AltaMed

To: Mr. Toby Douglas
Director California Department of Health Care Services

From: Jacqueline Ritacco
Vice President Government Relations AltaMed Health Services

RE: Comments on Coordinated Care Initiative

Dear Mr. Douglas:

After review of the State's draft proposal to CMS, the following are issues for consideration and response from the state:

Issue #1: Allowing for PACE Choice

Page 10 of the proposal states: "The State is proposing a passive enrollment process with a stable enrollment period to ensure a sufficient volume of enrollees over the demonstration period. Passive and stable enrollment will encourage beneficiaries to establish a relationship with a plan and providers, so beneficiaries can adequately evaluate this care model. Based on stakeholder feedback, the State will identify any beneficiary categories that may opt out during the six-month stable enrollment period."

Recommendation:

The state should allow those persons who have been identified as becoming eligible for PACE and who have chosen the PACE option during the stable enrollment period to opt out or easily disenroll from the health plan in order to move into PACE within the six month period.

Issue #2: Identification of PACE Eligible Enrollees

Page 8 of the proposal states: "California has several PACE sites, serving a largely dual eligible population. In demonstration areas where PACE is available, PACE enrollees will not be passively enrolled in the demonstration, and PACE will remain a clear enrollment option for dual eligible beneficiaries that meet the PACE enrollment criteria. Additionally, in counties where PACE is available, several demonstration health plans will coordinate closely with PACE to offer this option to nursing-home eligible dual eligible beneficiaries who wish to remain in the community."

Recommendation:

PACE providers must be included in the development of the process for identifying level of care for the dual eligible population during the passive enrollment and individual assessment phase. Additionally, a process for evaluating when the health status of a person changes to PACE level of care occurs and how they will be provided the option of a PACE program must be developed in concert with PACE providers.

Issue #3: PACE as an Independent Provider

Page 9 of the proposal states: "Demonstration sites will provide access to the full range of services currently covered by Medicare Parts A, B and D, as well as all State Plan benefits and services covered by Medi-Cal."

Page 35 and 36 of the proposal states: "Although current state law provides authority to implement the demonstration in up to four counties, the Governor's Coordinated Care Initiative seeks Legislative authority to implement the following aspects of the demonstration:

- Implement the demonstration in up to 10 counties in 2013, additional counties in 2014 and statewide by 2015.
- Maintain beneficiary enrollment for the first six months after initial enrollment.
- Establish a county maintenance of effort funding level for IHSS.
- Mandatory Medi-Cal managed care enrollment in demonstration counties.
- HCBS Universal Assessment, implemented as early as January 1, 2015"

Recommendation:

As PACE is provided for as a State Plan Benefit, please provide clear language that PACE is not included when referencing "All State Plan benefits" through the document. Additionally, please clarify that "Mandatory Medi-Cal managed care enrollment in demonstration counties" does not include PACE.

Issue #4: Financial Segregation of PACE

Page 27 of the proposal states: "The capitation model will include the full range of Medicare and Medicaid (both State Plan and home-and community-based waiver) services. The State and CMS will make monthly payments to health plans for the Medicaid and Medicare portions of the capitation rate."

Recommendation:

Since PACE is a state plan service, please provide clarification in the language that carves PACE out of this blended capitation rate for independent providers in dual demonstration counties.

Issue #5: PACE as a Carved Out Program

Page 32 of the proposal states: "Some health plans participating in the demonstration have expressed interest in contracting with PACE providers, to provide an additional option for members that meet the criteria for enrollment in PACE. The State will work with CMS to determine if any amendments to current authority for PACE are needed for this contracting option."

Recommendation:

Since PACE remains a carved out program with a three-way contract between the State, the Federal government and the PACE provider, subcontracting authority should not include any provision which would allow the state to mandate a subcontract between a health plan and a PACE provider in any of the dual demonstration sites. Additionally, in County Organized Health System sites, the State should seek a waiver to allow for the direct provision of services by a PACE contractor as a carved out program within the dual eligible demonstration.

Issue #6: PACE Regulation Flexibility

Page 14 of the proposal states: "Health plans will also use various strategies to identify the most vulnerable members: Health Risk Assessment, claims, self-referral and provider referral. Some plans already conduct outreach to community organizations to reach the most vulnerable members."

Recommendation: Maximum flexibility in implementing these strategies especially Health Risk Assessments and specialty programs should be afforded to the Health Plans. This flexibility should also extend to the PACE programs as they work in coordination with the Health Plans within the demo areas. As an example, a PACE organization who is doing health risk assessments or specialty disease management programs should not be constrained by PACE facility utilization for after hours programs.

Issue #7: Transparency in the Rate Setting Process

Page 27 and 28 of the proposal states: "Rates for participating health plans will be developed by the State in partnership with CMS based on baseline spending in both programs and anticipated savings that will result from integration and improved care management. The Part D portion of the rate will be based on the standardized national average bid amount and will be risk adjusted in accordance with the rules that apply for all other Part D plans. Medi-Cal and Medicare rates will be considered as one total capitation for savings projections and will be fully integrated at the plan level. Rates will continue to reflect any required legislative and policy changes occurring during the demonstration."

Recommendation:
There should be full public disclosure and transparency in the rate setting process. The success of this initiative will rely upon the state and federal governments fulfilling their obligation to provide actuarially sound rates to the health plans for this population. The entire process should be transparent and all data including the actuarial and population data need to be shared with all stakeholders, not just the plans.

Issue #8: Auto Assignment Algorithm
While not directly addressed in the proposal there should be algorithm standards that maintain levels appropriate to safety net providers who are prepared and ready to serve this population.

Thank you for the opportunity to respond to your proposal to CMS. We look forward to your response our comments.

Sincerely,

Jacqueline Ritacco, MBA
Vice President Government Relations

May 4, 2012

Re- Comment on Demo project for dual eligible patients

To Whom It May Concern:

As a community based rheumatologist in the greater Los Angeles and Orange areas I am gravely concerned about the upcoming dual eligible demonstration project. Our practice consists of three offices in Chinatown, Monterey Park and La Palma with four active rheumatologists. We therefore serve a large Medicare/Medi-Cal population that has very severe rheumatologic diseases such as rheumatoid arthritis, systemic lupus erymathosus and vasculitis. These patients require extensive and detailed care with close clinical follow up and treatment with expensive chemotherapy and biologic agents. We have already experienced a less than propitious start with the Medi-Cal managed care conversion this year, which is a parallel and comparative situation. I am afraid similar problems with access to care will arise in the future dual eligible project. Here are some of the difficulties that are looming.

First of all, rheumatology patients are gravely ill with a chronic often-debilitating course. Therapy often involves monthly follow up and the use of expensive pharmaceuticals. For example in the treatment of rheumatoid arthritis, TNF inhibitors, such as Enbrel, Remicade, or Humira cost approximately $ 200000.00per year and require close monitoring for complications. My Medi-Cal patients this year have frequently been lost to follow up and care as they are placed in an IPA. They subsequently do not receive their vital therapies such as outlined above. Rheumatoid arthritis patients will thus flare causing them severe disability, pain and loss of normal daily function.

Exacerbating the situation is the reticence of the HMO /IPA to approve the prescribed biologic treatment due to the financial burden to the group. Many times there is outright denial of the TNF inhibitor even though the patient had been previously well controlled on this treatment . The end result is suboptimal care for our chronically ill rheumatoid

patients. Even when the patients return to our practice through a contracted managed care organization, they are flaring, sick and not on an appropriate medical regimen. Again I have to fight with the utilization review department to reinitiate therapy.

In the meantime, while waiting for authorization, patients suffer severe joint pain and discomfort. Ironically, the interruption and denial of care will actually increase the cost and burden to the healthcare system. For instance, as these rheumatologic patients flare and their disease progresses out of control they will seek and over utilize the ER. The use of emergency services for the treatment of chronic diseases is not cost effective, efficient or medically appropriate. In a larger societal sense, severe arthritis is one of the leading causes of disability and this will only worsen with the dual demonstration project.

Additionally in the Medi-Cal conversion, the exemption form included chronic disease such as AIDs , renal failure and cancer as reasons to opt out of managed care. There was no exemption for our rheumatologic patients, even though their management is as involved, complicated and detailed as the patients above. Rheumatoid Arthritis, Lupus and vasculitis patients are relegated to an orphan status and do not receive the same attention as other severe diseases do.

I fear a similar situation will occur with the Medi-Medi project. It may even be graver as the patients are numerous, ill and already established with their own rheumatologist.

The movement to managed care is understandably a cost saving measure by the state targeting the sickest of the sick. Rationing of medical care should not involve the population that needs access to medical care the most. As the dual eligible project is finalized, HMO denials and the poor access to specialty care need to be addressed.

Thank you for this opportunity to voice our concerns.

Regards,

Gerald Y. Ho M.D.
Arthritis and Osteoporosis Medical Center

May 4, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, California 95899

SUBJECT: Invitation to Provide Public Comment – Coordinated Care Initiative: California's Dual Eligibles Demonstration

On behalf of the California Mental Health Directors Association (CMHDA), which represents the directors of public mental health authorities in counties throughout California, I am writing to communicate our perspective on the *Coordinated Care Initiative: California's Dual Eligibles Demonstration* that would impact California's community mental health system.

CMHDA strongly supports the proposal's emphasis on person-centered planning. Person-centered planning is consistent with the mental health recovery and resiliency principles outlined in California's Medi-Cal rehabilitation mental heath services state plan amendment. Effective partnership and collaboration with county mental health will make available to demonstration enrollees a wide variety of comprehensive, high quality, rehabilitative and targeted case management services. Increasing access to effective outpatient and crisis stabilization services provides an important opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental illness in the least restrictive manner possible.

California's local recovery and rehabilitation-focused mental health system plays an integral and essential role in California's public healthcare delivery system. While the proposal speaks to integration between various system partners, it should be recognized that California's current county mental health system in many ways already functions as an integrated system for persons with serious mental illness, with county Medi-Cal specialty mental health plans managing outpatient, inpatient and long-term care needs. It is imperative that the state and managed care organizations recognize the complexity of California's current mental health delivery system, and do not underestimate the valuable role that counties play in managing risk and financing critical services for Medi-Cal beneficiaries – particularly the counties' role in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries.

According to the draft proposal, specialty mental health services, which again are county-administered, will not initially be included in the capitation rate for demonstration health plans. However, according to the draft proposal, "health plans and county mental health agencies will develop coordination and integration strategies, which could include full financial integration in later years." CMHDA believes this statement underestimates the scope and complexity of

expanded mental health coverage available to Medi-Cal beneficiaries through our local risk management and financing system. Of particular note is the counties' role today in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries. Additionally, coverage through the county mental health system includes comprehensive rehabilitation and targeted case management services that have proven extremely effective in reducing costly emergency and inpatient services. Counties currently play an important role in coordinating this coverage with Medicare for both inpatient and outpatient services. Furthermore, county mental health authorities utilize local revenues to match federal dollars.

In order to assist in the collective understanding of the complexity of California's public mental health system, CMHDA has outlined below a brief history and overview of California's local recovery and rehabilitation-focused mental health system. Following the background, we have provided comments on a number of specific sections within the proposal for consideration. Finally, CMHDA appreciates the opportunity to continue to work with the Department of Health Care Services (DHCS) to further develop a more robust framework for shared accountability and savings between MCOs and county mental health authorities. We have attempted to provide an initial framework for such a strategy in our comments below.

COUNTY MENTAL HEALTH BACKGROUND

The Medicaid Title 42, Section 1915(b) "freedom of choice" waiver covering the mandatory enrollment of eligible Medi-Cal beneficiaries in the Mental Health Plans (MHP) for specialty mental health, emergency and hospital services was renewed by the Centers for Medicare and Medicaid Services (CMS) for this year. Under the provisions of this waiver the county mental health plans are considered prepaid inpatient health plans (PIHP) because they are responsible for assuring 24 hour, seven day/week access to emergency, hospital and post stabilization care for the covered psychiatric conditions for Medi-Cal beneficiaries.

In addition, California has two approved state plan amendments (SPA) that increase the scope of outpatient, crisis and residential and inpatient mental health coverage provided to Medi-Cal beneficiaries when medically necessary, by the mental health plans (MHP).

- The first, which was updated and approved by CMS in December 2010, covers targeted case management for persons with mental illness.
- The second, which was updated and approved by CMS in October 2010, covers mental health services available under the Rehabilitation Option, broadening the range of personnel and locations that were available to provide services to eligible beneficiaries.

In June of 2006, the California Code of Regulations (CCR) (Title 9) regulations governing the payment for and delivery of specialty mental health, emergency and psychiatric hospital services to eligible beneficiaries in California became permanent. In addition to the required contract between the department and the MHP, these regulations form the basis for the access, beneficiary protection and payment provisions governing operation of the MHPs. Through the process of successive 1915(b) renewal applications it was ultimately determined by CMS that the MHPs are subject to Code of Federal Regulation (CFR) Title 42, Part 438 Managed Care requirements. Among other things, these federal requirements specify additional access, beneficiary protection and quality management requirements that the MHP must conform to, many of which are specified in the contract.

Both federal and state code and regulation specify that there is to be a contract between the state and the MHP/PIHP specifying the conditions under which the managed care program will operate. State regulation specifies the process for developing changes to the contract, and the current waiver indicates that the contracts shall be in effect for three year periods subject to amendments, as necessary. The regulations and contract also specify requirements for the coordination of health and mental health treatment between the county and the state contracted health plans. One component of this coordination of care is the requirement that a memorandum of understanding (MOU) be in place between the county and each health plan specifying the process for timely referral and treatment of the beneficiary's health and mental health conditions.

COMMENTS ON DRAFT PROPOSAL

Provider Networks (Page 11)
According to the draft proposal, demonstration health plans will provide 24 hour, seven day/week access to non-emergency health lines staffed by medical professionals. Additionally, some plans, described as "innovative" in the proposal, plan to conduct a network analysis for adequacy of non-medical providers, such as those who provide long term services and supports (LTSS) and mental health services. It should be noted that the county mental health system already provides 24-7 emergency and non-emergency support to clients. California should explore ways to leverage this important existing infrastructure to better meet the spectrum of needs of demonstration enrollees around the clock.

Benefit Design and Supplemental Benefits (Page 12)
See Comments below regarding Behavioral Health Care Coordination

Person-Centered Care Planning (Page 14)
CMHDA strongly supports the emphasis on person-centered planning, as described in the draft proposal. Person-centered planning is consistent with the mental health recovery and resiliency principles outlined in California's Medi-Cal rehabilitation mental heath services state plan amendment.

Behavioral Health Care Coordination (Page 15)
According to the draft proposal, "health plans and county mental health agencies will develop coordination and integration strategies, which could include full financial integration in later years." As discussed earlier in our comments, CMHDA believes this statement underestimates the scope and complexity of expanded mental health coverage available to Medi-Cal beneficiaries through our local risk management and financing system. Of particular note is the counties' role today in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries. Additionally, coverage through the county mental health system includes comprehensive rehabilitation and targeted case management services that have proven extremely effective in reducing costly emergency and inpatient services. Counties currently play an important role in coordinating this coverage with Medicare for both inpatient and outpatient services. Furthermore, county mental health authorities utilize local revenues to match federal dollars.

CMHDA appreciates the opportunity to work with the Department over the next few weeks to identify specific strategies for shared accountability and savings between MCOs and county mental health authorities.

Health Plan Payments and Financial Incentives (Page 27)
According to the draft proposal, health plans have performance-based reimbursement or risk-sharing for their network providers, and plan to implement additional efforts. One such effort, as provided by a health plan, is to develop incentives to reward home- and community-based services agencies for helping members stay healthy and safe in their own homes, avoiding preventable hospital and nursing home admissions. CMHDA notes that the state and health plans may consider additional leveraging opportunities with county mental health to take advantage of the expanded coverage available through the specialty plans to assist in achieving this goal of keeping members healthy and safe in their own homes.

Potential Improvement Targets for Performance Measures (Page 29)
The proposal identifies several potential improvement targets, including reduced hospital utilization, emergency room utilization, skilled nursing facility utilization, and long-term nursing facility placements. CMHDA notes that the state and health plans may consider additional leveraging opportunities with county mental health to take advantage of the expanded coverage available through the specialty plans to assist in achieving this identified improvement target.

Expected Impact of Demonstration on Medicare and Medicaid Costs (Page 30)
According to the proposal, the state assumes that the combined Medicare and Medi-Cal federal and state savings from this demonstration will be shared equally between the state and federal governments. This assumption appears to overlook the important county partners, such as county mental health, who are poised to play an essential role in achieving savings in both public programs.

State Infrastructure/Capacity (Page 31)
While the proposal provides a detailed summary of the various state departments integral to the demonstration, the role of county government is absent from this section. CMHDA asks that this section be amended to include a stronger acknowledgement of the essential role that county mental health will play in the implementation and ongoing success of this demonstration. California's local recovery and rehabilitation-focused mental health risk management and financing system is an integral part of our state's healthcare delivery system. The valuable role that counties play in managing risk and financing critical services to Medi-Cal beneficiaries should be clearly recognized in the demonstration proposal as an essential component of the state infrastructure.

SHARED ACCOUNTABILITY AND SAVINGS FRAMEWORK

CMHDA appreciates the opportunity to work with DCHS staff and consulting partners over the next few weeks to further develop and refine a strategic framework for coordination and alignment, including shared accountability and savings, between managed care organizations (MCOs) and county mental health authorities in the demonstration. CMHDA is particularly interested in replicating the model provided by Pennsylvania as part of its Serious Mental Illness Innovation Pilot Project, in which the state created a shared savings pool from which dollars are allocated based on performance on measures that the physical health MCO and county behavioral health organization can jointly influence. CMHDA particularly supports the tiered approach to the Pennsylvania model that allows for a phased-in implementation. CMHDA believes that a phased approach to achieving a greater level of shared accountability and savings between MCOs and county mental health makes the most sense for California in this demonstration. For example, in the first year, measures could strictly be process-oriented, as outlined in Pennsylvania's project, representing tangible, measurable activities that indicate collaboration and form the foundation necessary for integrating care. Such measures could

include such activities as the establishment of care plans and hospitalization notification. The measures would then evolve to outcome measures in subsequent years. Such outcomes might include reduced emergency and inpatient utilization. In addition to the examples provided by Pennsylvania's project, the DHCS and CMS might look to the federal Medicare and Medicaid Electronic Health Records Incentive Programs which provide a good model for a tiered approach to joint accountability in achievement of specified measures.

Priority Areas for Shared Accountability and Savings

1) Inpatient and Emergency Utilization

2) Pharmacy

Key Issues for Consideration

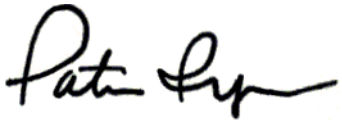
1) In order for many of the process targets to be met in the first year, a thorough analysis of current data and information technology systems should be done to ensure that the technology will support the desired information sharing between systems.

2) Similarly, regulatory and other legal barriers (or perceived barriers) to sharing essential information between systems should be identified and addressed as soon as possible.

3) If the state is to pursue a shared accountability and savings arrangement similar to the Pennsylvania model, further analysis should be done to identify opportunities for incentive payments in the first year before shared savings would be achieved as a result of the process changes implemented.

Thank you for your continued commitment to and leadership in California's community mental health system. We welcome the opportunity to discuss our comments and work collaboratively with the Department to further strengthen the proposal. If you have any additional questions, please do not hesitate to contact me directly at pryan@cmhda.org or Molly Brassil at mbrassil@cmhda.org.

Sincerely,



Patricia Ryan
Executive Director
California Mental Health Directors Association

Cc: Michael Wilkening, California Health & Human Services Agency
Kiyomi Burchill, California Health & Human Services Agency
Rollin Ives, Department of Health Care Services
Vanessa Baird, Department of Health Care Services
Cliff Allenby, Department of Mental Health

Kathy Gaither, Department of Mental Health
Diane Van Maren, Office of Senate Pro Tempore Steinberg
Agnes Lee, Office of the Assembly Speaker
Scott Bain, Senate Health Committee
Katie Trueworthy Senate Health Committee
Cassie Royce, Assembly Health Committee
Marjorie Swartz, Assembly Health Committee
Michelle Baass, Senate Budget Committee
Andrea Margolis, Assembly Budget Committee
Kelly Brooks, California State Association of Counties
Neal Adams, California Coalition for Whole Health
David Pating, California Coalition for Whole Health
Tom Renfree, County Alcohol and Drug Program Administrators Association
Sherri Gauger, Mental Health Services Oversight and Accountability Commission
Jane Adcock, California Mental Health Planning Council

Having Our Say!
Communities of Color's Stake in Health Care Reform

May 4, 2012

Department of Health Care Services
P.O. Box 15559
Sacramento, CA 95852-0559

Re: California's Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals

To whom it may concern:

On behalf of the Having Our Say coalition (HOS) and the Korean Resource Center (KRC), we greatly appreciate the opportunity to share our comments with you regarding the Department of Health Care Services' (DHCS) Coordinated Care Initiative: California's Dual Eligibles Demonstration project.

The Having Our Say coalition, a statewide coalition of over 40 organizations works to ensure that health care reform solutions address the needs of communities of color. The Korean Resource Center (KRC, 민족학교) was founded in 1983 to empower Korean American community, low-income immigrant and people of color communities through a holistic model that combines education, social services, and culture with effective community advocacy and organizing.

General Comments:

California has approximately 1.1 million low-income seniors and persons with disabilities who are dually eligible for Medicare and Medi-Cal. These dually eligible beneficiaries (dual eligibiles) are among the state's highest-need and highest-cost users of health care services. The Department of Health Care Services' Dual Eligible proposal would shift this population from fee-for-service to Medi-Cal Managed Care as early as January 2013. We are greatly concerned that the pace of this transition is too fast for the state to learn from past experiences and to put into place appropriate consumer protections to ensure that there is no interruption of care for California's vulnerable communities. Before this transition occurs, California must take the appropriate steps to ensure continued access to quality care for California's diverse communities including Limited-English-Proficient (LEP) enrollees.

California's population is one of the most diverse in the country, with almost 60% comprised of communities of color and over 100 different languages spoken. More than 40% of Californians speak a language other than English at home, and an estimated 6 to 7 million Californians (or one in five) are limited in their English meaning they speak

English less than "very well."[1] In California's Medi-Cal program, more than 25 languages are recorded as beneficiaries' preferred language with the top five languages being English, Spanish, Vietnamese, Cantonese, Armenian and Russian.[2]

Last year's mandatory enrollment of Medi-Cal only Seniors and Persons with Disabilities (SPDs) into Medi-Cal managed care, resulted in interruptions in primary care and higher costs to the state due to individuals turning to more expensive emergency rooms for their usual source of care. KRC, through its Social Service Program reports that for Limited-English-Proficient (LEP) and those with low health literacy, there was a basic lack of understanding of the concept of managed care and what was required of individuals during the transition. If individuals had not spoken to KRC staff, they would not have known how to fill out the forms and/or how to choose a health plan that offers access to a doctor that speaks their language. During the transition, KRC heard from many clients who needed help after having been automatically assigned to a doctor who did not speak their language. This was so stressful that in at least one case, KRC's client ended up turning to more expensive emergency room care more than twice during a four month period. After coming to KRC, they were then able to switch her to a more appropriate physician but with difficulty and far fewer choices of providers. Switching Medi-Cal to managed care was supposed to save the state money but instead, healthcare for this senior ended up costing many times more and put her through a lot of stress and worry that could only adversely affect her health. With some variation, this story is repeated many times at KRC alone. How many more cases are there like this all over California?

The Having Our Say coalition (HOS) and the Korean Resource Center (KRC) make the following recommendations:

- **Slow down the timeline for implementation** of the Dual Demonstration project until the state can demonstrate that it has learned from prior experience and can ensure the state has the appropriate consumer protections in place to guarantee continued access to care.
- **Provide written, translated forms** in Medi-Cal managed care threshold languages and a notice with taglines in at least 16 different languages of the availability of oral interpretation in any language for the 1.1 million Dual Eligibles who will be impacted by the transition.
- **Encourage partnerships** with the state, counties, and local community-based organizations to help ensure a smooth, successful transition for vulnerable populations including communities of color and LEP groups with low health literacy who may not be familiar with the concept of managed care.
- **Ensure county eligibility workers are properly trained** about the transition so they can answer questions, assist community members in enrolling into health plans that can provide access to culturally and linguistically competent care, and refer clients with grievances related to network adequacy, timely access to care, language access and access to specialists to the appropriate state bodies.

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[1] "American Community Survey, 2007" U.S. Census Bureau. May 7, 2009, www.census.gov/acs/www/

[2] "Providing Language Services for Limited English Proficient (LEP) patients in California: Developing a Services System for the State," a Recommendation by The Medi-Cal Language Access Services (MCLAS) Taskforce, March, 2009

- **Allow individuals to change their primary care doctor** on a month by month basis if the doctor assigned to them does not speak the person's language.
- **Allow individuals to opt-out of the demonstration project after six months** if the state/county is not able to guarantee an individual access to primary or specialty care providers who speak that person's language.
- **Ensure the list of providers is updated frequently across all forms of communication** from paper application forms to websites to ensure individuals have the necessary information to choose an appropriate provider that is capable of providing culturally and linguistically competent care.
- **Create a robust stakeholder process *during* the transition from fee-for-service to Medi-Cal managed care** to capture feedback and trouble shoot problems as they occur. The state should be required to collect and report publicly data on the race, ethnicity and primary language of enrollees as well as those who opt-out and those with grievances so as to better evaluate and target outreach and education efforts. Additionally the state should collect data on the number of providers who choose to provide care under the demonstration project versus those who drop out of Medi-Cal/Medicare after the demonstration project goes into effect.
- **Ensure health plans selected by the state meet Medi-Cal and Medicare quality ratings.** We are concerned by a May 2nd report released by the National Seniors Citizen Law Center (NSCLC) which suggests that the health plans approved for care of Dual Eligibles are poor performing health plans according to CMS. We urge the state to select health plans with a proven track record of providing quality care.
- **Make sure the rate structure is high enough to encourage health plans to offer vision and dental services.** This is extremely important for low-income populations who often lack access to critical dental and vision coverage.

We appreciate the opportunity to weigh in on this important proposal.

Sincerely,

Caroline B. Sanders
Director Policy Analysis & Having Our Say

Dae Joong Yoon
Executive Director/KRC

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
1	2, 10 & all other places this appears in the draft plan	Paragraph that begins with "In 2013, California intends to implement the demonstration in ten counties."	We oppose implementation in ten counties and believe implementation should be delayed for the three counties (with the exception of San Mateo County) to ensure the State, counties, and health plans are prepared to implement, and protections in place so that beneficiaries experience no break in their health care services. The four counties alone represent nearly 70% of the statewide Duals population. We question the capacity of the health plans, counties, and State to meet the January 2013 date due to the number of outstanding implementation issues currently unresolved, and given that these issues (including rate setting) will not be settled until the late summer and fall.
2	2 & 10	Page 2: "California will use a passive enrollment process through which dual eligible beneficiaries may choose to opt out of the demonstration. Those who do not opt out will be enrolled in the demonstration for an initial six-month stable enrollment period. Enrollment in the demonstration counties will be implemented on a phased-in basis throughout 2013. Page 10: "The Governor's Coordinated Care Initiative, which is pending in the state Legislature, proposes mandatory enrollment in managed care for Medi-Cal benefits."	CMS has indicated that states may request a later date to begin enrollment and at least four other states have decided to delay enrollment for their dual integration demonstration projects until January 1, 2014. We strongly encourage the state to extend the timeline for planning and initiate enrollment in 2014 for three of the four pilot counties (San Mateo being the exception). We are also opposed to passive enrollment and six-month lock-in. As has been seen with the mandatory enrollment of the SPD population, transitions for high need individuals who have well established networks serving their needs can be very disruptive. An opt-in approach would make it less likely that those individuals would be negatively affected and would make it more likely that individuals who join a pilot are those without satisfactory networks who would most benefit from an organized system of care. We also oppose the 6-month lock-in.
3	2 & 17	Page 2: "County social workers will continue determining IHSS hours and the fair hearing process will remain." Page 17: "A grievance and appeals process and other protections for IHSS consumers will remain in place."	These two sections contradict each other. One page 2, the proposal states the current fair hearing process will for IHSS will remain in place, which is not affirmed in the language on page 17. We believe that the current fair hearing process should remain in place whereby consumers can appeal the number of IHSS hours atuhorized following the assessment conducted by a county social worker. We understand the state's proposal to prohibit health plans from providing fewer IHSS hours than the amount authorized by the county, and support the authority of the health plan to authorize additional IHSS hours. But it doesn't make any sense to set up a different appeals process in those instances when a consumer disputes the number of IHSS hours authorized by a county.
4	2	"the demonstration will build on lessons learned during the 1115 waiver transition of Medi-Cal only seniors and persons with disabilities into managed care..."	We do not agree that sufficient lessons have been learned from the transition of SPDs into managed care and think additional time is needed for planning for implementation of the dual demonstration pilots. At the 1115 Stakeholder Advisory Committee meeting on April 23, 2012, DHCS reported that there is currently a backlog of 1500 medical exemption requests. When asked about the timeframe for responding to these requests, DHCS could not give an answer on a response time. In fact, DHCS indicated that when they implemented the mandatory enrollment of SPDs, they never envisioned that there would be such a large number (12,800 to date) of medical exemption requests. This is just one of many examples of problems with implementation related to the SPDs mandatory enrollment.
5	3	"...will require proof of ongoing stakeholder involvement at the local level that includes, at a minimum: a process for gathering ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections."	Our concern about "proof" of a local stakeholder process is based on the overly ambitious timeline proposed by the state. The local stakeholder process must build in sufficient time for comunity input in compliance with the Brown (Open Meeting) Act. Contracts or MOUs must be established between the health plans with the county social services department, mental health department, and IHSS Public Authority. Public hearings should be scheduled before the county Board of Supervisors to solicit input on those contracts to ensure adequate protections are in place for beneficairies, providers and the county itself. Final action on contracts should follow at a subsequent public hearing after consideration of input from stakeholders. It often takes 4-8 weeks for counties to post documents and agendas to comply with Brown Act requirements.
6	4	"Phased-in enrollment process starting January 1, 2013 in up to ten counties."	We respectfully urge the state to request CMS to approve enrollment to commence January 1, 2014 for three of the four pilot counties (San Mateo being the exception to proceed sooner).

7	5 & 9	Page 5: "The selected plans demonstrate a proven track record of business integrity and high quality service delivery." Page 17: "A grievance and appeals process and other protections for IHSS consumers will remain in place." Page 9: "California's demonstration accomplishes this by pairing experienced managed care plans with..."	A study recently released by the National Senior Citizens Law Center (May 2012) titled: "Assessing the Quality of California Dual Eligible Demonstration health Plans" demonstrates significant weaknesses among the selected demonstration plans and puts into serious doubt the health plans' ability to meet the complex needs of the dual eligible population. Every plan with the exception of San Mateo COHS received a plan rating of one out of five stars, based on DHCS's own assessment data.	
8	6	"In addition, the demonstration includes strong beneficiary protections that are proposed to be codified in state law."	The proposed trailer bill language released on March 26, 2012 does not contain sufficient beneficiary protections. For example, the state's language indicates there will be "a fair hearing process", but doesn't specify what that process will be.	
9	7	Population Descriptions & carve-outs	It is unclear what it means for any IHSS consumer to be carved out of the demonstration project because the proposal requires all IHSS consumers (not just the duals) to enroll in managed care. If an IHSS consumer opts out, are they losing their entitlement to receive home care services? Or will there be separate (non-managed care) services available? Also, the draft proposal is different from the draft trailer bill on the carve-out for children. The proposal says all beneficiaries under age 18 are carved out; the draft trailer bill only carves out foster children. Which is correct?	
10	10 & 32	Six-Month Stable Enrollment Period. "Enrollment in the demonstration is optional." ... "The State will use a unified, passive enrollment process through which dual eligible beneficiaries who do not make an affirmative choice to opt out will be automatically enrolled into a demonstration health plan." ..."once enrolled...beneficiaries will have another opportunity to opt-out after a six-month stable enrollment period.."	It is unclear how enrollment is made "optional" when the State is also proposing to move all LTSS services into managed care. An IHSS consumer, for example, would have no choice but to enroll into a demonstration in order to access his/her IHSS benefits under Medi-Cal. We have raised concerns previously with this proposal for passive enrollment with a six-month lock-in. A demonstration should ensure maximum choice to consumers from the start and throughout the life of the demonstration p project. Given the size and scale of the proposed project, we continue to have concerns with health plans' capacity, and the State's capacity, to manage these changes seamlessly for the consumer.	
11	11	"Each health plan will be subject to a joint state-federal readiness review before any beneficiaries are enrolled."	Health plans are required to establish contracts with counties and Public Authorities. It is common for a readiness test to include verification that contracts are in place to ensure health plans can meet the terms and conditions of their contract with the state and/or federal government. The proposal indicates that readiness reviews will be conducted in June-July 2012. Compliance with the Brown Act will make it extremely difficult for counties and Public Authorities to finalize contracts with the health plans in that time frame (with the possible exception of San Mateo).	
12	13	"Care Coordination standards...will be developed in collaboration with public stakeholders."	While we appreciate a stakeholder-driven process to identify standards, we are concerned that there is not sufficient time to develop these standards, communicate these standards to the health plans, operationalize the standards through contracts between health plans and providers (including County IHSS), and training of staff. This re-enforces our belief that the pilots will not be ready to proceed on January 1, 2013.	
13	13	Comprehensive Assessment	Given that the health plans will be relying on County IHSS, County behavioral health, and possibly other entities to identify the total needs of the beneficiaries served, we suggest this section should reflect that process. Specifically, the "Demonstration plans will be responsible for an in-depth risk assessment process, through a coordinated response with other duals-serving agencies, capable of..."	
14	13	"Care management will require close collaboration with a number of agencies, such as county social service agencies for IHSS, county mental health agencies, local Area Agencies on Aging and community-based organizations, to adequately address the complex and various needs of individual beneficiaries."	Public Authorities should be included in the list of agencies that may be involved with care management to assist consumers with finding a replacement IHSS worker or emergency back-up services.	
15	14	"Person-centered medical homes and interdisciplinary care teams (ICT). Demonstration plans will offer person-centered medical homes with multidisciplinary care teams. These teams may include the designated primary physician, nurse case manager, social worker, patient navigator, county IHSS social worker (for IHSS consumers), pharmacist, and other professional staff within the provider network."	There will also be times when it is appropriate for Public Authority staff to participate in the Care Coordination team when consumers need immediate assistance to find a replacement IHSS worker.	

16	14, 26	"Building on lessons from the transition of seniors…. necessary process and procedures…to support timely health risk assessments…promising practices, such as…phone, mail, interactive voice by pone, web-based planning.." (pg 14) and "Health Risk Assessment" section (pg 26)	The draft plan implies a one-sided approach, working in a siloed fashion, to collect minimum information necessary to serve the beneficiary, which will result in poor outcomes for beneficiaries. We support true care coordination, which will be appropriate for high risk, high need populations, for a subset of all dual beneficiaries. The examples listed in this section are not considered promising nor are they effective ways to work with the beneficiary to identify needs and link to appropriate services. Strategies that are effective include use of case coordinators and team-based meetings that include the beneficiary and service providers (including County IHSS, and IHSS providers if the beneficiary chooses).	
17	15-16	Behavioral Health Section	California's local recovery and rehabilitation-focused mental health system plays an integral and essential role in California's public healthcare delivery system. While the proposal speaks to integration between various system partners, it should be recognized that California's current county mental health system in many ways already functions as an integrated system for persons with serious mental illness, with county Medi-Cal specialty mental health plans managing outpatient, inpatient and long-term care needs. It is imperative that the state and managed care organizations recognize the complexity of California's current mental health delivery system and do not underestimate the valuable role that counties play in managing risk and financing critical services for Medi-Cal beneficiaries – particularly the counties' role in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries. According to the draft proposal, specialty mental health services, which again are county-administered, will not initially be included in the capitation rate for demonstration health plans. However, according to the draft proposal, "health plans and county mental health agencies will develop coordination and integration strategies, which could include full financial integration in later years." CMHDA believes this statement underestimates the scope and complexity of expanded mental health coverage available to Medi-Cal beneficiaries through our local risk management and financing system. Of particular note is the counties' role today in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries. Additionally, coverage through the county mental health system includes comprehensive rehabilitation and targeted case management services that have proven extremely effective in reducing costly emergency and inpatient services. Counties currently play an important role in coordinating this coverage with Medicare for both inpatient and outpatient services. Furthermore, county mental health authorities utilize local revenues to match federal dollars. It is imperative that the state and the health plans recognize the complexity of California's current mental health delivery system and do not underestimate the valuable role that counties play in managing risk and financing critical services to Medi-Cal beneficiaries. CMHDA strongly supports the emphasis on person-centered planning, as described in the draft proposal. Person-centered planning is consistent with the mental health recovery and resiliency principles outlined in California's Medi-Cal rehabilitation mental heath services state plan amendment. Effective partnership and collaboration with county mental health will make available to demonstration enrollees a wide variety of comprehensive, high quality, rehabilitative and targeted case management services. Increasing access to effective outpatient and crisis stabilization services provides an important opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental illness in the least restrictive manner possible. CMHDA welcomes the opportunity to work with the Department staff and consulting partners over the next few weeks to further develop and refine a strategic framework for coordination and alignment, including shared accountability and savings, between managed care organizations (MCOs) and county mental health authorities in the demonstration.	
18	17	"Under this demonstration, managed care plans will assume responsibility for the provision and payment of all LTSS, in addition to their current provision of medical services. LTSS includes IHSS, MSSP, CBAS, nursing facility care and other home- and community-based waiver services.	The proposed trailer bill does not make statutory changes to the requirement that local county welfare departments administer the IHSS program with oversight by DSS. The State has not articulated specifically, however, how managed care plans will "assume responsibility" and how the current statutory framework supports this particular statement. We believe this draft plan needs to distinguish between IHSS services (as per current law) and any additional IHSS services purchased by the health plans for which managed care health plans may assume direct responsibility (to authorize additional hours beyond the County's assessment). There also needs to be a distinction between the financial responsibility for IHSS (which will be shared by the counties and health plans through the proposed MOE in the trailer bill) and the programmatic responsibility (which will continue to rest with counties under State oversight).	
19	17	"Care coordination teams for IHSS consumers will be established as needed, and will include the consumer, health plan, and county social services agency, and may include others."	We support this statement but believe this statement should be augmented to say that care coordination team will be established "as determined by the health plans and based on the unique care needs of the individual. In addition, county social service agencies will participate on teams, based on local agreements that will be negotiated between the counties and health plans."	

20	17	"A grievance and appeals process and other protections for IHSS consumers will remain in place."	The draft plan and proposed trailer bill does not clearly define the specific grievance and appeals process that will be available to the IHSS consumer. Specifically, it's unclear if IHSS consumers will continue to use the State's Fair Hearing process or the managed care arbitration process. Because IHSS is to become a managed care benefit, and the health plan would be able to add hours to the county's IHSS assessment, it's unclear if those additional hours would be treated in the same way (and thus potentially a grievance issue) or differently than the county's authorization. Would the IHSS consumer have a right to grievance if, at the annual recertification, the health plan does not "renew" any previously-authorized hours in excess of the County's assessment?	
21	17	"IHSS assessments will be conducted in conjunction with health plan care coordination teams, as needed."	The proposed trailer bill (and this draft Plan) indicate that County Welfare Departments will continue to have sole responsibility to perform assessments and authorize IHSS services. However, this statement indicates that these assessments will be performed with health care coordination teams. We recommend clarifying that the assessments will be performed by the county and "information shared between the county and the health plan as negotiated per local agreements, in order to maximize home- and community-based services to the IHSS Consumer."	
22	17	"Health plans may authorize additional home-and community-based services, including IHSS hours above the statutory limits, using the funding provided under the capitation payment."	First, this draft plan should say that these additional services will not be paid using County funds, since these funds could be considered as part of the capitated amount per consumer and covered entirely by the health plan. Second, it's unclear if the additional personal care service hours would be in addition to any authorized IHSS tasks/activities, or if the health plan could purchase services outside of the statutorily-mandated tasks? For example, can the health plan purchase reading services to the blind, which is not currently an IHSS-allowable task? What is the tracking mechanism for enhanced IHSS that is approved by the health plan? CMIPS?	
23	17	The demonstration and the Coordinated Care Initiative would allow health plans to enter into performance-based contracts with counties, and contract with counties for additional assessments of IHSS hours.	First, it's unclear if and how the "demonstration" is different from "the Coordinated Care Initiative," aren't' these one in the same? Second, we believe some form of agreement (whether it is an MOU or a contract) between the Health Plan and the county will be necessary (either contract or MOU). Counties currently are not funded adequate to perform additional activities beyond those currently in statute, and specifically, are not able to participate in Care Coordination Teams nor share information with the health plan to facilitate care coordination, without some agreement between the county and the health plan. Thus, the language should be changed to note that health plans will need to enter into agreements with counties for care coordination activities and any other enhanced services beyond what IHSS currently provides.	
24	17	"IHSS program structure under the demonstration. Under the demonstration and the Governor's Coordinated Care Initiative, health plans will develop and expand care coordination practices with counties, nursing facilities, and other home-and community-based services, and share best practices. IHSS program structure under the demonstration. Under the demonstration and the Governor's Coordinated Care Initiative, health plans will develop and expand care coordination practices with counties, nursing facilities, and other home-and community-based services, and share best practices. Care coordination teams for IHSS consumers will be established as needed, and will include the consumer, health plan, and county social services agency, and may include others. County social services agencies will continue to perform their current IHSS functions, including assessment, authorization, and final determinations of IHSS hours in accordance with statutory provisions for IHSS eligibility, on behalf of the Med-Cal managed care health plans."	This section should also outline key services provided by Public Authorities. Suggested language, "Public Authorities will continue to peform their IHSS functions, such as operation of provider registries, urgent back-up attendant services, training of IHSS consumers and providers, provider enrollment (when so delegated by the county), and assistance to consumers with their employer-related responsibilities.	
25	18	In 2015, California may also implement the Managed Fee-for-Service (FFS) model…"	Counties support exploration of this approach, particularly for smaller and more rural counties where managed care may not be practical and there is a lack of access to services.	

26	21	By the third year of the Demonstration, MSSP will cease to exist as a separate, independent program from the plans' care management operation."	We have concerns that the this successful model program will be completely folded into the managed care structure, thereby eliminating what has been a successful, community-based program that is highly cost-effective in transitioning persons out of nursing home settings. These beneficiaries typically also receive IHSS services; however, they cannot remain at home independently with IHSS support alone, and rely on the case management and ancillary supports that come with MSSP. We believe this program should be preserved, and that the MSSP model should be one that all health plans are required to adapt as a standard practice for persons who wish to transition from nursing home placement, and for those in the demonstration who would otherwise quality for the MSSP program.	
27	23	Local stakeholder process	It is important to note that many of the health plans indicated in their applications that the state did not provide sufficient time to collaborate with local agencies, providers and stakeholders.	
28	24	Ongoing Stakeholder Feedback section	These stakeholder workgroups have only recently begun to meet and each has an extraordinary number of issues to address. If the workgroups complete their activities on schedule, the policies will still need to be translated into operational guidelines, conveyed to heath plans, embodied in local contracts, and linked to staff training. Again, this assumes the policy issues are satisfactorily resolved on a timely basis. This further reinforces our belief that a delayed implementation is appropriate.	
29	27	Appeals and Grievance section	For IHSS consumers, we believe it is appropriate to continue to allow IHSS Consumers the use of the State Fair Hearing (ALJ) process for IHSS appeals.	
30	27	Financing and Payment section	There is no reference to the County contribution in the IHSS program, although this is addressed in the proposed trailer bill. It is unrealistic for some counties to establish contracts with health plans or agree to yet-to-be-defined financial commitments until the financing issues are determined.	
31	34	"Note also that the (CCI) provides that if (DOF) determines, annually on September 1, that the initiative has caused utilization changes that result in higher State costs than would have occurred absent the Initiative…then the State will discontinue the provisions of the Initiative."	The State needs to articulate the process to discontinue the Initiative and beneficiary protections to ensure no breakage of services.	
32	34	Capitation Rate Development	How can contracts be finalized or health plans agree to meet the demonstration standards when they will not know capitated rates until September 2012? Also, it seems unrealistic to require enrollment materials to be mailed on October 1, 2012 -- only weeks after the capitated rates are finalized.	
32	35	"Comprehensive Care Coordination in Partnership with County Agencies: In California, community behavioral health services and IHSS are administered by county agencies and are funded in whole or in part by counties."	Suggested change, In California, community behavioral health services and IHSS are administered by county agencies and Public Authorities, and are funded in whole or in part by counties.	
33	35 & 42	Ambitious timelines & proposed workplan/timeline	See comment # 2.	

34	45	Under IHSS -	The proposal is flawed by only referencing the collective bargaining role for Public Authorities. Public authorities provide the following services for IHSS consumers and providers: a) Establish and maintain a registry of available IHSS Independent Providers (IPs) in the County; • Match IHSS Consumers who request assistance from the Public Authority Registry to obtain properly trained providers who have cleared a background check; • Investigate the qualifications and background of registry applicants, including criminal background checks. • Provide lists of screened IPs for IHSS Consumers to interview; • Provide post-match support services; b) Operate Emergency Back-up or On Call programs that employ IPs who are willing to be called on short notice and dispatched to assist consumers who need a replacement worker; c) Provide orientation and training for IPs. • How to complete timesheets • Skill training such as properly lifting an individual in and out of bed or the bath, properly turning a bed ridden individual, safely administering medications, changing bandages, and other important care related tasks. d) Most counties have contracted with the Public Authority to administer Provider Enrollment activities, including screening criminal records, conducting provider orientation and processing mandated provider enrollment forms. e) Act as employee of record of IPs for collective bargaining purposes f) Assist IHSS Consumers in hiring and supervising IPs; g) Administer individual health benefits for IPs	

CALIFORNIA ASSOCIATION OF SOCIAL REHABILITATION AGENCIES

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Asian Pacific Counseling & Treatment Centers

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Bay Area Community Services

Berkeley Places

Bonita House

Buckelew Programs

Caminar

Community Solutions

Conard House

Consumer's Self-Help

Crossroads Diversified Services

Didi Hirsch Community Mental Health Center

El Hogar

Human Resource Consultants

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Mental Health Consumer Concerns, Inc.

Momentum for Mental Health

Portals, Division of Pacific Clinics

Progress Foundation

Project Return Peer Support Network

Rubicon Programs

San Fernando Valley Community Mental Health Center

Santa Cruz Community Counseling Center

Transitional Living & Community Support

Transitions- Mental Health America

Turning Point Community Programs

Turning Point Foundation

Yolo Community Care Continuum

May 4, 2012

Director Toby Douglas
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899-7413

RE: Public Comment on DRAFT Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals

Dear Director Douglas:

Members of the California Association of Social Rehabilitation Agencies (CASRA), a statewide organization of private, not-for-profit, public benefit corporations that provide recovery-oriented services to clients of the California public mental health system, have reviewed the DRAFT Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals. We recognize your continued efforts to collaborate with community providers and consumers and your commitment to a clear and transparent process. We appreciate the opportunity to provide feedback on this document and have identified the following items:

Page 10 (Enrollment Process- passive): We oppose passive enrollment and believe that it is critical for beneficiaries to be able to make enrollment changes as and when needed.

Page 10 (Based on stakeholder feedback, the State will identify any beneficiary categories that may opt out…): The manner in which the State gathers stakeholder feedback will be critical in ensuring an inclusive process and should be structured in a way that promotes collaboration among special interest groups. We strongly encourage stakeholder participation in the planning of how this feedback will be obtained.

Page 11 (Monitoring the adequacy of provider networks): This is a critical task; however, the current draft lacks specificity preventing us to comment at this time. We strongly encourage stakeholder participation in the designing of how the adequacy of provider networks will be assessed and monitored and request an opportunity to provide public comment following a draft plan.

Page 13 (Medi-Cal and Medicare medical necessity standards will not be restricted by health plans, ensuring that individuals have access to any benefits they would have had access to absent the demonstration): This assurance is critical and closely monitoring this going forward will be essential.

Page 13 (Comprehensive health risk assessments and care planning): What assessment tools are administered, by whom and where and how they are linked to care planning are critical questions. We strongly encourage stakeholder participation in the process of answering these questions.

Page 16 (LTSS Care Coordination): Plans should provide active assistance (in addition to providing a list), when requested, to beneficiaries in arranging services with a provider.

Page 19 (County Specialty Mental Health Services and Substance Use Services): Plans should be strongly encouraged to utilize all three of the services under the Specialty Mental Health Services waiver i.e. 1) Psychiatric inpatient hospital services, 2) targeted case management services and 3) rehabilitation services. Despite a significant cost difference, proven outcomes and clear consumer preference there is often a single (and myopic) focus on inpatient psychiatric hospitalization in lieu of alternatives including adult residential treatment services and crisis residential treatment services for those in need of acute psychiatric care. In addition, when contracting with providers, plans should be strongly encouraged to contract with community providers that have an established record of successful outcomes, working with underserved communities across the lifespan, embrace wellness and recovery principles, etc.

Page 25 (Self-direction of care): Either the phrase "when appropriate" in the last sentence of the first paragraph ("Specifically, when appropriate, beneficiaries will:") shall be removed or clearly defined.

Page 26 (Health-Risk Assessment): What assessment tools are administered, by whom and where and how they are linked to care planning are critical questions. We strongly encourage stakeholder participation in the process of answering these questions.

Page 32 (Six-Month Stable Enrollment Period): We oppose the six month stable enrollment period and believe that beneficiaries should have more flexibility. In addition, we believe that Plans should involve consumers in creating outreach plans to underserved and hard to reach populations and the outcomes of these efforts should be closely monitored.

Please contact me if I can provide additional information. Thank you in advance for your consideration of our feedback.

Sincerely,

Joseph Robinson, LCSW CADAC II
Associate Director for Public Policy
California Association of Social Rehabilitation Agencies (CASRA)
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California Council of Community Mental Health Agencies (CCCMHA) comments on Draft Plan for Dual Eligibles Pilot Program for Los Angeles, Orange, San Diego and San Mateo Counties

CCCMHA is the state association of non profit community mental health providers who primarily serve people of all ages with severe and disabling mental illnesses and receive virtually all of their funding through contracts with county mental health departments.

CCCMHA drafted and co-sponsored Proposition 63 to close funding gaps in the significant unmet needs for this population and to establish prevention and early intervention programs to keep mental illnesses from become severe and disabling before someone got help.

The Duals Demonstration Projects are designed in perfect alignment with our vision and the combined federal state local funding streams and our comments seek only to clarify and provide details for this framework.

To understand behavioral health for the duals it is necessary to segment the enrollees into several categories:

1. People with severe and disabling mental illnesses as defined in Welfare and Institutions Code Section 5600.3 who are currently receiving services in accordance with the Mental Health Adult and Older Adult System of Care as set forth in Welfare and Institutions Code Section 5806.

2. People with severe and disabling mental illnesses not receiving system of care services.

3. People who do not have severe and disabling mental illnesses who are currently mental health receiving care appropriate for their condition.

4. People who do not have severe and disabling mental illnesses who are not currently receiving care appropriate for their condition.

1. **People with severe and disabling mental illnesses as defined in Welfare and Institutions Code Section 5600.3 who are currently receiving services in accordance with the Mental Health Adult and Older Adult System of Care as set forth in Welfare and Institutions Code Section 5806.**

For this population the plan should clarify the following:

- Plans must have an agreement with county mental health that assures the county that it will receive federal matching funds for all services provided by the county or its contractors with other funding

- All mental health and alcohol and drug services are to be provided through county contracts and plans will not attempt to serve this population through any other network or funding
- Agreements must include plans paying for and providing physical health staff to be co-located where the case management and majority of mental health services are being delivered for these enrollees as those services include the Medical Home concept of care coordination. Moreover, these providers have significant experience and expertise in managing and coordinating a wide range of physical health mental health and related services that these individuals require.
- Agreements must include periodic reports of outcomes including the Mental Health System of Care Outcomes set forth in Welfare and Institutions Code Section 5814 as well as periodic measurable physical health indicators such as body mass index, blood pressure, glucose A 1 C, and cholesterol level.
- Agreements must allow for the counties to share in savings as a result of improved physical health that results from the coordination of physical and mental health that these plans facilitate.

2. **People with severe and disabling mental illnesses not receiving system of care services.**

As stated in Proposition 63 – the mental health services act, all people with severe and disabling mental illnesses as defined in Welfare and Institutions Code Section 5600.3 should be receiving services in accordance with the system of care as set forth in Welfare and Institutions Code Section 5806. However, due to lack of funding and lack of coordination with physical health care large numbers of such people are currently unserved. This undoubtedly includes thousands of dual eligibles. These individuals will come into contact with the health plans mostly through the emergency room but occasionally through primary care. Whenever or wherever they show up there must be a process established to identify them and to begin the engagement process to enroll them into a county mental health funded adult and older adult system of care program.

3. **People who do not have severe and disabling mental illnesses who are currently receiving outpatient mental health care appropriate for their condition.**

The main issue for this population will be continuity of care. In general these individuals would be receiving care through Medicare fee for service under the premise that Medicare is the payer of first resort so that MediCal would not be paying. For this population it would appear that county mental health should not be responsible for the non federal share of costs and that even though these providers are

not part of any network there must be a way to continue that care and to reimburse those providers as it would be inappropriate to disrupt that care and require those individuals to receive care through a different provider.

(It is possible that some are receiving care through county mental health and MediCal even though that requires a request for Medicare payment which has to be denied before MediCal can pay. For those individuals the plans and agreements with county mental health should require that the plans pay the counties for the federal share of costs.

4. **People who do not have severe and disabling mental illnesses who are not currently receiving care appropriate for their condition.**

These individuals are mostly seniors and are most likely to be frequent visitors to primary care but are not likely to seek behavioral health services even though studies show that a very high percentage (possibly more than half of duals) have diagnosable mental health and/or substance use disorders. For this population the plans are expected to screen them in primary care for these conditions. Once a screen indicates a need for services then there is the question of who the provider should be and how that care should be funded.

Numerous studies indicate that the best model is to have that care co-located with primary care but to utilize the community mental health providers funded or operated by counties to coordinate that care and be the overall healthcare coordinators. Many of these providers have been receiving grants to establish this type of care coordination and many counties have already established these services for similar populations. (See attached article on Santa Cruz County providing these services to people in the Low Income Health Program.)

Accordingly agreements with county mental health should include providing for these services to be included in the contracts. However, all of the funding should be provided with the state and federal funds that the health plan receives and county mental health should not be required to contribute additional funds unless the individual is determined to have a severe and disabling mental illness requiring the Medicaid rehabilitation option services that are not covered by Medicare.

Besides the fact that Medicare is the payer of first resort, numerous studies indicate that this care produces savings in physical health – especially inpatient that more than covers the costs and justifies the health plan covering these costs since they will reap the benefit.

TO: Department of Health Care Services
FROM: California Dialysis Council

Thank you for inviting comments on the April 4, 2012 draft proposal entitled "California's Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals."

The California Dialysis Council (CDC) is a statewide association which has represented the dialysis community in Sacramento since the creation of the association in 1982. The CDC Board of Directors has an excellent understanding of the needs of patients who suffer from End Stage Renal Disease (ESRD)—dialysis patients.

GENERAL COMMENTS:

1. Dialysis patients should be excluded from the dually eligible demonstration project.

· Dialysis patients represent less than 5% of the population of dually eligible beneficiaries. Thus, the impact on the demonstration project will be small. However, the impact on these patients—where there are problems—is huge.

· Many dialysis patients experienced grave problems during the mandatory transition of the "Medi-Cal only" SPD population to MCMC. The exemption process did not work well and many patients had problems getting catheters replaced by vascular surgeons, continuing care at transplant centers where they were obtaining treatment, and obtaining non-emergency transportation services (NEMT) previously approved by a TAR--along with other coordination issues.

· ESRD is the only condition which brings Medicare eligibility for persons below the age of 65. Thus, the children within the dually eligible category are virtually all dialysis patients.

· Dialysis patients are already in a well-managed environment. The providers for dialysis services are reimbursed according to a modified capitated rate and the nephrologist serves as the case manager for patients undergoing outpatient dialysis treatment.

· The nephrologist is the best person to manage the care for dialysis patients, rather than a primary care physician affiliated with a physician group to which the patient has been assigned by the managed care plan

—but which may be miles away from the patient's home.

· Dialysis patients have many co-morbid conditions which require the services of many specialists. The treating nephrologist needs to have the flexibility to send the patients to the providers who can best addresses the needs of the patients in a timely manner. For example, delay in replacing a catheter with a fistula or a graph leaves the patient open for infection which causes the need for hospitalization.

2. Dual demonstration should not be expanded until results of the 4-county pilot are known.

· It is important that the Dual Demo establishes best practices for enrollment, contracting, opt-out, PCP assignment, and Medicare-Medicaid benefit coordination in its first year. We recommend that the Dual Demo only start with the four counties already awarded in the first year to establish benchmarks for clinical outcomes, utilization and cost outcomes, and patient and provider satisfaction outcomes, before expanding county coverage. We are very concerned that in the rush to manage these beneficiaries immediately, it may come at the expense of patient education and satisfaction and may jeopardize longer term beneficiary support for the initiative.

SPECIFIC COMMENTS:

1. Enrollment process Page 10

· Patients should be given the opportunity to opt out entirely—not for only Medicare services

· Passive enrollment process will result in dialysis patients being enrolled without their knowledge—that is what occurred during the SPD transition. The notification letter to the member should be sent at least 90 days in advance of their enrollment date and should show who their designated Primary Care Physician will be under the new Dual Demo plan and what their choices are (i.e. do nothing and enroll automatically, opt out by completing included forms or calling a toll free number). A listing of standard benefits for Part A/B, Part D, and Medi-Cal-specific benefit coverage under this new Dual Demo Health Plan compared to current Medicare FFS / Medi-Cal should also be included in the notification letter.

Finally, the winning Dual Demo Health Plan should also simultaneously inform that patient's current Primary Care Physician (if known) and current Medicare Advantage Plan (if applicable) of the 90 day enrollment process for that new member.

· On April 5, 2012, the MedPac Payment Advisory Commission discussed the CA demonstration projects at length and expressed serious concern with the passive enrollment and opt-out provisions contemplated in California's plan. We echo their concerns.

· The Dual Demo should maintain access to care for patients. Assignment of dual beneficiaries to Dual Demo Health Plans should allow for maximum flexibility so that beneficiaries can choose the best coverage for their needs. Additionally, the winning Dual Demo Health Plan should inform the Medicare Advantage and Medicare Advantage SNP's in their territory of the impending eligibility change and give the MA plan an opportunity to reach out to its current Dual Eligible members and explain the pros and cons of the new benefit plans.

· If dialysis patients are included in the project, they must be given an opportunity to opt out during the "six-month stable enrollment period."

· The current proposal does not exclude Medicare Advantage and MA SNP members from being enrolled into the Dual Demo. We recommend that existing Medicare Advantage and MA SNP members be excluded from automatic enrollment because they are already receiving managed care and most likely, a better benefit package. We think it is important that multiple plans get to compete for beneficiary enrollment and beneficiary satisfaction.

· Dialysis patients experienced significant problems during the shift of the SPD population when mid-way through the Medi-Cal only transition, certain counties/county plans simply decided to enroll all the patients into MCMC plan at once—instead of enrolling the patients in the month of their birthday as promised by the Department.

2. Network Adequacy and Care Continuity Pages 26-27

· **Continuity of care**. The continuity of care requirements established in current law did not work for dialysis patients during the SPD transition

to MCMC.

· **Option to Select Specialist as PCP.** Individuals with kidney failure often manage many co-morbid conditions. As such, dual beneficiaries with kidney failure and enrolled in a Dual Demo Health Plan should be given the opportunity to select a new primary care physician, including specialists such as Nephrologists or Cardiologists, if the default assigned physician is not acceptable to the patient.

· **Access to out-of-network Medi-Cal providers.** The treating nephrologist must have the authority to obtain care for dialysis patients even where the nephrologist has an "affiliation" with the health plan and even where the non-contracting provider from whom the patient needs service (e.g. the vascular surgeon) does not have an ongoing relationship with the patient.

· **Clarification of out-of-network provider issues.** Clarification is needed as to whether the 6 month 'stability' period overlaps with the 12 month period during which a dual beneficiary can continue to receive care through an out-of-network provider. Additionally, and to prevent confusion on the part of the beneficiary and out of network rendering providers, the Dual Demo should indicate that default non-contracted providers will be paid at minimum 100% of the Medicare FFS allowable rate for both the 6 month and 12 month periods. Again, the Medicare Allowable rate for dialysis treatment claims should be calculated in accordance with the ESRD prospective payment system ("PPS") methodology.

3. Health Plan Payments and Financial Incentives Page 27

· **Risk Adjustment for Dialysis Patients:** The Dual Demo should consider applying Medicare's risk-adjustment methodology, particularly for high risk beneficiaries such as ESRD. CMS recognizes that ESRD members are consistently more expensive than typical beneficiaries and not only has a separate Medicare Advantage premium for ESRD members, it even has a higher premium for new Dual Eligible ESRD members. Applying a normal, unadjusted capitation rate to ESRD members may result in the curtailment of benefits necessary to support this population.

· **20% Co-pay for Medicare beneficiaries**: In keeping with current Medi-Cal ESRD payment policy, Dual Demo plans should continue payment of Medi-Cal secondary co-insurance claims defined as 100% of

the Medi-Cal allowable amount (20% Medi-Cal copayment of ESRD claims).

· **Existing Medicare contracts:** DHCS should clarify that a Medicare Primary patient prior to enrollment in the Dual Demo is deemed a Medicare Primary patient following enrollment and pre-existing Medicare Advantage contractual agreements should apply.

· **Pre-authorization for dialysis treatment not needed:** DHCS should exempt dialysis beneficiaries from any TAR-like authorization process required by a plan. Dialysis is life sustaining and must occur at least three times per week for the life of the patient. When a patient's kidneys stop functioning, there is need for dialysis and over-utilization is not a concern. If pre-authorizations are required for every dual, it will be a significant administrative burden for providers and could delay payment from Plans.

· **The Dual Demo should encourage open access to patients**. It should stipulate that non-contracted (by the Dual Demo Health Plan) dialysis providers rendering service to Dual Demo members shall be reimbursed by the Dual Demo Health Plan at 100% of the Medicare Allowable rate at a minimum as calculated in accordance with the ESRD prospective payment system ("PPS") methodology.

Thank you for your consideration of these comments.

Michael Arnold
Legislative Advocate
California Dialysis Council
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Sacramento, CA 95814
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(916) 446-2646

CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

May 3, 2012

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue, MS 0000
Sacramento, CA 95899-7413

Delivered electronically to info@calduals.org

Re: Public Comment – Coordinated Care Initiative: California's Dual Eligibles Demonstration

Dear Mr. Douglas:

Thank you for providing California Hospital Association (CHA) with the opportunity to comment on the draft demonstration proposal prior to submission to the Centers for Medicare and Medicaid Services (CMS). CHA represents over 500 hospitals and health systems in the State of California and strives to ensure that every Californian has equitable access to affordable, safe, high-quality, medically necessary health care.

CHA supports improved care coordination for dual eligibles. Improved care coordination is an important first step and can reduce potentially preventable admissions; resulting in overall health care cost savings. Hospitals recognize that better care coordination may result in lower utilization of health care services, including inpatient and outpatient hospital services. Care coordination must include financial incentives aimed at Medi-Cal managed care plans to ensure patients have access to all appropriate levels of care and services they need.

Patients, hospitals and other providers must not be held financially responsible for non-covered services or inappropriate levels of care resulting from an inadequate network. In addition, dual eligible patients are Medicare enrollees first and foremost; therefore, ***Medicare services should be reimbursed at full Medicare rates to providers***.

When a dual eligible is hospitalized and the care providers determine the patient is ready to be transferred to a post-acute or community-care setting, Medi-Cal managed care plans must maintain an adequate network of service and providers at every level of care to ensure the patient does not remain in the hospital setting for longer than necessary. Moreover, the patient should not bear any financial liability for a prolonged hospital stay as a result of waiting for a transfer to other care. Further, the hospital should not bear the financial risk of caring for a patient during that transitional period caused by an inadequate network.

The plans must bear the burden of the financial risk to create incentives that encourage the most appropriate levels of care delivery across the full continuum of services.

CHA previously provided the Department of Health Care Services (DHCS) with suggested statutory language that we believe captures these protections for patients and ensures full participation by hospitals in dual eligible networks of care.

In the *Financing and Payment* section of the draft proposal to CMS, DHCS fails to mention these financial protections of full Medicare payments for Medicare covered services to hospitals. We think this is an important addition that would improve the proposal to demonstrate to CMS that DHCS is serious about developing the appropriate financial incentives to ensure the patient has access to the appropriate level of care at the appropriate time.

In the *Beneficiary Protections* section of the draft proposal, we believe additional provisions are necessary to protect patients and provide them with a process to resolve care denials and to ensure timely access to medically necessary care. Specifically, health plans should be prohibited from transferring the patient until an appeal decision is rendered, and should be required to continue to be financially responsible for the patients' care pending the results of the appeal. We also believe that providers should not be prohibited from assisting beneficiaries with appeals or pursuing appeals on behalf of beneficiaries.

This protection is particularly important in the context of access to transitional or rehabilitative care post-hospitalization. The ability to access the appropriate level of care in the days and weeks following an acute hospitalization is a critical factor in the beneficiaries' ultimate success in transitioning back to home and community.

Medicare FFS beneficiaries can readily access medically necessary transitional and rehabilitative care, including hospital level care (inpatient acute rehabilitation, or long term care hospital), skilled nursing care, or home health or outpatient care. By contrast, beneficiaries enrolled in Medicare Advantage (MA) have variable access to medically necessary post-acute transitional and rehabilitative services. Access appears to vary most directly in relation to the practices and of the individual plan and/or medical group. An effective "real-time" appeals process is essential to ensure beneficiary access to Medicare services which they require.

> *Example*
> Many MA plans routinely deny authorization for admission to an inpatient rehabilitation facility (IRF). (IRF care is a defined Medicare benefit, most appropriate for patients who require ongoing and coordinated medical management and intensive therapy after hospitalization for a disabling injury or illness.)
>
> For example, an individual who suffers a stroke may be admitted to the acute care hospital for 3 -4 days for medical treatment. At the end of his/her acute stay, he/she very likely is not able to go directly home, but with the right level of continued medical care and therapy will be able to regain enough function to return home in a reasonable period of time (70 %+ IRF patients return to home and community, after average lengths of stay

of 2-3 weeks). The patient will likely be referred for a rehab consult, and the rehabilitation physician will determine if he/she requires IRF admission.

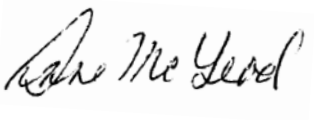
In the case of the FFS, the patient would be transferred as soon as possible, often on the same day as referral. In the case of MA, a prior authorization must be obtained. As many MA plans routinely deny IRF care, even though it is an established Medicare benefit. As a result, the patient will patient will be transferred to a SNF, limiting potential for medical and functional recovery and return to community. The current expedited appeal process is ineffective - the patient will not be able to stay in the acute care hospital for the 72 hour-or-more turnaround period, and will be transferred to a SNF.

We strongly suggest DHCS ensure that beneficiaries have access to an effective "real-time" appeals process to resolve care denials. The appeals process for hospital discharge/transition to post-acute setting, should have a maximum turnaround time of 48 hours. The plan should be prohibited from transferring the patient until an appeal decision is rendered, and should be required to reimburse the facility pending the results of the appeal. Providers should be able to pursue appeals on behalf of beneficiaries.

In the *Care Model Overview* section of the proposal, we did not see a good description of how care decisions will be made. Decisions regarding care, including access to specialized levels of care such as acute inpatient rehabilitation, should be based on the recommendations of the patient's primary care physician and/or designated care team based on the patients' individual needs. ***Plan authorizations for care should be based on objective written criteria, and not on "rules of thumb".*** Plans should be required to provide information regarding the criteria used to render a care decision, and in the event of a denial, the immediate opportunity to discuss/review the care decision with the plan's medical director. Once again, we believe the draft proposal would be strengthened with such provisions.
Once again, please accept our appreciation for the opportunity to comment on the draft proposal. Our suggestions should help strengthen the document and demonstrate the DHCS commitment to ensure protections for this very vulnerable population.

As we continue to work with you and learn more about the initiative, we will keep providing you with our thoughts and comments.

Sincerely,



Anne McLeod
Senior Vice President, Health Policy
California Hospital Association

May 4, 2012

Attn: Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individual
Director's Office
Department of Health Care Services
1502 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Sir or Madam:

I am writing in response to the invitation to provide public comment on Governor Brown's proposed "Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals." The California Academy of Family Physicians (CAFP), representing more than 8,000 family physicians and medical students in California, recognizes that coordinated care and the establishment of integrated delivery and payment for individuals eligible for both Medicare and Medi-Cal could be a significant step toward the improved health and well-being of a particularly vulnerable population. We are long-standing advocates for quality health care and improved access for dual eligible individuals and appreciate the state's efforts to improve care. As advocates for this population, we have specific concerns about the proposed initiative that we address in detail below. We thank you for the opportunity to share our views.

Access to Care and Continuity of Physician-Patient Relationships

The proposal states that "Demonstration health plans will have networks of medical and supportive service providers that are appropriate for and proficient in addressing the needs of their dual eligible members." CAFP appreciates the network adequacy and care continuity standards for health plans described in this proposal, but we believe that beneficiaries will face access issues and disruptions in physician-patient relationships under the Initiative as currently proposed. We believe the state can and should do more to ensure access to care and continuity of relationships.

The proposed initiative moves a population from health care that is largely paid for by Medicare fee-for-service to care paid for by Medi-Cal managed care plans operating under a capitated payment model. There are significant implications for access and physician-patient relationships with this kind of transition. According to the oft-cited research of Drs. Kevin Grumbach and Andrew Bindman, far fewer California physicians

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participate in Medi-Cal than participate in Medicare. Among primary care physicians, the contrast is stark: Eighty-nine percent of California family physicians report participating in Medicare and 65 percent report participating in Medi-Cal. Ninety-two percent of internists report participating in Medicare and 67 percent report participating in Medi-Cal. Only 57 percent of California physicians report that they were willing to accept new Medi-Cal patients. These numbers suggest that the state is moving a population with expansive health care needs into a much more limited pool of care providers. The foreseeable result is a decline in access to care, particularly primary care, and a resulting decline in quality of care and increase in costs.

CAFP urges the state to consider these statistics and their relationship to payment as it works with the Center for Medicare and Medicaid Services (CMS) to develop a capitated rate structure and negotiates with health plans. We urge the state to adopt an honest payment structure and protections for physicians that ensure needed access to care, particularly primary care. CAFP also urges the state to transition these vulnerable populations into this initiative at a slower pace than what is proposed, carefully monitoring network adequacy and care continuity to ensure health plans are meeting the standards described in the proposal. The state should maintain responsibility for monitoring and reporting on access and continuity, rather than forgoing this responsibility to plans.

The proposed initiative offers beneficiaries the opportunity to continue receiving services from out-of-network Medicare providers for six months if certain criteria are met. Beneficiaries will have access to out-of-network Medi-Cal providers for up to 12 months if the provider will accept the health plan's rate or applicable Medi-Cal fee-for-service rate, whichever is higher. CAFP believes the state should lengthen the period of time that beneficiaries can see out-of-network providers with whom they have an existing relationship as the state monitors the effect of the program on access and physician-patient relationships. The state should also permit some categories of beneficiaries (those for whom disruptions in relationships with their physicians would be particularly harmful) to continue receiving services from out-of-network Medicare providers.

Meaningful Choice for Beneficiaries

CAFP believes that beneficiaries should be engaged in the health care decision-making process, beginning with the ability to opt out of new delivery models, demonstrations and pilots that may result in disruptions in care. We are concerned that the "unified, passive enrollment process", during which beneficiaries who do not make an affirmative choice to opt out will automatically be enrolled in the Initiative, followed by the "stable enrollment period" or six-month period during which beneficiaries may not opt out of the Initiative, has the effect of eliminating meaningful choice for beneficiaries.

Given the vulnerability of this particular population and some foreseeable difficulty in educating its members about their ability to opt out, CAFP urges the state to adopt an active, opt-in process for enrollment or eliminate the six-month period during which beneficiaries may not opt out. As is, the Initiative can be viewed as a trap for passive, as opposed to engaged, beneficiaries. We appreciate that, during the six-month stable

enrollment period, beneficiaries are permitted to maintain relationships with out-of-network providers. If the stable enrollment period is maintained, we urge the state to ensure needed access to out-of-network providers. Heavy administrative burdens should not be placed on beneficiaries or providers who wish to maintain their current physician-patient relationship during the stable enrollment period.

Patient Centered Medical Homes

The proposal states that "Demonstration plans will offer person-centered medical homes with multidisciplinary care teams. These teams may include the designated primary physician, nurse case manager, social worker, patient navigator, county IHSS social worker (for IHSS consumers), pharmacist, and other professional staff within the provider network." CAFP is pleased with the inclusion of this important model for the delivery of care; it has proven value in improving care and health outcomes and reducing costs. To have a meaningful effect, however, research suggests the patient centered medical home must meet certain criteria. Foremost among the criteria is that the patient must have an ongoing relationship with a personal physician.

CAFP believes that patient centered medical homes should adhere to the "Joint Principles of the Patient Centered Medical Home" adopted by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association. In essence, these principles state that each beneficiary should have an ongoing relationship with a personal physician leading a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. There is a whole person orientation and care is coordinated and/or integrated across all elements of the complex health care system and the patient's community. Quality and safety are hallmarks of the medical home as is enhanced access to care. Payment appropriately recognizes the added value provided to patients who have a patient centered medical home.

CAFP urges the state to include principles of the Health Home in this initiative. We believe there would be great value to the state and beneficiaries in requiring plans to serve beneficiaries in meaningful medical homes, whenever possible. We also believe that the value of patient centered medical homes should be recognized through payment and that the state should consider this as it negotiates with health plans.

Rapid Program Expansion and Concerns about Health Plans

Rapid program expansion and new delivery models leave beneficiaries and providers vulnerable. CAFP believes that the Initiative should be phased in and its impact on a more limited population monitored before expanding to a larger number or all beneficiaries. CAFP agrees with the conclusion of the Legislative Analyst's Office (LAO) that the state should evaluate the initial four-county demonstration to determine whether the model of care was successful and to identify improvements that could be made before expanding the model statewide. We agree with the LAO that the proposal to implement statewide is premature and urge the state to return to the four-county pilot that was initially proposed. The state has a valuable opportunity to learn from the four counties and other states participating in the national pilot.

The financial solvency of participating health plans is also a concern. CAFP urges the state to establish the solvency of plans before contracting with them and closely monitor their financial condition. A failure to do so will be harmful to beneficiaries.

Beneficiary Education

Beneficiaries should be informed of their rights under California Continuity of Care regulations to ensure smooth care transitions and minimize disruptions to existing medication or treatment regimens. All beneficiaries and, when appropriate, legal guardians should be given adequate information, including the Department of Managed Health Care's toll-free Help Center phone number, to determine if they qualify for Continuity of Care. All dual eligible individuals who are passively enrolled into the proposed initiative should be deemed eligible for "new enrollee" continuity of care status.

Beneficiaries should be informed about enrollment rights and options, plan benefits and rules, and care plan elements with sufficient time to make informed choices. This information should be delivered in a format and language that is accessible to enrollees. CAFP appreciates the state's intention to educate beneficiaries about the program in a culturally and linguistically appropriate way. In the area of beneficiary education, as in others, we urge the state to maintain oversight of health plans.

Oversight, Monitoring and Appeals

CAFP believes that strong oversight of health plans is essential. We agree with the LAO that there are potential benefits of managed care, but that the state must have strong monitoring and enforcement of standards related to provider network adequacy, provision of beneficiary services, financial solvency and more. While we appreciate that the proposed initiative is at an early stage of development, we view the lack of oversight, monitoring and enforcement standards as a weakness in the current proposal. CAFP urges the state to make agency authority clear and to develop systems to respond quickly to problems. Clear authority and operational capacity should exist to address problems identified through oversight.

CAFP believes the proposed initiative should include a comprehensive appeals process for beneficiaries who are denied services and for physicians who are denied payment. We appreciate the state's stated intention to work with CMS and stakeholders to develop a unified state and federal grievance and appeals process for beneficiaries enrolled in the demonstration.

Again, we appreciate the opportunity to comment on this proposal. The Initiative represents an important effort to improve the quality of health care and services provided to a particularly vulnerable population. As family physicians, we will continue to champion the health and well-being of our dual eligible patients and appreciate the state's attention to our concerns.

Sincerely,

Steve Green, MD
President

CH1LDREN NOW

FAMILY VOICES of California

May 4, 2012

Toby Douglas
Director
Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Douglas:

We write as providers and advocates for children and youth to thank you for exempting persons under age 18 from the State's coordinated care initiative for dual eligible Medi-Cal and Medicare beneficiaries. As the State moves forward in finalizing this initiative, we urge consideration be given to exempting all persons under the age of 21 to be consistent with current eligibility guidelines for the California Children's Services (CCS) program.

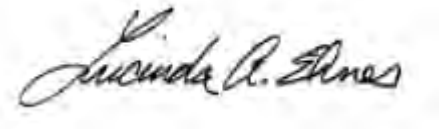
As you know, only a small number of children and youth currently qualify for the Medicare program. The vast majority of these individuals have been diagnosed with end stage renal disease (ESRD). The estimates we are aware of suggest that less than 200 individuals under the age of 21 are enrolled in Medicare and living with ESRD in California. ESRD is also a CCS qualifying condition. As the name suggests, children and youth living with ESRD are at the end of their lives and have typically been seen by the same physicians and providers over the course of many years of treatment. It would be very disruptive to have to change providers at this late point in treatment. Also, this project has been designed for the typical Medicare/Medi-Cal enrollee, not a 19-year-old with ESRD. Since ESRD presents quite differently in youth in comparison to adults, with different causes, courses and treatments, changing providers could be medically dangerous as well as interfere with continuity of care. While the State has proposed that youth above age 18 can "opt out" of managed care, this is an onerous requirement for families that are dealing with a dying and/or medically fragile child. In addition, the "opt out" decision may be complicated by the fact that youth 18 and over are legal adults and responsible for their own medical decision-making. We fear that "opt out" decisions may be delayed or will not occur with these youth, resulting in defaulting into an adult-oriented demonstration project and compromising access to care for these terminally ill youth.

The CCS program currently provides services to children and youth under the age of 21 living with ESRD and ensures that they receive care appropriate to their condition and age. These services are carved-out from managed care under current law. Implementing this initiative on a mandatory basis raises questions about how the project will coordinate with the CCS carveout for this group of youth. **We ask you to provide us with information on how the Department intends to coordinate this project for youth ages 18-21 with the CCS**

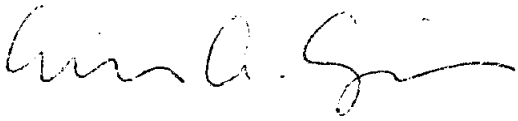
program. Because of our concerns, we urge you to exempt children and youth under age 21 from the dual coordinated care initiative in order to maintain consistency with the CCS program.

We would be happy to discuss this issue further with you and your staff. We support the idea of improving care coordination for medically fragile populations like the dual eligible. We believe that the CCS program currently offers such services for youth and children enrolled in the program.

Sincerely,



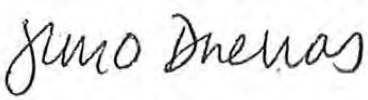
Lucinda A. Ehnes
President & CEO



Erin Aaberg Givans
Executive Director
Children's Specialty Care Coalition

Wendy Lazarus
Founder and Co-President
Children's Partnership

Michael Odeh
Senior Associate, Health Policy
CHILDREN NOW



Juno Duenas
Executive Director
Support for Families of Children with Disabilities

California Medical Association
Physicians dedicated to the health of Californians

May 4, 2012

Mr. Toby Douglas
Director, Department of Health Care Serrvices
1501 Capitol Mall
Sacramento, CA 95814

Re: Comments of the California Medical Association (CMA) regarding the "Coordinated Care Initiative: Dual Eligibles Demonstration"

Director Douglas:

On behalf of the 35,000 physician and medical student members of the California Medical Association (CMA), thank you for the opportunity to comment on the draft of the "Coordinated Care Initiative: Dual Eligibles Demonstration." The proper care and treatment of California's dual eligible population is an issue of utmost concern to physicians across the state.

CMA will be providing comments using the form provided on calduals.org. However, we are also sending this letter to express several overarching concerns that are not specific to the language of the proposal.

Size and Scope of the Proposed Project

First and foremost among these concerns is that the proposed project is simply too large to rightly be described as a "demonstration project" as outlined in Senate Bill (SB) 208. Based on numbers published by the Department of Health Care Services (DHCS), just the four initial counties would account for at least 47% of the state's dual eligible population. The additional six counties included in the expanded proposal would bring the total to more than 70%. It appears that the counties were selected based on having the largest population of dual eligibles, not on the lessons that could be learned from their inclusion.

By moving so aggressively, the state has lost the chance to gain lessons learned from smaller, more focused projects. For example, there were no rural counties included in the project. And the proposed project is heavily tilted toward Southern California. This may limit the state's ability to apply any learning to other settings.

CMA strongly recommends that DHCS consider either choosing other, smaller counties to be included in the demonstration, or only including a portion of the dual eligible population in the larger counties, until data and lessons learned can be evaluated.

Plan Oversight

CMA would also like to raise a serious concern about the ability of DHCS or the Department of Managed Health Care (DMHC), as currently staffed, to perform the heightened level of plan oversight needed for this ambitious proposal.

Based on the Governor's January Budget Proposal, the DHCS Medi-Cal Managed Care Division (MMCD) currently oversees 60% of the enrollment in the Medi-Cal program, but has only 6% of the DHCS budget and 8% of the department's staff. The staffing of DMHC has been the subject of hearings in the state legislature, as the department has not filled positions that are already authorized in law. MMCD and DMHC will have massive new workloads presented to them as a result of these proposals.

A report released this week by the Senior Citizens' Law Center highlighted the importance of this issue[1]. It showed that seven of the eight plans included in the proposed demonstration projects are failing to meet basic quality standards for Medicaid managed care plans. This is despite the fact that all of these plans have long-standing contracts with the Department of Health Care Services.

CMA urges DHCS and DMHC to perform a comprehensive review of staffing needs to implement this project, and adjust resources accordingly. We believe it is likely that, given the ongoing shift toward managed care, DHCS may be able to sift resources from purely fee-for-service functions into the oversight of the managed care program.

LTSS Integration

A third major concern with this proposal as currently constructed in the integration of long-term supports and services (LTSS) into the Medi-Cal managed care plans. Although CMA understands the important role that these care providers play as members of the care team, this proposal places managed care plans at risk for a benefit they cannot control. Since the counties will be determining eligibility for LTSS services, the plans will have no ability to control the size and scope of a benefit for which they will be at financial risk.

CMA would ask that the plans be given two separate capitation payments – one for medical services and one for LTSS. We would further request that there be a "firewall" between the two disparate funding streams to protect the acute care needs of the Medi-Cal population (including Medi-Cal recipients outside of the demonstration, such as pediatric recipients), to cover long-term care costs.

Passive Enrollment

A final, overarching concern is regarding the proposal to passively enroll dual eligibles into the demonstration project. Although Medi-Cal managed care can work well for some patients in some circumstances, CMA strongly believes that it should be the patient's choice whether or not to participate in the project.

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[1] http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/Plan-Ratings-Report-May-2012.pdf.

The ongoing mandatory enrollment of seniors and persons with disabilities (SPDs) into Medi-Cal managed care plans has caused confusion and disruption for both patients and physicians. The considerable number of "auto-assignments" that have take place in that process have disrupted many physician-patient relationships and hurt patient care.

If the plans can successfully integrate Medicare and Medi-Cal services, we believe that both patients and physicians will choose to be involved in the project. However, forcing them to do so is a recipe for disaster.

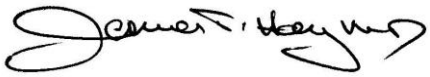
CMA would also request that a copy of any forms and letters sent to beneficiaries regarding the duals transition also be sent to Medi-Cal physicians and to CMA. When patients receive these kinds of materials, they often turn to their physicians for information. Providing this information ahead of time can help us educate patients about their options.

Other Comments

As mentioned above, CMA will be providing other, more specific comments on the provided form. Please see the attached.

Thank you in advance for your consideration of our comments. We look forward to working with you in the weeks and months to come.

Sincerely,



James T. Hay, MD
President, California Medical Association

Barnaby & Barnaby
Attorneys
Lobbyists

May 3, 2012

Director's Office
Department of Health Care Services (DHCS)
1501 Capitol Avenue, MS 0000,
P.O. Box 997413
Sacramento, CA 95899-7413

RE: DUALS DEMONSTRATION PROJECT/PUBLIC COMMENT

Sir/Madam:

The following comments are submitted on behalf of our client, the California Medical Transportation Association (CMTA) which consists of private businesses that are duly enrolled providers of non-emergency medical transportation (NEMT) services in the Medi-Cal program. Some general comments are followed by specific comments which reference the applicable pages in the Coordinated Care Initiative (CCI) draft document.

1. General Comments

NEMT and Dialysis

Most, though not all, users of Medi-Cal NEMT are patients requiring hemodialysis treatment for End Stage Renal Disease (ESRD). A diagnosis of ESRD renders an individual eligible for Medicare disability coverage. Hence many, though not all, of these NEMT users are dual eligibles and most are Seniors with Disabilities (SPDs). Many have co-morbidities and are among the most fragile Medi-Cal beneficiaries.

Conventional outpatient dialysis consists of three treatments a week in a chronic dialysis clinic for four hours per session. Failure to receive the full treatment prevents optimum removal of toxins/impurities from the patient's blood and can result in fluid overload and enlargement of the heart necessitating hospital emergency department care. Timely transportation to dialysis appointments is essential to effective treatment and avoidance of more costly emergency care.

Loss of NEMT due to mandatory transfer

The mandatory transfer of Medi-Cal-only SPDs from fee-for-service (FFS) to Medi-Cal Managed Care (MCMC) has caused many beneficiaries to lose long-standing arrangements with their existing NEMT providers. These are beneficiaries for whom Treatment Authorization Requests (TARs) have been approved by DHCS based on physician certification that functional limitations contraindicated the use of ordinary public or private means of conveyance.

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In carrying out the involuntary transfer of Medi-Cal only SPDs, two provisions of the underlying statutory authority have not been, in our view, properly followed. Enacted as part of SB 208 of 2010, Welfare and Institutions (W&I) Code Section 14180, a demonstration project involving SPDs was authorized with certain requirements detailed in W&I § 14182.

More specifically, W&I § 14182(b)(13) states DHCS shall:

> *(13) Ensure that managed care health plans participating in the demonstration project provide access to out-of-network providers for new individual members enrolled under this section who have an ongoing relationship with a provider if the provider will accept the health plan's rate for the service offered, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.*

Additionally, W&I 14182(b)(15) states DHCS shall:

> *(15) Ensure that the medical exemption criteria applied in counties operating under Chapter 4.1 (commencing with Section 53800)or Chapter 4.5 (commencing with Section 53900) of Subdivision 1 of Division 3 of Title 22 of the California Code of Regulations are applied to seniors and persons with disabilities served under this section.*

The specific regulation for a Two Plan Model (as in Los Angeles County) in this connection is Title 22, CCR, 53887. The pertinent part is 22 CCR 53887(a)(2) which states:

> *An eligible beneficiary who is receiving fee-for-service Medi-Cal treatment or services for a complex medical condition, from a physician, a certified nurse midwife, or a licensed midwife who is participating in the Medi-Cal program* ***but is not a contracting provider*** *of either plan in the eligible beneficiary's county of residence, may request a medical exemption to continue fee-for-service Medi-Cal for purposes of continuity of care. (Emphasis Added)*

Under 22 CCR 53887(a)(2)(A)3 one of the conditions meeting the criteria of a "complex medical condition" is

> *An eligible beneficiary is receiving chronic renal dialysis treatment.*

Further, 22 CCR 53887(c) states in pertinent part:

> *The Health Care Options Program, as authorized by the department, shall approve each request for exemption from plan enrollment that meets the requirements of this section.*

Notwithstanding the narrow limitation imposed upon the medical exemption process that providers not be contracted with a managed care plan, the form used for exemption applications states in pertinent part:

> *"Dear Medi-Cal Physician: If you are currently providing medical services to the Medi-Cal beneficiary identified in Part I and who has one of the conditions or reasons for a medical exemption listed in Box 13 of this page AND you are NOT affiliated with any Medi-Cal Managed Care health plans in the county of residence of the beneficiary, you may be able to continue providing services to the individual."*

"Contracting provider of either plan" does not mean and is much more limited than "affiliated with any Medi-Cal Managed Care health plans." The form's use of "affiliated" changed the meaning of the regulation. A contract is defined as "an agreement between two or more parties creating obligations that are enforceable or otherwise recognizable at law," (See Black's Law Dictionary 9th Ed. 2009). Accordingly, a contract imposes a direct obligation to perform or provide something of value. In this case, it means a physician's obligation to provide certain services to enrollees of a managed care plan. "Affiliated," on the other hand, describes a relationship between parties that may or may not have anything to do with whether a physician has an obligation to provide certain medical services to certain patients.

In any event, numerous medical exemption requests on behalf of dialysis patients were denied. As a result of their forced transfer into MCMC, these beneficiaries lost their long standing access to Title 22-compliant NEMT. In effect, determinations made by treating physicians and approved by Medi-Cal Field Office consultants were, for many beneficiaries, negated. As discussed at several DHCS stakeholder and workgroup sessions, the medical exemption process has had problems to date. While DHCS spokespersons have assured these problems have been recognized and improvements are forthcoming, the impact on affected beneficiaries warrants mention in the context of moving forward with the demonstration project as it affects dual eligible beneficiaries.

Specific Comments

Passive enrollment and opt-out in duals demonstration (Page 10 in CCI draft)

The foregoing discussion of medical exemption problems for Medi-Cal-onlys is intended to highlight the need for an effective "opt-out" process for the much larger numbers of dual eligibles covered in this Coordinated Care proposal.

For affected dual beneficiaries to make informed decisions whether to opt out of managed care or allow their care to be switched away from FFS, a more detailed notice and educational effort must be undertaken. The beneficiaries should understand that being transferred to managed care for a Medicare benefit, dialysis, is likely to strongly impact, if not, terminate the NEMT, a Medi-Cal benefit for which they have been qualified and which has facilitated access to life-sustaining treatment. Without a full understanding of the total effect of enrollment in managed care, truly informed opt-out decisions are not possible.

Network Adequacy and Continuity of Care (Pages 26 – 27)

The draft states health plans will be required to *"(e)nsure that each health plan has non-emergency medical transportation available in sufficient supply and accessibility so that individuals have timely access for scheduled and unscheduled medical care appointments."*

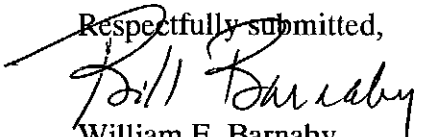
The document goes on to assure that "*(b)eneficiaries will have access to out-of-network Medi-Cal providers, for up to 12 months, for new members enrolled under the demonstration who have an ongoing relationship with a provider if the provider will accept the health plan's rate for the service offered, or applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.*" This restates the statute quoted earlier (W&I § 14182(b)(13).

CMTA welcomes these assurances and looks forward to their implementation. If carried out properly, many of the transportation difficulties of the SPD transfers can be avoided.

Please bear in mind, however, that simply allowing managed care plans to assign beneficiaries to a brokered NEMT service does not fulfill the above quoted requirement. NEMT brokers override or second guess the medical determinations of treating physicians whether their patients' conditions "medically contraindicate" the use of normally available means of conveyance.

Dual eligible beneficiaries have complex medical conditions and, by and large, are very fragile. They have difficulty in accommodating to changes in established relationships with caregivers. They should be allowed to retain established NEMT arrangements that meet their needs and fully comply with Title 22 requirements.

Respectfully submitted,



William E. Barnaby
CMTA Legislative Counsel

cc: Steve Horne, President, CMTA

May 4, 2012

Director's Office
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899-7413

RE: Coordinated Care Initiative: California's Dual Eligibles Demonstration

Dear Director Douglas:

The California Primary Care Association (CPCA) represents more than 850 not-for-profits community clinics and health centers in California that provide comprehensive, quality health care services to primarily low-income, uninsured, and underserved Californians. California's community clinics and health centers served more than 4.8 million low-income Californians in 2011, the vast majority of whom were under 200% of the Federal Poverty Level. Most community clinics and health centers currently serve patients who are dually eligible for Medi-Cal and Medicare. The comprehensive service delivery model used by CCHCs has been shown to provide high-quality and cost- effective care that reduces hospitalizations, emergency department visits, and costly care by specialists.

CPCA and its members support the purpose of the draft Dual Eligibles Demonstration Project as stated in the introduction to the proposal "California intends to combine a full continuum of acute, primary, institutional, and home and community-based services for dually eligible beneficiaries into a single benefit package, delivered through an organized service delivery system." However, CPCA has several concerns about the specifics of implementation.

Contracting Language: Successfully implementing health care reform through this proposed pilot project and other implementation efforts will require a new and robust level of safety net integration. We believe there should be mandatory CCHC contracting language in the requirements of participating health plans, modeled on the successful collaboration already in place with many Local Initiatives and County Organized Health Systems. From CPCA's experience, without specific mandates from the State for health plans to work with CCHCs, their

contributions to the health provider infrastructure will not be sufficiently recognized, thus limiting some of the best options for patient care coordination, continuity of care and delivery of comprehensive primary care.

The draft proposal states that "Health plans will be responsible for providing seamless access to robust networks of providers across this broader continuum of care, as well as upholding strong beneficiary protections established by the state through the stakeholder process." This language will only be meaningful if it is fully encouraged, enforced and monitored. Before the demonstration projects begin, there should be clear direction from DHCS stating exactly how these issues will be monitored, including the potential impact on a broad range of patients with different geographic and language and cultural needs.

Dental and Vision Services: Many of California's CCHCs provide dental and vision services to their patients. Often these services are the only low-cost, easily accessible, culturally competent services available in low-income communities. CCHCs' dental and vision services should be included in managed care contracting on behalf of the dual eligibles in the pilot projects.

Behavioral Health: The State's proposal highlights the importance of integrating behavioral health services into care for dual eligible recipients. As trusted patient-centered health homes for many underserved, ethnically and racially diverse Californians, many CCHCs already play a unique role in providing integrated behavioral health services to those who may never seek out or have access to traditional mental health or substance use services. CCHCs are recognized leaders in the movement to integrate behavioral health into primary care, but also collaborate with the county's specialty mental health system to address the comprehensive treatment and supportive services needs of the safety net's most seriously mentally ill. Therefore, CCHC's behavioral health services should also be expressly integrated into the managed care plan's provider networks, including requiring that both the Medi-Cal managed care plans and managed care behavioral health plans that subcontract with managed health care plans to include CCHCs with experience provided these services as network providers. Otherwise, there may be significant disruption in care for the most vulnerable patients.

Beneficiary assistance: As several health plans reported in their comments on the SPD transition into managed care, ordinary customer service telephone lines and short welcoming calls proved insufficient when dealing with a more complex population. Many dual eligible recipients will need concrete and continued assistance in understanding how they can continue to see their current providers as well as how to seek additional services and how all the services will be coordinated, integrated and accessed. Many patients will ask their current providers questions about how to get the health care they need, and the managed care plans must keep the providers informed and actively involved in responding to patients' questions and needs. The health plans must incorporate accurate and timely information to all community health providers, so that the providers can help patients directly. With continuity of care as a goal, it is necessary for health plans to also contract with community clinics and health centers to provide care coordination and case management services if that is the primary source of care for a beneficiary.

In addition, assistance must be fully funded outside of the health plans themselves in order to make sure patients make informed choices about whether to opt out of passive enrollment and decide what health plan to choose so that beneficiaries can continue to see as many of their current providers as possible.

Currently, it is suggested in the draft proposal that health plans contract with "community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting dual eligible beneficiaries in understanding their health care coverage options." It is further stated that this important program is "Contingent upon available private or public dollars other than moneys from the General Fund." We believe that this funding must be identified in advance by DHCS. Without funding for community-based advocacy organizations and our member CCHCs and others to assist dual eligible recipients in this process, patients may not be able to make well-informed choices assisted by a trusted source or stay connected to their current providers or access new services that may now be available to them, and that are critical in promoting prevention and community based care, rather than institutional care.

Inside the health plans, there should be a dedicated phone line and dedicated staff specially trained and available to serve dual eligible patients, their caregivers, navigators and advocates working on beneficiaries' behalf in this pilot project. The health plan employees who staff these lines should be evaluated on how many problems they solve to their customer's satisfaction, instead of how many calls they deal with in a certain amount of time. Call wait times should be limited and monitored, as part of an on-going quality assurance process organized by DHCS.

Rates: California's CCHCs, with a network of providers throughout the state and its expertise in providing culturally and linguistically competent care, must be critical partners in the dual eligible demonstration projects. However, the continued existence of these important providers and the services they provide is dependent on receiving the PPS rate for their services in a timely fashion. It is critical that the mechanism for billing the managed care plans and DHCS for the "wrap around rate" be understood by all three parties (DHCS, health plans and CCHCs) before the demonstration projects begin. In addition there may need to be a risk adjusted rate to account for the increasing complexity of these patients.

Continuity of care and robust provider networks: Beneficiaries and stakeholders repeatedly have emphasized the importance of continuity of care when considering new delivery models. We have learned from the SPD transition that this requires far more attention at the outset of the process.

The proposal states that during the six-month stable enrollment period for Medicare, a beneficiary may continue receiving services from an out-of-network Medicare provider for primary and specialty care services if, among other things "the provider is willing to accept payment from the demonstration site based on the current Medicare fee schedule." We are concerned about the language requiring "that the provider is willing to accept payment from the demonstration site based on the current Medicare fee schedule" and suggest that instead the

language read that "the provider is willing to accept payment from the demonstration site based on their current Medicare reimbursement methodology." All regulations regarding this demonstration project must include the special payment provisions for federally qualified health centers and look-alikes.

CPCA is also concerned that this six month "stability" period may have adverse impacts on this fragile population. Based on providers' experiences with integration of SPDs into managed care, we believe that it is difficult to ensure that patients choose or are assigned to managed health care plans that include as many of their current providers as possible. The six month "lock out" provision may not be appropriate for a population that has not been previously integrated into managed care, and which has particular challenges in learning to use a managed health care system.

The proposal currently states that "Passive and stable enrollment will encourage beneficiaries to establish a relationship with a plan and providers, so beneficiaries can adequately evaluate this care model." However, it does not make sense to beneficiaries to establish new relationships if they can instead have access to a broader range of services with CCHCs where they have had long standing relationships.

In addition to robust contracting with CCHCs, it is important that a patient who is assigned to a managed health care plan that does not contract with their usual provider is allowed to switch plans in the first six months to avoid the complications of receiving care from an "out of network" provider. While we understand the need for managed health care plans to have a "stable" population, we believe that it would cause unnecessary distress to fragile patients if they do not have sufficient information to enroll in the plan that uses trusted providers or if they are auto-enrolled especially in the early months of this transition.

Long Term Services and Supports (LTSS): Many CCHCs provide a comprehensive range of enabling and support services for their patients including translation and interpretation services in many languages, transportation services to important medical and non-medical services, nutrition services, care coordination and case management services and linkages to important community resources. Managed care plans should be encouraged, to contract for additional LTSS services, where available with CCHCs, in order to promote full integration of care within the patient-centered health home. We want to make sure that those CCHCs that provide these services will be allowed to continue providing them and be paid for them for their patients enrolled in the demonstration project.

CPCA appreciates the opportunity to comment on this important proposal, and look forward to working together to provide the best care for some of the most vulnerable Californians.

Sincerely,

Carmela Castellano-Garcia
President and CEO

CSAC-CWDA-CAPA feedback on the Coordinated Care Initiative Trailer Bill (rev. 5-4-12)

Page 1: Draft language provides, "In addition, many of these beneficiaries ~~are~~ also ~~eligible for~~ receive personal care services through the In Home Supportive Services (IHSS) program, which is locally administered and includes a county share-of-cost. " Why is the state proposing to strike "eligible for"? This implies intent to undermine the entitlement of IHSS.

Page 2 (and all sections where the TBL contains language to authorize implementation in 10 counties & requires or authorizes enrollment on January 1, 2013): We oppose implementation in ten counties and believe implementation should be delayed for the three counties (with the possible exception of San Mateo County) to ensure the State, counties, and health plans are prepared to implement, and protections in place so that beneficiaries experience no break in their health care services. The four counties alone represent nearly 70% of the statewide Duals population. We question the capacity of the health plans, counties, and State to meet the January 2013 date due to the number of outstanding implementation issues currently unresolved, and given that these issues (including rate setting) will not be settled until the late summer and fall.

CMS has indicated that states may request a later date to begin enrollment and at least four other states have decided to delay enrollment for their dual integration demonstration projects until January 1, 2014. We strongly encourage the state to extend the timeline for planning and initiate enrollment in 2014 for three of the four pilot counties (San Mateo being the exception). We are also opposed to passive enrollment and six-month lock-in.

Page 3: This is the legislative intent section and states that "counties will continue their current role in conducting assessments and determining IHSS authorized hours for consumers." This language should be broadened. Counties perform other activities associated with the IHSS program. I'm assuming the Administration still intends for counties to perform these functions (for example, provider enrollment, QA, Appeals, and payroll functions). It could be changed to say, "counties will continue their current role in administration of the IHSS program, including conducting assessments and determining authorized hours for consumers."

This section should also outline key services provided by Public Authorities. Suggested language, "Public Authorities will continue to perform their IHSS functions, such as operation of provider registries, urgent back-up attendant services, training of IHSS consumers and providers, provider enrollment (when so delegated by the county), and assistance to consumers with their employer-related responsibilities.

In the definition section (WIC 14132.275), definitions are needed for the terms "care coordination," "case management", "person-centered", and "consumer-directed."

Page 5: The draft currently provides, "(2) As of January 1, 2013, the department may expand the number of demonstration sites into additional counties as long as the demonstration site meets the terms and conditions of the memorandum of understanding referenced in subdivision (i) of this section and any additional criteria developed by the department." We object to this language because it doesn't contain any limit on the number of counties for implementation of the CCI.

Page 6 (v): "If the demonstration site is using an alternative payment methodology to pay for services, such as a capitated rate, the payment must be actuarially equivalent to the same or similar payments for services in Medicare or Medi-Cal fee-for-service." We are concerned that this language establishes a ceiling, rather than a floor, on provider payments and could result in service reductions.

Page 7 (k): Says, “In the event of a conflict between the memorandum of understanding and this section, the memorandum of understanding shall control.” The code section is WIC 14132.275 to give DHCS authority to establish the demonstration and contact with CMS, and it indirectly impacts IHSS (there’s a cross-reference to Section 4.6 of the TBL which references LTSS/ IHSS). This is overly broad authority to DHCS and allows the administration to ignore statutes passed by the legislature. Of note is that Harbage Consulting shared a timeline with advocates on Friday, which shows the MOU between CMS and DHCS being finalized in July. So, it seems this language may be unnecessary, if the Administration is able to find a legislative vehicle to make statutory changes in August-Sept to accommodate for any changes needed to effectuate the MOU. DHCS should be required to come back to the legislature to affirm any changes. We propose to mirror CWS TBL in their Rulemaking section, as follows: “Any policy change or directive, issued by all county letter, emergency regulations, or MOU, shall expire 12 months after issuance unless these changes are ratified by the legislature.”

Page 7 (m)(1): We oppose passive enrollment. As has been seen with the mandatory enrollment of the SPD population, transitions for high need individuals who have well established networks serving their needs can be very disruptive. An opt-in approach would make it less likely that those individuals would be negatively affected and would make it more likely those individuals who join a pilot are those without satisfactory networks who would most benefit from an organized system of care.

Page 8 (m(2): We are opposed to the six-month lock-in.

Page 8 section (n): Requires DHCS to conduct an evaluation on outcomes and experiences of duals and to report to the legislature annually. The scope and structure of the evaluation are not specified, instead they are to be determined by a group of stakeholders. We recommend that some areas of evaluation be specified, at minimum, in the TBL. For the IHSS program, we suggest that the department report on the pre/post pilot comparison of authorized number of IHSS hours, % of clients who had additional hours given by the health plan, types of additional home and community-based services including IHSS hours authorized by the health plan, and changes in health outcomes for beneficiaries who received care coordination.

Page 9 (b)(E): Strike “manage” and insert “supervise” – which is consistent with current provisions of IHSS statutes.

Page 9, section (b)(6) “Counties will continue to have a role in the assessment of beneficiaries for IHSS.” Change to “Counties shall continue to perform assessments and authorize IHSS services pursuant to Section 12300 et seq.” This is reflected elsewhere (on page 14), but needs to be here also.

Page 9 – add (b)(7) to read: “Public Authorities will continue to perform their IHSS functions, including operation of provider registries, urgent back-up attendant services, training of IHSS consumers and providers, and assistance to consumers with their employer-related responsibilities.

Page 9, section (c)(1) Suggest language here to tighten the county’s participation on care coordination teams. For example, “managed care health plans shall work with counties on care coordination and IHSS assessments for beneficiaries who are identified to receive coordinated care services. Nothing shall preclude the county from also referring IHSS beneficiaries to receive coordinated care for IHSS beneficiaries who request such services to the health plan care.” Similar change needed on page 13 section (e).

Page 9, section (c) – “Health plans may authorize additional home and community based services, including IHSS hours.” Needs to be more specific, for example: “Health plans may authorize additional home and community-based services, including additional IHSS services as

defined in WIC Section 12300, or personal care services to assist the individual to remain in their home safely and to improve the quality of life. A health plan that authorizes additional services, to be provided by a personal care assistant, shall inform the IHSS social worker of its determination, and the county shall be authorized to adjust the services through the Case Management Information System (CMIPS). The additional hours as authorized by the health plan shall be determined as ancillary to the services authorized under Section 12300." We also believe a cross-reference is needed in WIC 12300 to allow for (1) County IHSS to increase the hours authorized above the social worker assessment (assuming that County staff will be running the additional hours through CMIPS) and (2) clarify that the additional hours will be separate and apart from the IHSS assessment and will not be used to set a new baseline of services, for example, at reassessment. Outstanding question: Are CMIPS changes needed to run additional hours through the system? How will CMIPS track for these services? Will the system be ready by January 1, 2013 to accommodate?

Page 10 (c) (1) and (4) grievances: Grievance/Appeals (page 10): It says now that "A grievance and appeals process another protections for IHSS consumers will (change to"shall") remain in place." This is in the code section under managed care health plan responsibilities, implying that the health plans would do the appeals even for IHSS. In another section (page 15) under DSS responsibilities it has DSS providing a grievance process for IHSS and below that it says the consumer has the right to appeal, but it doesn't say to whom. What's the role of the Health Plan? The county? Also, it's possible that the recipient may be appealing the county's assessment, or they may be appealing the health plan's authorization of additional hours beyond IHSS. But the TBL isn't clear how to distinguish between the two. The current statute has this appeals wording, this could be used in the TBL: A recipient shall have all appeal rights otherwise provided for under Chapter 7 (commencing with Section 10950) of Part 2.

The language is vague by stating that "A grievance and appeals process and other protections for IHSS consumers will remain in place." We believe that the current fair hearing process (pursuant to WIC 10950) should remain in place whereby consumers can appeal the number of IHSS hours authorized following the assessment conducted by a county social worker. We understand the state's proposal to prohibit health plans from providing fewer IHSS hours than the amount authorized by the county, and support the authority of the health plan to authorize additional IHSS hours. But it doesn't make any sense to set up a different appeals process in those instances when a consumer disputes the number of IHSS hours authorized by a county.

Page 12 (d)(B): The proposal says all beneficiaries under age 18 are carved out; the draft trailer bill only carves out foster children. Which is correct?

Page 13 (e)(1)(B): Should also include a cross-reference to WIC 12302.2 (the IP mode for consumers that don't elect to use the Public Authority).

Page 14 – Section (G) is the code section that makes IHSS a managed care benefit. In (G) the TBL requires health plans to enter into contracts with counties and says, "Assessments shall be conducted in coordination with care coordination teams." And "Plans may contract with counties for additional assessments and enter into performance based contracts." These are broad statements that need to be clarified. Is the intent for the counties to include health plan reps in the in-home assessments, or just share information? Also, a cross-reference in WIC 12300 might be appropriate to enable counties to share information on the assessments and authorize additional hours.
Page 14 – section (G)(iv) "Refer providers to the pubic authority for purposes of wages and benefits" - is just odd, the PA doesn't provide wages and benefits, but are the employer-of-record for purposes of collective bargaining. This should read, "Refer providers to the public

authority for purposes of wages and benefits within the meaning of Chapter 10 (commencing with Section 3500) of Division 4 of Title 1 of the Government Code."

Page 14 (G)(vii) should be moved into the Public Authority section at (H).

Page 17 WIC 14146.5 (a): is overly broad by granting the DHCS sole authority to completely ignore the statutes enacted by the legislature.

page 21 (E) has "Contingent upon available private or public dollars other than money from the State General Fund, (the department will) contract with a community-based, nonprofit consumer or health insurance assistance organization with expertise in assisting dual eligible beneficiaries in understanding their health coverage options." My concern is that Options counseling in a passive enrollment environment should be a "MUST" – otherwise we get the same confusion as the Part D enrollment process. The State really needs to include this cost in their proposed demo project.

Page 25 – delete (C) which refers to care for children, since the demonstration is only intended for adults aged 18 and older.

No Page #: The Massachusetts model there is BOTH a Primary Care Coordinator (in the health plan) and an LTSS Care Coordinator. The principles adopted by Disability Rights California makes a recommendation for Targeted Case management (TCM) /Personal Services coordination. We think this is a good strategy and suggest the county can play a role. There are several persons can provide this service, including IHSS social workers, public authority workers, Local Area Agencies on Aging staff, etc. This could also support the CMS principle of "conflict free case management" and having a representative outside of the Health Plan Structure (whereby the health plan theoretically controls all services for the beneficiary)

County MOE – We recommend default formula for establishing the county MOE that will protect counties, but also allow counties and health plans to negotiate other agreements that may include sharing in the costs and savings. Possible language: "Counties shall contribute to the demonstration at a level no greater than of the county share of nonfederal spending in 2011-12, unless the county and health plan mutually reach an alternative agreement."

CalOptima
A Public Agency
Better. Together.

May 4, 2012

SENT VIA ELECTRONIC COPY

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RE: California Demonstration to Integrate Care for Dual Eligible Individuals: Draft for Public Comment

Thank you for the opportunity to comment on the Department of Health Care Services' draft proposal for California's Demonstration to Integrate Care for Dual Eligible Individuals (Demonstration). CalOptima is supportive of the State's efforts to improve care for dual eligible individuals through more fully integrated systems of care. As the sole Medi-Cal managed care plan in Orange County, one of the four counties selected as an initial pilot site, CalOptima looks forward to working closely with DHCS to develop the components of the Demonstration to ensure its successful implementation.

CalOptima offers comments and requests clarification regarding the following key areas:

1. Demonstration population
2. Beneficiary enrollment
3. Enrollment process for existing Dual Eligible Special Needs Plan (D-SNP) members
4. Rate development

1) <u>Demonstration population</u>

While not explicitly stated in the draft Demonstration proposal, we understand that the State is considering excluding dual eligible beneficiaries with End Stage Renal Disease (ESRD) from participation in the Demonstration. As we have expressed to DHCS in other comments, we do not support the exclusion of ESRD beneficiaries from the Demonstration. As a County Organized Health System (COHS), these beneficiaries are already CalOptima Medi-Cal members. Excluding them from the pilot would not only disrupt their care but also limit their access to more effective care coordination via Medicare and Medi-Cal integration. A coordinated delivery system should be available to all beneficiaries and we request that DHCS reconsider the exclusion of dual eligible beneficiaries with ESRD.

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2) Beneficiary Enrollment

There are many open policy and operational questions related to the enrollment of dual eligible beneficiaries into the Demonstration. Recognizing the limited time available before the target implementation date, clarity around the enrollment processes and requirements that health plans must meet is critical. CalOptima appreciates DHCS' willingness to work with participating health plans to develop the Demonstration and the transparency with which program development is being conducted. We applaud DHCS for convening a workgroup to address beneficiary notifications, appeals and protections, and offer the following comments for the workgroup's consideration:

Passive enrollment: CalOptima believes that it would be most beneficial to beneficiaries and to participating plans to assign most enrollment functions directly to the health, maintaining a clear and direct relationship between the plan and members while allowing coordination with Community Based Organization.

Opt out: We understand and appreciate the importance of maintaining beneficiary choice, CalOptima supports efforts to ensure that choice is protected through an option to opt out of the Demonstration. As the State designs the particulars of the opt out process, we encourage DHCS to ensure the participating plans are able to provide beneficiaries with information and materials to fully inform them of their options. As a County Organized Health System (COHS), CalOptima already provides Medi-Cal benefits to these potential beneficiaries. Maintaining and leveraging that existing, direct relationship where possible could reduce confusion for beneficiaries and eliminate unnecessary administrative complexity.

Member education and outreach: Ensuring that beneficiaries fully understand the goals of duals integration and the choices available to them will be critical to the success of this Demonstration. CalOptima supports allowing plans to actively provide outreach and education to beneficiaries, such as welcome packets. Given the aggressive timeline of this Demonstration, beneficiaries should be contacted as soon as possible to allow them time to consider their options and made aware of available resources to help them navigate this new environment.

Providers/continuity of care: Ensuring that beneficiaries receive uninterrupted, coordinated, quality health care is cornerstone of the Demonstration. CalOptima encourages DHCS to allow participating plans to request information from beneficiaries about their current providers and any active treatment plans prior to enrollment to guarantee continuity of care should beneficiaries choose to remain in the Demonstration.

3) **Enrollment process for existing D-SNP members**

Since 2005, CalOptima has operated a D-SNP, OneCare. OneCare received an overall score of four stars by the Medicare Quality Rating System in 2012. It is critical that the more than 13,000 members currently enrolled in OneCare continue to receive this high quality level of care with no disruptions and experience a completely seamless transition into the Demonstration.

CalOptima would like to have the opportunity to separately develop outreach and education materials to clearly communicate with this population to ensure our OneCare members that this change would improve and enrich their current benefits and experience. And that we will be able to process the change seamlessly for them, and they would not need to do anything. We need the ability to communicate now, since there are so many brokers and MA and SNP plan providers already informing patients/members, potentially encouraging them to select to opt out of the Demonstration. It would be efficient for our plan to allow all of our OneCare members to transition to our Dual Demonstration plan on January 2, 2013 and not transition each member based on birth month.

4) **Rate development**

CalOptima recognizes that capitation rates for the Demonstration will be determined through an ongoing, collaborative process with DHCS and CMS. We appreciate the commitment of DHCS to ensure transparency during this process and provide opportunities for participating plans to provide input. We look forward to working with the State to fully understand the baseline assumptions that will be used to develop actuarially sound rates.

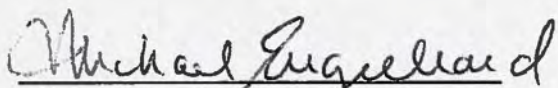
As part of this initial discussion, we request clarification around the following:

- Does DHCS intend to utilize Aid Code and Aid Code Categories to define both rates and benefits?
- Will CMS' existing Hierarchical Condition Categories (HCC) drive rates?
- Has DHCS determined whether capitation rates will be per member per month (PMPM) or Percentage of Premium (POP), the current methodology for D-SNPs?

Additionally, access to Orange County specific, de-identified data will also be critical in the planning and development stages of this project. We appreciate DHCS' efforts to obtain and disseminate this data and recognize that there are many administrative and legal complexities yet to be addressed as this process moves forward.

Again, thank you for the opportunity to provide comment on DHCS' draft proposal for California's Demonstration to Integrate Care for Dual Eligible Individuals. We look forward to continuing our partnership to improve the quality of care for dual eligible beneficiaries. Please do not hesitate to contact me with any questions or if I can be of assistance at MEngelhard@caloptima.org.

Sincerely,



Michael Engelhard
Interim Chief Executive Officer
CalOptima

CalPACE Comments on Draft Demonstration Proposal for Dual Eligibles

Page	Topic and Proposal Language	CalPACE Comment
8	**Demonstration Population -- PACE Enrollees** In demonstration areas where PACE is available, PACE enrollees will not be passively enrolled in the demonstration, and PACE will remain a clear enrollment option for dual eligible beneficiaries that meet the PACE enrollment criteria. Additionally, in counties where PACE is available, several demonstration health plans will coordinate closely with PACE to offer this option to nursing-home eligible dual eligible beneficiaries who wish to remain in the community.	The proposal should go further and provide that PACE is presented as an enrollment choice in the same manner as participating health plans. Enrollees who wish to choose PACE should not be required to go through a confusing process of first opting out of enrolling in a demonstration plan, choosing a managed care plan for their LTSS, and being subsequently disenrolled from the plan if they are found to be PACE eligible. Persons who choose PACE should remain in fee for service Medi-Cal and Medicare and not be assigned to plans, or PACE, until they are assessed for eligibility for PACE.
10	**Stable Enrollment Period** The State is proposing a passive enrollment process with a stable enrollment period to ensure a sufficient volume of enrollees over the demonstration period. Passive and stable enrollment will encourage beneficiaries to establish a relationship with a plan and providers, so beneficiaries can adequately evaluate this care model. Based on stakeholder feedback, the State will identify any beneficiary categories that may opt out during the six-month stable enrollment period.	Consistent with CMS guidance to states, the proposal should not include any enrollment lock-ins. At a minimum, the proposal should provide a special election period for persons who become eligible for PACE that allows them to disenroll from the plan they are enrolled in and enroll in PACE at any time during the stable enrollment periods. This will ensure that beneficiaries with extraordinary needs, whose needs make them eligible for PACE, have access to a proven model of care, and will ensure better outcomes for this subcategory of beneficiaries.
13	**Comprehensive health risk assessments and care planning**	Given its experience with performing level of care assessments, PACE programs should be included in the process for developing the assessment processes and tools used by plans.
14	**Care Transitions**	The assessment process that occurs during care transitions and at regularly scheduled intervals should include identification of PACE eligibility to facilitate transfer to PACE of persons who meet PACE eligibility.

27	**Health Plan Payments and Financial Incentives**	Health plan payment rates must include a rate tier that reflects the true costs of the subpopulation that is served by PACE, in order to facilitate the transfer of beneficiaries who are PACE eligible to PACE programs.
32	**Medicare or Medicaid Waivers** Some health plans participating in the demonstration have expressed interest in contracting with PACE providers, to provide an additional option for members that meet the criteria for enrollment in PACE. The State will work with CMS to determine if any amendments to current authority for PACE are needed for this contracting option.	1. Any authority for contracting or subcontracting should not require PACE programs to contract or subcontract in order to maintain access to potential enrollees. 2. The proposal should additionally request amendments to current authority for PACE, to provide flexibility for PACE programs to utilize alternative care settings for providing services; use community based physicians; vary the make-up of the interdisciplinary team based on the needs of each beneficiary; allow new and existing PACE programs to more readily create community awareness of their programs and to use enrollment brokers; share PACE center space and staff between PACE programs and non-PACE program services; and make Medicare and Medi-Cal reporting requirements more consistent.

California Mental Health Planning Council

CHAIRPERSON
John Black

EXECUTIVE OFFICER
Jane Adcock

May 7, 2012

Sarah Arnquist, MPH
Harbage Consulting
C/O: California Duals

Dear Ms. Arnquist:

Thank you so much for your presentation on the Dual-Eligible demonstration project to our CMHPC Policy and System Development committee on April 21, 2012. You took a very complicated subject and made it easy for us to follow and learn about. We are excited to see what types of programs develop, and how they will eventually replicate throughout the state.

After hearing the presentation, our committee developed some input that they would like to share with you and the program administrators. The first is an example of what constitutes "meaningful stakeholder involvement", for which, based on our experience with the implementation of the Mental Health Services Act, we have adopted the following definition:

"When consumers and families have enough information to understand the strategic direction and/or issues and how that might affect services to consumers and families and can discuss those changes and make recommendations to affect their direction. It also means they have a chance to discuss among themselves the directions and issues in a forum that is not dominated by providers' and funders' comments and/or concerns."

The next two recommendations are in regard to communications and/or training.

1) Collect and post examples of good stakeholder engagement that you receive as part of your Request for Solutions process, so that others can learn from them.
2) Set up processes with County Mental Health Directors and Health Plan Administrators for training their network providers on how to educate consumers and their families in ways that are inclusive of all diverse populations and demonstrate cultural competency.

Both of these practices could go a long way toward enhancing the services and improving outcomes for the special populations addressed in this proposal.

Thank you again for making the time and commitment to keep us informed on this important process.

Cordially,

Cindi Murphy for

Beverly K. Abbott, Chair
Policy and System Development Committee

cc: Vanessa Baird, Acting Deputy Director – DHCS Mental Health and Substance Disorder Branch
Sherri Gauger, Executive Director – MHSOAC

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Center for Health Care Rights
ADVOCACY FOR HEALTH CARE CONSUMERS

May 2, 2012

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Director's Office
Department of Health Care Services
1501 Capitol Avenue, MS 0000
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Sacramento, CA 95899-7413

Filed electronically: info@CalDuals.org

Comments on Draft Proposal for California's Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals

Dear Mr. Douglas:

The Center for Health Care Rights (CHCR) submits these comments to California's draft Proposal for California's Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals.

The Center for Health Care Rights (CHCR) is a non-profit health care advocacy organization dedicated to improving consumer access to quality health care. As an integral part of this mission, CHCR provides Medicare advocacy and health insurance counseling services to Medicare beneficiaries and their families in Los Angeles County. Since 1985, CHCR has served as the Health Insurance Counseling and Advocacy Program contractor for the City and County of Los Angeles. As the HICAP contractor, CHCR is also the SHIP contractor for Los Angeles. CHCR also receives funding from the State Bar of California Legal Services Trust Fund Program to provide Medicare legal services to low income dual eligible Medicare/Medicaid beneficiaries.

The Center for Health Care Rights has significant experience with the dual eligible population in Los Angeles County. More than 25% of all dual eligibles in California reside in Los Angeles County. On a daily basis, our agency sees firsthand the obstacles that dual eligibles encounter navigating the complex system of Medicare and Medicaid coverage. As the current data on dual eligible documents, dual eligibles are more likely to have multiple chronic conditions, suffer from mental illness and/or cognitive impairment, and reside in institutional settings. In addition, dual eligibles are also more likely to have low literacy and to have limited English proficiency.

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These comments present our recommendations for key principles that should be used to develop and select effective Demonstration sites that will be able to provide the effective delivery of care to dual eligibles. These key recommendations include:

1. A truly voluntary enrollment model.

2. No stable enrollment period or lock-period of any duration.

3. Access to the Medicare Advantage appeal rights that provide beneficiaries with critical access to expedited reviews with an Independent Review Entity for hospital, skilled nursing facility (SNF) and home health discharges, and for service denials.

4. Beneficiary notification that clearly articulates how a beneficiary's choice to participate in the Demonstration affects the beneficiary's ability to make Part D enrollment changes during the Part D Annual Election Period (AEP) and other prescribed Part D enrollment periods.

5. A more gradual and measured approach to implementation which limits the initial implementation of the Demonstration to four counties, and delays implementation in large complex counties like Los Angeles until after the first year in order to better assess the feasibility of the Demonstration.

Comment # 1: Proposed Demonstration Population
(Pages 3 and 7-8)

While CHCR believes that dual eligibles should not be excluded from participation in the Demonstration based on any health conditions, we believe that individuals who have HIV/AIDS, End-Stage Renal Disease (ESRD), Amyotrophic Lateral Sclerosis (ALS), and individuals who have been institutionalized (nursing facility , ICF/MR, IMD, and long-term psychiatric hospital residents) for more than 90 days, should be exempt from both passive enrollment and any lock-in period due to the complex nature of their medical conditions. Instead these individuals should be afforded the opportunity to voluntarily enroll into the Demonstration.

In addition, CHCR believes that dual eligibles already enrolled in Medicare Advantage (MA) plans should not be passively enrolled into the Demonstration in order to avoid disrupting their care and contravening beneficiary choice. One of the primary goals of the Demonstration is to provide better coordinated care for dual eligibles and this goal is also achieved when dual eligibles enroll themselves into MA plans and so that enrollment choice should not be disrupted by the Demonstration. Beneficiaries who are disenrolled from their current MA plan through which they have already been assigned a primary care physician and received authorizations for services, and defaulted into the Demonstration

will likely find themselves confused about how to access care. Instead, dual eligibles already enrolled in Medicare Advantage plans should be given the opportunity to enroll into the Demonstration by making an active and voluntary choice.

Comment # 2: Proposed Demonstration Population and Geographic Service Area
(Pages 2-4 and 10)

The Proposal states that California intends to implement the Demonstration in ten counties, an expansion beyond the four counties that is authorized under current law.

The Center for Health Care Rights believes that a Demonstration that includes an estimated 72% of all dual eligibles in California is overly ambitious and does not provide a true opportunity to test and study the impact of a Medicare/Medicaid integration model using a smaller and more manageable population. We ask the State to reconsider a ten county demonstration proposal and limit the demonstration to four counties.

In addition, we ask the State to reassess the inclusion of Los Angeles County as a demonstration site for the following reasons: Los Angeles County with a highly diverse dual eligible population of over 370,000 beneficiaries is too large to include in an initial demonstration model.[1] Secondly, the two Medi-Cal plans, LA Care and Health Net, which would serve this county in a proposed demonstration model, do not have prior experience serving a large number of dual eligibles. Both LA Care and Health Net have very small Medicare dual eligible special needs (D-SNP) plans. According to CMS data, as of April 2012, LA Care's D-SNP plan has an enrollment of 2,860, and Health Net's D-SNP plans have an enrollment of 4,632.[2] In its application to be a Demonstration health plan, LA Care stated it expects to have between 100,000 to 170,000 dual eligible members as a result of the Demonstration, which would be 35 to 59 times greater than the D-SNP plan's current enrollment.[3] Health Net estimates that it will enroll in excess of 188,000 dual eligibles as part of the Demonstration, a figure that is over 40 times greater than the their current D-SNP enrollment.[4] CHCR is concerned that the existing Medi-Cal plans do not have the existing infrastructure and experience to provide the full scope of Medicare and Medicaid services to hundreds of thousands of dual eligibles by January 2013.

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[1] www.dhcs.ca.gov/dataandstats/statistics/Documents/20_AVG_Monthly_Dual_Eligible_LTC_Users_by_County_2010.xls

[2] CMS, Monthly Enrollment by Contract/Plan/State/County - Report Period 2012-04, CPSC_Enrollment_Info2012_04.csv, (April 2012), available at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract-Plan-State-County-Items/Monthly-Enrollment-by-CPSC.html

[3] LA Care, California's Dual Eligible Demonstration Request for Solutions Response (February 2012), available at http://www.dhcs.ca.gov/provgovpart/Documents/Duals/RFS%20Applications/L.A.%20Care.pdf. (p. 5)

[4] Health Net, Application in Response to California's Dual Eligible Demonstration Request for Solutions, (February 2012), available at http://www.dhcs.ca.gov/provgovpart/Documents/Duals/RFS%20Applications/Health%20Net%20LA%20County%20Large%20Format.pdf (p.12)

Comment # 3: Enrollment Process
(Page 10)

California proposes to use a passive enrollment model through which dual eligible beneficiaries who do not make an active choice to opt out will be automatically enrolled into the Demonstration. A voluntary, "opt-in" model is needed to respond to the following situations:

- beneficiaries who, due to language, literacy, illness or disability, did not understand that they would be passively enrolled into a health plan if they did not opt out of the demonstration; and

- beneficiaries who are unable to continue receiving services from an out of network Medicare provider under the circumstances outlined in the Proposal.

CHCR believes it is important to learn from the experience of the enrollment of Seniors and Persons with Disabilities (SPD) population into mandatory Medi-Cal managed care where there was a very high rate of default into plans and a relatively low percentage of SPD beneficiaries actively selecting their health plan. The dual eligible population faces many of the similar barriers the SPD population does in understanding the enrollment process as evidenced by CHCR's experience with dual eligibles and the implementation of Medicare Part D which is similar to a passive enrollment, or "opt-out" model. Many duals who are auto-assigned to a Part D plan do not realize there has been change in their drug coverage and that they have been auto-assigned to a Part D plan, and do not understand how to obtain drug coverage through their auto-assigned drug plan. In addition, many dual eligibles remain in auto-assigned plans that do not cover all their medications even though they are experiencing drug access issues because they do not understand how to change plans, and are only able to do so with outside assistance. CHCR recommends that the State use a truly voluntary opt-in model that ensures that only dual eligibles who truly want to enroll in the Demonstration are enrolled.

The State has previously indicated that they will seek CMS approval to be the entity responsible for enrollments on both the Medicare and Medi-Cal sides into the Demonstration. CHCR asks that the State clarify what entity will have responsibility for the enrollments, whether it is Health Care Options (HCO) or an outside contractor. If the State intends for Health Care Options to be the entity responsible for enrollments, CHCR asks the State to clarify what additional training HCO staff will receive and whether the staffing of HCO will increase to accommodate the increased work volume.

CHCR also asks the State to clarify the manner in which beneficiaries will be able to enroll, opt-out, and disenroll from the Demonstration. Currently, dual eligible beneficiaries are able to enroll or disenroll in Medicare Part D plans through the following methods: 1) by telephone by contacting either 1-800-Medicare or the plan directly; 2) online using the www.medicare.gov website; and 3) by submitting a written enrollment or disenrollment

request. Medi-Cal beneficiaries have the ability to make enrollment changes to their Medi-Cal health plan by submitting a Medi-Cal Choice form to Health Care options, or in some circumstances requesting disenrollment over the telephone by calling HCO. CHCR recommends that dual eligible beneficiaries should retain the ability to make enrollment choices regarding the Demonstration by telephone and writing, instead of being limited to just one method of requesting enrollment or disenrollment.

In addition, CHCR asks the State to address the following questions:

- What will be the timeframe for processing enrollment/disenrollment elections and the effective date of the enrollment change? Under Medicare rules, an enrollment change is effective the first day of the month following the month the enrollment change was requested, regardless of whether the enrollment change was requested on the first day of the month or the 30th of the month. Under Medi-Cal rules, the effective date of enrollment changes can vary as enrollment changes can be effective either the first day of the following month, or the first day of the second month following the month the enrollment or disenrollment request was processed, based on whether the enrollment request was processed before or after the monthly MEDS update.[5] CHCR recommends that the Demonstration follow the Medicare timeframe for the effective date of the enrollment change to provide consistency and predictability for beneficiaries.

- The draft Proposal appears to focus on enrollment of already-existing dual eligibles but is unclear on how enrollment for beneficiaries who become newly dual eligible in 2013 and beyond. How will notification and enrollment of new dual eligibles be handled? What will be the timeframe for notification and enrollment?

- What is the time frame for disenrollment for beneficiaries enrolled in the Demonstration who lose Medi-Cal eligibility or are assessed a Share of Cost (SOC)? Currently, there are different rules for Medicare Advantage plans and Medi-Cal health plans. According to CMS' *Medicare Managed Care Manual (MMCM)*, D-SNP plans must continue to provide care for at least one full calendar month, and up to six months, to a member who is no longer Medicaid eligible as long as the plan can provide the appropriate care and the member can reasonably be expected to regain Medicaid eligibility in the next six months.[6] Under Medi-Cal rules, individuals who lose Medi-Cal eligibility or are assessed a SOC are immediately disenrolled from their Medi-Cal health plan.

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[5] DHCS, Medi-Cal Managed Care Division All-Plan Letter 00013 (December 2000), available at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2000/MMCDAPL00013.pdf

[6] CMS, Medicare Managed Care Manual, Ch. 2, Sect. 50.2.5, "Loss of Special Needs Status."

Comment # 4: Stable Enrollment Period
(Page 10 and 32)

CHCR opposes the stable enrollment/lock-in period proposed by DHCS. Lock-in prevents beneficiaries from exercising the right to choose their providers and the manner in which they receive their health care. The majority of the states pursuing dual eligible coordinated care initiatives, including New York and Texas, the states with the second and third highest dual eligible population in the country behind California, have not proposed any lock-in period.[7] Illinois' Coordinated Care Initiative proposal does not include a lock-in period and states that the ability to disenroll at any time is an important beneficiary protection.[8] Imposing a lock-in period would also treat dual eligibles in the Demonstration differently than other dual eligibles who are entitled to a continuous Medicare Part D Special Enrollment Period (SEP) that provides them with the ability to change their Medicare Part D enrollment on a monthly basis. Dual eligibles enrolled in the Demonstration project should have all the same rights and protections afforded to other dual eligibles.

The Proposal states that the Demonstration's six month stable enrollment period is needed to provide plans with sufficient time to develop care plans and implement care improvements for new members. However, if CHCR's anecdotal experience with the SPD transition can be used as a benchmark, length of time spent in the plan provides no guarantee that new members will receive care management services that will facilitate their use of in plan services. We have assisted many SPD clients who had been in a plan for three or more months who had not received any assistance in arranging for needed specialty services such as incontinence supplies, medical equipment, dialysis, and chemotherapy services.

A passive enrollment process with a stable enrollment period is a flawed method of ensuring sufficient participation in the Demonstration because it takes away beneficiary choice. The best way to ensure sufficient and prolonged participation in the Demonstration project is through the achievement of the Demonstration's stated goals: an attractive benefits package and a robust provider network that provides a high quality of care, and strong care coordination.

If a stable enrollment is imposed, CHCR believes that there must be automatic exemptions (i.e., beneficiaries will be automatically granted the exemption and will not need to apply for one) to the stable enrollment period to protect dual eligible beneficiaries with complex medical conditions such as HIV/AIDS, ESRD, cancer, ALS, patients awaiting organ transplants, and institutionalized individuals.

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[7] National Senior Citizens Law Center, "Proposed Enrollment Method by State," (April 2012), available at http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/Proposed-Enrollment-042712.pdf.
[8] Available at http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx.

Additionally, CHCR opposes the mandatory enrollment of Medi-cal benefits for dual eligibles. As CHCR has already observed after the rollout and implementation of managed care for Medi-Cal only SPDs, a mandatory enrollment of Medi-cal benefits will cause access to care problems. In addition, mandatory Medi-Cal managed care enrollment will likely cause coordination of benefits and billing problems for those who are enrolled in fee-for-service Medicare or non-SNP Medicare Advantage plans.

Comment # 5: Part D Benefit Component of the Benefit Structure
(Page 12)

CHCR asks that the State clarify how the Part D benefit will be administered in the Demonstration and whether it is the State's intention to keep the Part D appeals process separate from the integrated appeals process for the other medical services provided by the Demonstration. CHCR also recommends that dual eligibles enrolled in the Demonstration retain the ability to file Part D complaints with the 1-800-Medicare hotline which are entered into the CMS-monitored Complaint Tracking (CTM) system. The ability of beneficiaries to file complaints with 1-800-Medicare and the CTM system are important consumer protections and important data collection/monitoring tools for CMS.

Comment # 6: Beneficiary Protections – Notification about Enrollment Process
(Page 25)

In this section of the Proposal, the State outlines the key elements of the processes and strategies that will be used to develop beneficiary notification about the enrollment process. CHCR believes that the notification process for the Demonstration must include clear, understandable, and timely notice provided in the beneficiary's primary language. Written materials must be in appropriate-sized fonts. CHCR has the following questions regarding beneficiary notification:

- Who will be responsible for providing notification? Will it be CMS, DHCS, or the Demonstration health plans?

- Which entity will be responsible for reviewing and approving notices and marketing materials?

- Which entity will be responsible for monitoring and oversight of plan marketing activities?

- The Proposal states that the State will ensure that health plans and their provider networks are able to provide communication and services to dual eligibles in a variety of formats. To what extent and in what ways will plans and plan contractors be involved in the notification about the enrollment process? Will the plans be

permitted to send out marketing materials to all beneficiaries in the demonstration geographic area during the 90 days prior to enrollment? How will any authorized plan marketing activities be coordinated with other DHCS contracted enrollment activities?

- The Proposal states that the enrollment notification process will start in September 2012 and will continue through the Medicare Part D Annual Election Period (AEP). During this time period, beneficiaries receive numerous marketing materials from Medicare Part D plans. CHCR is concerned that dual eligibles will confuse the Demonstration enrollment outreach activities with Medicare Part D marketing information that they will be receiving at the same time. It is highly likely that beneficiaries may think that the selection of a different Medicare Part D plan will take care of any need to make an enrollment decision relating to participation in a Demonstration health plan. What steps will the State take to help beneficiaries understand how the Demonstration enrollment process is distinct but related to selecting a Medicare Part D plan? How will CMS and the State coordinate the Demonstration's enrollment system with CMS' Part D enrollment system? How will a dual eligible beneficiary's attempt to enroll into another Part D plan impact the beneficiary's enrollment into the Demonstration?

- The State's development of enrollment notification outreach strategies should look at successful outreach efforts that have been used recently to educate Medicare beneficiaries about Part D enrollment changes. For example, during the 2011 Annual Election Period, Part D plans and CMS used a variety of media, television, radio, and newspaper ads to educate Medicare consumers that the Part D enrollment period had a new timeframe. Use of the media to emphasize the change in the timeframe was very effective is getting the message to most consumers. The State should strongly consider the use of media messaging in Demonstration counties with extremely large dual eligible populations such as Los Angeles County. CHCR recommends that the State review the experience of the SPD enrollment and what types of notice were most effective in communicating with beneficiaries.

- The Proposal's description of beneficiary notification regarding enrollment is limited to a reference to a written notice that is sent to beneficiaries 90 days prior to enrollment. This seems to suggest that DHCS will use similar enrollment notification methods that were used with the SPD population transition to managed care. Is this accurate? If the enrollment notification process will be similar to the process used during the SPD transition, what changes will be made to address the enrollment problems that occurred during the SPD transition?

- The Proposal states that partnership with consumer and beneficiary groups will be critical to a successful Demonstration enrollment outreach and education effort. Given the short planning and implementation timeframe challenges for this

Demonstration, what steps will the State take to ensure that consumer and beneficiary community groups have access to timely enrollment and education information to help beneficiaries understand their health care options in the Demonstration? How does the State intend to work with consumer and beneficiary groups to develop and implement outreach and education programs for beneficiaries?

- The State recognizes that community based non-profit organizations that have expertise with assisting dual eligibles understand their Demonstration health care options will play a critical role in Demonstration counties. These agencies include local legal services organizations, HICAP programs, the Independent Living Centers, the Regional Centers, disability rights organizations and other advocacy organizations. All these organizations have a commitment to improving health care access and beneficiary rights for dual eligibles. However, the State must recognize that most of these agencies already experience difficulty meeting current consumer demand for services. Without new resources, these agencies will have great difficulty responding to the demand for health care counseling services from thousands of new consumers that a large scale Demonstration would create.

Comment # 7: Network Adequacy and Care Continuity
(Page 26)

The draft Proposal provides for a continuity of care policy which appears to be the same as the SPD continuity of care policy. Based on the experience of the SPD population, CHCR has serious concerns about the ability of dual eligibles enrolled in the Demonstration to access continuity of care under such a policy. According to data compiled by the State, only 3,809 continuity of care requests were made by SPD beneficiaries during the time period of October – December 2011 while a total of 56,634 SPD beneficiaries were enrolled into Medi-Cal health plans during that same period.[9] The number of continuity requests represents only 6.27% of the SPD beneficiaries enrolled during this time period, and the number of SPD beneficiaries does not include those who were enrolled in prior months. The small percentage of SPD beneficiaries who submitted continuity of care requests draws into question how accessible continuity of care is under the current policy. Based on our work with SPD beneficiaries, we feel that the low number of continuity requests are due to several factors: 1) very few fee-for-service providers wish to work with health plans because of perceived difficulties with the plan authorization and payment process; 2) a significant portion of beneficiaries do not know of the existence of the continuity of care policy; and/or 3) a significant portion of beneficiaries are aware of the continuity of care policy but are unclear on how to access such continuity of care and find that they are unable to get much information from their health plans on how to initiate the process.

[9] DHCS, SPD Data Dashboard, Sects. 1.1, 2.1, available at http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ChartsRptsData/SPD_Dashboard.pdf

If the proposed continuity of care policy is adopted for the Demonstration, CHCR recommends that providers covered under the continuity of care policy be expanded to include not just physicians but also other health care providers such as DME suppliers and home health agencies.

Additionally, health plan case managers should be available to assist with the continuity of care option, access to plan services, and plan authorization processes. Once a beneficiary is enrolled in a health plan they frequently need assistance with navigating the managed care network. After the SPD managed care enrollment, CHCR received countless calls from beneficiaries who encountered serious obstacles to health care caused by in-plan authorization delays, problems with primary care physicians, and transportation issues. CHCR believes that the use of case managers and nurse practitioners must be expanded so that the plans can accommodate each beneficiary in their plan.

Comment # 8: Appeals and Grievances
(Page 27)

The State proposes to create a unified state and federal grievance and appeals process for beneficiaries enrolled in the Demonstration. CHCR believes a unified grievance and appeals process must provide beneficiaries enrolled in the Demonstration with rights and protections at least equal to those afforded to other dual eligibles. CHCR believes that a unified appeals and grievance process should contain the following elements:

1. Clear, understandable, and timely notice provided in the beneficiary's primary language and available in large font;

2. Access to an external appeal outside of the health plan with an Independent Review Entity that is knowledgeable in the applicable coverage guidelines;

3. Access to expedited appeals of service denials that follows the Medicare Advantage timeframe for a decision of 72 hours;

4. Access to Aid Paid Pending;

5. Access to the expedited appeals process with the Quality Improvement Organization (QIO) for hospital, SNF and home health discharges that is available in the Medicare Advantage appeals process which provides Medicare beneficiaries with critical access to processes to resolve service denial and termination situations in a time sensitive situations and provide the opportunity to an independent external review that is outside of the plan;

6. Clear direction as to which entity (CMS or DHCS) has oversight/enforcement authority over the appeals and grievance process;

7. The ability of health care providers to submit appeals on behalf of beneficiaries. CMS recently promulgated regulations that allow physician's and other prescribers to file Medicare Part D appeals on behalf of patients and CHCR recommends that this be adopted for the Demonstration appeals process;

8. Access to an independent outside entity, like an Ombudsman, that can provide beneficiaries with assistance on appeals and other issues.

CHCR also recommends that the Demonstration appeals and grievances process should require health plans to provide strong oversight and internal controls if any stages of the appeals process are delegated to plan providers as part of the medical services authorization process. In the current Medicare Advantage and Medi-Cal plans, beneficiaries frequently encounter serious obstacles to obtaining covered medical care because decision making regarding authorization is in the hands of plan contracted providers, not the plan.

In addition, CHCR recommends that Demonstration health plans be required to have dedicated units which advocates can communicate with to better assist beneficiaries with problems/issues like appeals, grievances, authorizations, and claims payments. CHCR suggests that Demonstration health plans follow the practice of many Medicare Part D plans that have created dedicated escalated units designed to assist advocates and beneficiaries with resolving problems.

Comment # 9: Expected Outcomes: State's Ability to Monitor, Collect and Tract Data on Quality and Cost
(Page 28)

The draft Proposal states that California will, in partnership with CMS, monitor, collect and track data on key metrics related to the model's quality and cost outcomes for the target population, including beneficiary experience, access to care, utilization of services, etc., in order to ensure beneficiaries receive a high quality of care and for the purposes of evaluation. CHCR recommends that the State implement a centralized beneficiary complaint system like CMS' Medicare Part D Complaint Tracking Module (CTM) system. The CTM system allows CMS to monitor Part D plans' timely resolution of beneficiary complaints filed with the 1-800-Medicare hotline and is an important source of data on plan performance and compliance.[10]

[10]CMS, Updated Complaint Tracking Module (CTM) Guidance on Standard Operating Procedures (April 2009), available at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/HPMS_Memo_Plan_Guidance_Final_040309.pdf

Comment # 10: Infrastructure and Implementation: State Infrastructure/Capacity
(Page 31)

The Proposal identifies the California Department of Aging as a partner agency that will help with the implementation of the Demonstration. The HICAP Program, a program administered by CDA, is identified as a program that provides consumers with counseling on Medicare, managed care and other health insurance issues.

As the HICAP contractor for Los Angeles County for more than 25 years, the Center for Health Care Rights has provided vital Medicare information and counseling services to thousands of dual eligible consumers in Los Angeles County. If the Demonstration is implemented in Los Angeles County, CHCR is committed to helping dual eligibles make health care decisions regarding their participation in the Demonstration. However, we have strong reservations regarding including Los Angeles County in the proposed Demonstration. Los Angeles has the highest concentration of dual eligibles in California, with 25% of all dual eligibles in the state. Transitioning a dual eligible population of this size into Medi-Cal plans with no initial testing and evaluation will result in serious access to care for many individuals that the continuity of care requirements may not address.

Comment # 11: Medicare Star Rating and Alternatives
(Page 35)

The Proposal states that California believes that the CMS Medicare Advantage Stars Rating that evaluates plan Medicare performance is flawed and may limit health plan participation in the Demonstration. Because one of the primary goals of the Demonstration is to provide a higher quality of care to dual eligible beneficiaries, CHCR recommends that any plan that participates in the Demonstration should have a strong Medicare performance track record as measured by the Medicare Stars Rating.

Comment # 12: Potential Barriers/Challenges: Ambitious Timeframes
(Page 35)

The draft Proposal acknowledges that CMS timeframes present challenges for completing the Demonstration implementation activities. Given the short timeframe for development of such an immense project, CHCR again urges the State to consider limiting the initial implementation of the Demonstration to no more than four counties in 2013 and to avoid large, complex counties like Los Angeles. A smaller scale implementation will allow the State more time to gather data, review performance, and develop successful practices for the Demonstration.

We thank you for the opportunity to submit comments regarding the draft Proposal for California's Dual Eligibles Demonstration. We look forward to working with you to ensure that the Medicare and Medi-Cal programs provide high quality care and services to older adults and people with disabilities.

Sincerely,

Aileen Harper	Bridget Homer	Stephanie Lee
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MEMBER CLINICS:

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Comprehensive Community Health Centers, Inc.
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Garfield Health Center, Inc.
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Korean Health, Education, Info & Research Cntr
Los Angeles Christian Health Centers
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Northeast Community Clinic
Northeast Valley Health Corporation
Our Saviour Center/Cleaver Family Wellness Clinic
Planned Parenthood Los Angeles
QueensCare Family Clinics
St. John's Well Child & Family Center
South Bay Family Healthcare Center
South Central Family Health Center
Saint Anthony Medical Centers
Tarzana Treatment Center, Inc.
T.H.E. Clinic, Inc.
The Children's Clinic, Serving Children & Their Families
The Saban Free Clinic
UMMA Community Clinic
URDC/Bill Moore Community Health Clinic
Valley Community Clinic
Venice Family Clinic
Watts Healthcare Corporation
Westside Family Health Center
Westside Neighborhood Clinic
Wilmington Community Clinic

May 4, 2012

Director's Office, Department of Health Care Services
1501 Capitol Avenue, MS 0000, P.O. Box 997413
Sacramento, CA 95899-7413
Via email: info@calduals.org

RE: Comments on California's Dual Eligibles Demonstration (April 4, 2012)

To Whom It May Concern:

The Community Clinic Association of Los Angeles County (CCALAC) is pleased to respond to the April 4, 2012 Proposal for a State Demonstration to Integrate Care for Dual Eligible Individuals (proposal) issued by the Department of Health Care Services (DHCS).

CCALAC represents 47 nonprofit community clinics and health centers (CCHCs) serving nearly 1 million patients at over 145 licensed sites throughout Los Angeles County (LA County). These clinics provide high-quality, cost-effective primary, dental, and specialty care as well as enabling services (i.e. translation, transportation services, smoking cessation classes) to nearly 1 million low-income, uninsured and underserved individuals and their families.

CCALAC requests that DHCS consider the following comments on its proposal before its submission to the Center for Medicare and Medicaid Innovation and as the planning process for implementing the proposal moves forward. As requested, CCALAC has provided comments using the template provided on the DHCS website and it is attached. CCALAC's main concerns have been largely informed by other recent efforts, including the transition of Seniors and Persons with Disabilities (SPDs) into managed care and implementation of LA County's Low Income Health Program (LIHP), Healthy Way LA (HWLA):

Education and Outreach to Beneficiaries and Providers. During the SPD transition, beneficiaries received minimal notification of the potential changes to their care that would occur as well as the opportunity to select a new provider that would be covered under managed care. Literature was also difficult for beneficiaries to understand. As a result, SPD patients were assigned to new primary care providers (PCPs), particularly CCHCs, without their knowledge. Through the high number of these default assignments, CCALAC member clinics experienced incredible capacity challenges. CCALAC recommends that beneficiaries be notified through several avenues (e.g. telephone, mailing and through current providers) well in advance of the impending transition. Communications must also be clear and appropriate for the population it intends to reach.

Adequately engaging providers during the transition will also be critical to its success. DHCS and health plans must engage in significant outreach with patients' current providers and include them in the transition process. Both fee-for-service providers and those that will participate in managed care must be educated and

trained on new processes and protocols well in advance of the transition.

Monitoring and Management of Provider Capacity. During the SPD transition, several challenges resulted in an unusually high number (nearly 70 percent) of default provider assignments in LA County. Also, safety-net providers were the only providers receiving these default patients. As County and independent safety net facilities began experiencing capacity challenges, they began acting to limit the number of default patients assigned to them. LA County requested a modification to the default algorithm and some clinics temporarily closed to all Medi-Cal patients in order to limit their default assignments of SPDs. This dangerous phenomenon can lead to a "cascade" effect, creating more stress on clinics that remain open to receiving these patients.

The SPD transition came at a time when clinics were undergoing several other major systems and program changes. During the 2011-12 fiscal year, clinics have been engaged in many initiatives including ramping up efforts for patient-centered medical home designation, implementing electronic medical records, launching LA County's LIHP program and participating in an effort to decompress LA County's specialty care system. Each of these efforts have come with their own challenges and, combined, have caused significant financial strain on community clinics and health centers. While clinics want to remain partners throughout the reform process, each change must be approached in a thoughtful and deliberate manner so as not to further destabilize the current system.

CCALAC strongly recommends that providers be engaged in transition planning for the Dual Eligibles Demonstration early on in the process to consider issues such as default assignments and communications with health plans. Patient assignment and communication must be carefully monitored, particularly in the early months of the transition, to ensure that capacity among providers is being properly managed.

Improved Care Coordination. One of the most significant challenges experienced during the SPD transition was that of care coordination for the patients newly assigned to clinics. Lack of outreach and education led to many new patients presenting at clinics with urgent needs and demanding immediate assistance. Many times, these patients required specialty care or other services that clinics are not able to provide. Health Risk Assessments were often not completed or were very inadequate in providing information to the patients new PCP. No link to the patient's former provider existed leading to difficulties in care coordination and the provision of basic services. Even providing medications to patients became a serious challenge. Clinic staffs were left to sort out the complex maze of patients' previous care and required significant additional clinic resources to ensure that patients did not experience catastrophic disruptions in their care.

Care coordination efforts were further complicated by the unclear designation of responsibilities between health plans and independent physicians associations (IPAs). Clinics often went back and forth between the two when requesting items like durable medical equipment. Before the duals transition begins, these responsibilities must be clearly assigned and communicated to providers to ensure timely care for beneficiaries. CCALAC strongly recommends that a robust evaluation of plans, providers and IPAs take place to ensure readiness for the duals transition.

In summary, the DHCS proposal is vague but provides a significant opportunity to address the many challenges that exist before the Dual Eligibles Demonstration project begins. CCALAC's member clinics continue to experience significant challenges with the transformation required in preparation for reform but remain committed partners in making expanded access, improved quality and better care coordination

a reality for all LA County residents. CCALAC looks forward to participating in continued planning efforts at the state, county and plan level to ensure that the Dual Eligibles transition to managed care is a success for all involved.

CCALAC appreciates the opportunity to comment on this proposal for a State Demonstration to Integrate Care for Dual Eligible Individuals.

Sincerely,

Louise McCarthy, MPP
President & CEO