-Home Supportive Services (IHSS) programs on the State's behalf, and provide medical safety net services through California's Public Hospital system. All of these local programs, and the clients they serve, will be impacted by the Duals Demonstration. For example, in the IHSS program, 70-85 percent of the statewide IHSS caseload is dual beneficiaries. Counties determine eligibility for Medi-Cal services and also deliver these safety net services, and in this capacity we are uniquely positioned to inform and engage in discussions regarding the Duals Demonstration project to improve the health and quality of life for dual beneficiaries.

Following are our responses and recommendations based on the Key Questions presented in the October 2011 Duals Demonstration Background and Process document:

Key Question: Goals

In general, we support the overarching goals listed in the background paper but have a few comments. First, beneficiary satisfaction comes when the consumer is aware of the choices they have in their care and can act on those choices. The first goal – "Improve beneficiaries' quality of life, health care and satisfaction with the health care system" – should also include the goal of maximizing consumer choice and improving consumers' ability to make informed choices in their care needs.

Second, counties are diverse and thus the Duals Demonstration must accommodate for diverse medical and social delivery systems. We concur that this will require significant input and collaboration between the State, counties, beneficiaries, providers, health plans and advocates to develop models to achieve the articulated goals. However, we are concerned that the financial model that would propose to place all accountability for the delivery, coordination and management of all needed services -- including IHSS – with a single entity (presumably the Health Plan), may cause significant complications at the local level because counties would

continue to be the safety net provider of these services. We support and advocate for a shared accountability structure through which care would be coordinated that includes both counties and health plans, with counties retaining current care coordination responsibilities for social and behavioral supports that include mental health, alcohol and drug, and IHSS services. Counties have the expertise and existing infrastructures to meet the needs of dual beneficiaries in our communities.

Key Question: Financing

The Background and Process Overview indicates that discussions around financing are at an early stage; however, issues around financing are very much at the core of this discussion. We urge the Department of Health Care Services (DHCS) and Department of Social Services (DSS) to work with counties to determine how the Dual Demonstrations will be financed and whether and how county funds will be used in the pilots under a blended payment. Counties currently pay 35% of the nonfederal costs for IHSS services and administration, and in fiscal year 2011-12 will bear 100% of the costs for alcohol and drug programs and in 2012-13 counties will bear 100% of the costs for mental health services as a result of the 2011 realignment. Counties' costs in support of these programs are significant and will need to be factored in to determine the blended, capitated rates established under the Duals Demonstration.

In addition, the capitated approach option presented by CMS is unworkable in counties where there is no managed care entity. If the Duals Demonstration intends to improve health outcomes and quality of life for dual beneficiaries, then all of California's dual eligible beneficiaries should have the opportunity to participate upon conclusion of the pilots, if the goal is to implement this approach statewide in the future. Thus, it will be necessary to test approaches to coordinated care in those counties that continue to operate through a fee-for-service model.

Key Question: Site Selection

We agree that applicants should demonstrate their ability to satisfy site selection criteria, and we encourage the State to establish a rigorous set of criteria based on input from stakeholders identified in SB 208, including county programs. Site selection criteria should be person-centered and include a requirement that integrating entities will uphold existing statutory and regulatory requirements in the IHSS program, including consumer protections and a county-based assessment process. Although we do not have comments on which competitive process (RFP or RFS) should be used, we encourage DHCS to require any applicant to demonstrate their ability to enter into contracts with counties in the use of IHSS providers (via the Public Authority) and IHSS authorization for services (via the County Board of Supervisors). We concur with the proposal that one criterion for participation should require the entity to have a Medi-Cal service contract and, thus, experience in serving the Medi-Cal population.

Key Question: Potential Demonstration Participants

As the background paper indicates, SB 208 does not prescribe the number of participants to be enrolled into the Duals Demonstration. However, DHCS has indicated to CMS that the demonstration would enroll at least 150,000 dual eligible, and has also indicated that given the interest from urban counties, the number of enrollees is likely to be even higher. We believe there will be significant challenges in setting up demonstration sites of this size and establishing agreements among service providers. It is for this reason that we question whether such a large-scale implementation can be easily accomplished within the short time period identified by the State, which proposes to have the project operational by December 2012.

Pilots by design are intended to test innovative strategies and models within a limited scope of implementation. Not all dual beneficiaries will benefit from care coordination as envisioned by the demonstration project architects. For example, many IHSS disabled consumers live healthy, productive lives with limited assistance with activities of their daily living from the IHSS program, enabling them to remain in their own homes and communities. Intensive care coordination may be appropriate for some, but not all, consumers of IHSS, so it is unclear what benefit would be derived from enrolling all dual eligibles in a county into the demonstration.

Appendix: Evaluating Success

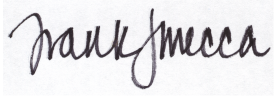
We recommend the following changes (bolded/underline):

4. What where the levels of service used by enrollees in each of the following categories, before and 6 months after enrollment in the pilots? One year? **Two years?** **Three years?**
Did utilization increase or decrease?
(c) Home- and community-based long-term supportive services, **and specifically IHSS**.

Note: The evaluation questions suggest that the pilots would be only one-year in duration; however many RFI respondents indicated that a 3-year demonstration would be needed to ascertain program effectiveness.

Thank you again for this opportunity comment and feel free to contact us with any questions.

Sincerely,



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