CONGRESS OF CALIFORNIA SENIORS

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May 4, 2012

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

Dear Director Douglas:

Thank you for the invitation to comment on the draft proposal for California’s Dual Eligibles Demonstration Project and the Coordinated Care Initiative. The Congress of California Seniors (CCS) has been an active participant in the stakeholder process, beginning with the enactment of SB 208 which gives the Administration legislative authority to undertake a pilot in concert with the federal Centers for Medicare and Medicaid. We have attended all the public forums and stakeholder workgroup sessions. We have met in various collaborative groups with persons in and consultants to your department who are working on this important effort.

First, we want to begin by thanking you for the efforts you and your staff have made to create an inclusive stakeholder process. We appreciate the efforts made by the state to engage in a robust stakeholder conversation and understand that it is difficult to satisfy everyone who may want input. We believe the state has made great strides to be more transparent and inclusive than was the case with the development of the 1115 Waiver. We also understand that this is a work in progress with various workgroups still underway and a review and endorsement by the Legislature on portions of the proposal.

Second, we recognize that this proposal incorporates a number of changes from earlier drafts and that some of those changes reflect input from stakeholders in the process just described.

As we have stated on a number of occasions, CCS supports the principles of this proposal to integrate care across programs and services for an estimated 1.1 million frail seniors and people with disabilities who are eligible for both Medicare and Medi-Cal. We believe it offers the opportunity to improve care and make care more available and understandable to many people who have faced a confusing and disconnected set of siloed services under fee for service. We also hope and expect that the proposal will create financial incentives to shift people and resources into community-based settings rather than institutional settings. This said, we continue to have a number of specific concerns similar to those expressed by many consumer advocates.

This letter summarizes most of our remaining concerns with the proposal as written.

Timing

The Administration proposes to expand the number of demonstration counties authorized in current law from four to ten in the twelve months beginning January 2013. We believe this pace of transition could lead to problems because of plan readiness and because of state capacity to prepare for, monitor, and evaluate this many demonstrations. Specifically, our comments are

- Two of the county pilots (Sacramento and Contra Costa) do not appear to have complied with state guidance in their proposals, and one of these counties (Sacramento) appears to have problems with the population they serve at present.
- One county (Santa Clara) appears to have insufficient experience operating a Duals Special Needs Plan, which was one of the criteria set by the state to determine plan readiness.
- One county (Los Angeles) is larger than twenty other states combined and is home to 370,000 duals. Further, Los Angeles County experienced many of the transition problems under implementation of the SPD 1115 waiver transition this past year, according to the anecdotal evidence available.

We do not simply say “go slow” because we are uncertain about managed care. We say “proceed with caution” so the demonstration can show success and those in the first year will have experience to demonstrate to other counties how best to proceed. <u>We recommend a first year demonstration with seven counties (holding Sacramento, Contra Costa, and Santa Clara until the second year) and transitioning into Los Angeles County over twenty-four months instead of twelve months. Assuming the transitions went well, we would then support adding twenty-three counties in 2014.</u>

We have concerns that the amount of work which need to be accomplished by the plans, by stakeholder workgroups, and by the state is too extensive to be accomplished and in place to allow enrollment starting in January 2013. We are also concerned that the Medicare open enrollment process which runs from October to December will create significant confusion for enrollees. The state may want to consider an implementation start up that gives all the players more time and lessens enrollee confusion. <u>Specifically, we recommend that the state look at the possibility of beginning the transition of the first round of counties in October 2013. Thereafter, transitions of future counties would also begin in October rather than January of each year.</u>

The Administration further proposes, by January 2015, to institute care management and coordination in twenty-eight smaller rural counties which have no managed care today. We believe much work needs to be done to create provider networks and to examine different models of care management coordination that might be used in these very diverse settings. <u>Therefore, we recommend a second specific Legislative authorization (policy bill or budget trailer bill provision) before the state proceeds to add any of these counties.</u> Such authorization should become effective no later than January 2014.

<u>Enrollment</u>

We understand and accept the notion that, to insure a sufficient number of enrollees for the demonstration to succeed, the state and plans seek a system of passive enrollment, with an active opt out mechanism. The experience with the transition of SPDs was that seventy percent of enrollees were arbitrarily assigned to plans and that requests for reassignment for medical exceptions was handled poorly and unevenly.

We accept the need for passive enrollment under the following conditions.

- Plans (and the state) should be held to a standard of active choice by 70% of enrollees and no more than 30% should be automatically assigned on a plan by plan (not statewide basis). We also believe that any request for exemption should be processed within fifteen days with financial penalties on plans or contracted processors of requests for exemptions or continuity of care by current providers, if the fifteen day time limit is not met.
- We oppose the six month lock in provision and believe it violates current Medicare policy.
- At the earliest possible date, the state needs to establish a stakeholder task force to examine the issue of enrollment of IHSS clients into managed care. We believe that we need to recognize different types of IHSS clients (frail elderly and/or cognitively impaired adults who need intense care coordination), adults with disabilities with certain physical limitations which require caregiver support, but who value self directed care over integrated care, and children with disabilities with family caregivers where it is impossible to separate the concerns of clients and caregivers.

The state should consider the feasibility of setting different standards of passive versus active enrollment for these different clients.

We believe achievement of these goals will require the state and the plans to engage in person-to-person education of enrollees and provide choice educators/navigators.

We disagree with the notion that helping enrollees understand their coverage options should only be undertaken with no public funding. Rather, we believe these services should be the responsibility of plans of part of the education/outreach effort and funding should be incorporated as a specific item in plans' capitated rates.

Assessment

We believe high quality and thorough assessment of this population will determine the success or failure of the demonstration. We are concerned that the state proposal asserts that plans will take on this task. While plans may have experience determining the degree of health risk of young and middle age enrollees, this population is significantly different. Multiple conditions are the rule not the exception. Most patients experience the interplay between physical and behavioral health, and are caught in the lack of coordination between primary/acute care and long term care.

We continue to support a multi-tiered assessment process which begins with a uniform assessment of each enrollee (conducted within thirty days of enrollment) to serve as a triage of further assessment needs in a variety of areas: mental health concerns, substance abuse concerns, chronic physical conditions, incapacity in key activities of daily living, dementia, etc.

Plans should be required (not simply encouraged) to involve patients and caregivers in these assessments and the plans of care they suggest.

We reject out of hand the notion that plans can learn and implement services comparable to those now available through the MSSP program within twelve months (before most plans have begun the enrollment of duals). As was recognized in the decision to back away from sudden changes in the IHSS program, MSSP programs and sites should be extended for three to five years after implementation of the transition. MSSP should be assigned the task of independently assessing the care and service needs of the 20% of duals and SPDs most at risk of long term care institutionalization. They should be the point at which enrollees learn about PACE and the services it offers. They should be the primary referral to CBAS services. During the 3 to 5 year continuation of MSSP the state should undertake an independent analysis of the services and recommend to the Legislature any subsequent actions with regard to MSSP.

Financing

This aspect of the proposal is the one in which we have the lowest confidence in the state's projections and the greatest concern for reaching the goals laid out in the demonstration.

First, we believe that the state needs to open up the rate setting process, recognizing that some of the information used in that process is proprietary. For advocates to be effective in our support of managed care, we need to engage in the budget process for these services. That requires that we have information about what this new group of members is likely to cost and how well plans are set to handle them. We want assurance that assessment and coordination are recognized costs and are separate from overhead and administration that might fall under medical loss ratio calculations.

To the degree possible, Medicare savings that result from the care integration and emphasis on community based care need to be re-invested in the system of home and community-based services. We would hope that some recognition would be made that the savings in Medicare should go to the plans to allow greater investment in cost savings activities. If they are all delivered through the General Fund, they could likely disappear in the demands of Proposition 98 and competing needs for

state funds from other worthy programs. The result will be continued deterioration and elimination of the very programs that must help people pursue lower cost service options.

We would also hope that the considerable infusion of income into managed care plans that will increase income from the gross receipts tax will be recognized as available for home and community-based services for seniors and people with disabilities, not just to strengthen funding for children's health programs.

Quality and Measurement

The proposal asserts that managed care plans have a proven track record of high quality service and business integrity. Some of the data and reporting regarding plan services suggest just the opposite. Plans are not rated well in the CAHPS surveys. Recent information from the National Senior Citizen's Law Center also gives little encouragement.

We recognize that neither HEDIS nor CAHPS data sufficiently describe the needs and care rendered to this older and high user population. Nor do we have data describing quality or patient satisfaction of the current fee for service system. It is essential, as this initiative moves forward, that we develop appropriate standards of performance for plans and all providers (including those providing long term services), and that we monitor and report achievement of these standards. Some pieces of this (such as plan adequacy and readiness; how well consumer protections, appeals and grievance procedures are understood and working; how well enrollees understand their options; member satisfaction; and clinical health status data) need to be developed immediately rather than after the transition is underway.

Finally, we are troubled by the suggestion that, if the California Department of Finance determines that projected cost savings are not being realized, that the state will suspend and end this initiative in short order. This assertion belies all the assurances by the state that the goals of the Coordinated Care Initiative are to improve quality of care, achieve better integration of services to make them more accessible, encourage community-based services over institutional as well as allow better use of resources. Why doesn't the proposal lay out fail-safe steps if any of the other goals are not achieved? How can the state suggest that the entire initiative could be shut down in 90 days when it will take three or more years to create? What will happen to providers that are significantly impacted? How would the state re-transition people in three months into a fee for service system that had been dismantled without endangering the participants? We believe that language should be stricken from the proposal or significantly rewritten to provide for a ninety day shut down for failure to provide higher quality, more accessible and more community focused care.

Thank you for giving us the opportunity to share our concerns and make comments on the draft proposal. We look forward to working with you on presenting a revised proposal to the Centers for Medicare and Medicaid Services and passing legislation and budget provisions to implement this important reform.

Sincerely,

Gary Passmore
Vice President and Director

CADPAAC doesn't have many specific comments on the Duals Demonstration project proposal, but we would offer the following general comments:

1. There are several references to "Mental Health" where it appears that Substance Use Disorder services are also encompassed under that title. Though our two fields serve many of the same clients, it would be better to specify both types of services (Mental Health & Substance Use Disorders) if both are contemplated.
2. There should be some acknowledgment in the proposal that there are different models of county healthcare programs in terms of the way the services are administered, funded and delivered. In many counties, for example, behavioral health departments encompass both mental health and substance use disorder services. In other counties (including L.A.), substance use disorder services are part of the Public Health agency, while Mental Health is a separate department.

Please feel free to contact me if you have any questions about CADPAAC's comments.

Tom

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We've Moved! Effective January 31, 2012, our offices have moved to the 10th floor, Suite 1000 (same street address, same building).

Disability Rights Education & Defense Fund

DREDF

May 8, 2012

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

RE: Coordinated Care Initiative: California's Dual Eligibles Demonstration, April 4, 2012 Draft for Public Comment

Dear Director Douglas:

Thank you for the opportunity to comment on the California Department of Health Care Services April 4, 2012 draft proposal to integrate care for Medicare and Medicaid eligible individuals (draft proposal). The Disability Rights Education and Defense Fund (DREDF) is a leading national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. We have closely followed the national and state processes relating to care coordination and program integration for dual eligibles due to the profound impact that such integration will have on people with disabilities, including people with disabilities of all ages.

Much of the language of California's draft proposal is familiar from the stakeholder process, and laudable in its broad outlines. The state has consistently reiterated having the goals of coordinating state and federal public health care benefits for dual eligible, improving the availability and delivery of home- and community-based services (HCBS), preserving self-directed consumer care, and optimizing Medicare, Medi-Cal and state/county resources. One initial observation we have about the draft is how difficult it is to comment when the actual method and details for realizing these goals is often simply stated as "demonstration sites/health plans will be responsible." Even the draft admits at page 14 that only "some of California's health plans already provide a highly integrated approach to care planning." Many or most of the state's managed care organizations are primarily experienced in managing care for generally healthy adults, families, and children. The draft proposal's timeline projects a virtually complete transition of California counties to Medi-Cal managed care for seniors, people with disabilities, and dual eligibles by 2015, beginning imminently in January 2013. The plan places immense care coordination and delivery responsibility upon managed care organizations that do **not** have sufficient experience with, or understanding of, the medical, social, and behavioral support needs of a very non-homogenous population.

Our other overarching comment on the entire draft proposal is that all of its goals have implicit short, mid, and long-term dimensions to their achievement. While the two fundamental stated goals of improving the quality of beneficiary care and maximizing public resources are always presented as equally important, the enrollment plan, consumer protections, monitoring and enforcement provisions, and the actual implementation timeline undeniably favor short-term goals of resource savings above both immediate and structural investments needed to preserve beneficiary well-being in the short term and sustain improved patient care in the mid- and long-term. These aspects of the proposal will be discussed in order in the following section.

Risks

Outreach and the enrollment process are the first crucial areas where resource concerns of the state and demonstration sites come into potential conflict with what is best for consumers. The draft proposal asserts that health plans "will need sufficient enrollment in the demonstration to sustain a capitated model" and "can only achieve the benefits of coordinated care if they have sufficient time to develop a case plan and implement care improvements." On the other hand, respect for consumer choice and well-being argues for **first** having a plan credibly establish its capacity to serve the health care needs of people with multiple impairments and chronic conditions, and **then** offering those options to dual eligibles, who will stay with a plan that appropriately provides effective care assessment, coordination and services. As the PACE model has shown, managed care that can do the job and keep people at home safely in their homes is sustainable and will retain eligible consumers.

Unfortunately, almost every choice in these initial areas has been made in favor of the short term gain of the state and health plans over the short, mid- and long-term needs of consumers. Medi-Cal services can only be obtained through mandatory managed care. Dual eligibles will be passively enrolled in Medicare. Individuals who do not actively opt out of the demonstration will be locked in to a particular health plan for 6 months. Enrollees are left to rely upon a 6 month care continuity option, that does not appear to extend to such critical ancillary providers as Durable Medical Equipment (DME) suppliers and seating fitters, and a Medi-Cal Medical Exemptions Request (MER) process that has been fraught with interpretation and implementation difficulties during the mandatory enrollment of seniors and persons with disabilities under the 1115 waiver. Moreover, these decisions are made in the context of known outreach difficulties that have been captured in such sources as the California HealthCare Foundation's study on the 1115 waiver process. Community and advocacy groups have reported on how limited English proficient (LEP) individuals received 1115 waiver enrollment notices and packages that they did not understand, and vision impaired individuals failed to receive enrollment packages in alternate formats when requested.

Passive enrollment for the draft project would be less troubling if we were confident that outreach would be highly effective, including for such difficult to reach beneficiaries as those who may lack a permanent home address or phone number, those who have

cognitive, behavioral, and/or communication impairments, or whose primary language is not English. We are not confident about this. A lock-in period would be less problematic if it applied to a beneficiary's active choice **to** enroll in a particular plan. It does not. Incomplete outreach, passive enrollment, and a lock-in together might conceivably be less dangerous if consumers had continuity of care mechanisms that applied broadly to all necessary primary, specialist and ancillary providers **and** well-established MER procedures with no backlog of requests. This is not the case. There is the additional fact that due process and appeal procedures, and the applicability of Aid Paid Pending protections to Medicare benefits, are still very much works in progress. Finally, state and CMS monitoring, oversight, and evaluation of health plans – a vital element when plans will be assuming responsibility for entire service areas such as In-Home Supportive Services (IHSS) that they have little familiarity with – are also clearly in development. It must also be noted that the word "enforcement" is generally absent from the entire draft proposal.

The above factors establish a "perfect storm" that will catch those least likely to respond to outreach, those with complex health conditions that have the most to lose if care continuity is disturbed, and those least able to navigate the intricacies of MER requests and appeals in a unified system that has even been worked out yet. This is not a criticism of the administration's initiation of a workgroup structure on such important issues as beneficiary protections and appeal procedures. DREDF supports the state's commitment to gathering multiple stakeholder input for the development of performance measures and continues to hope that consumer needs will be well-reflected in the establishment of performance measures and targets. This is a strong criticism of the administration's current timeline and enrollment decisions which leave all stakeholders – consumers, community and advocacy groups, providers, and plans - with virtually no margin of error for affecting a safe transition to managed care.

Other states have proposed later alternatives to a January 2013 start date in their dual eligible integration proposals. In general, these are states that have a much lower percentage of the nation's dual eligibles than California, where a "demonstration" involving Los Angeles County implicates thousands and thousands of individuals. The immediacy of California's proposal appears to be primarily budget-driven, from a state eager to achieve projected savings through a managed care transition of high-cost dual eligibles. The central question is who bears the risk of favoring short-term gain over a longer-term commitment to developing and testing the kinds of network readiness standards and tools, beneficiary protections, integrated appeal processes, and monitoring and enforcement mechanisms that should be put in place **before** enrollment takes place? Beneficiaries are on the front lines, and face care disruptions, delays in appropriate treatment, reduced functionality, and compromised health. Circling back to the topics of outreach and enrollment, at least two questions have to be raised:

- If effective outreach is one of the mechanisms relied upon for ensuring that passive enrollment actually reflects genuine choice, that same outreach should be recognized as an effective way to persuade potential enrollees of the benefits of *voluntary* membership in a plan;

- If, as we are reassured, the demonstration plans stand ready to provide effective case plans and care improvements for the dual eligible population, then isn't the best way to avoid "enrollment churning and interruptions for an initial six month enrollment period" to lock-in only those that have actively chosen a plan and exhibited a commitment to realizing the benefits of switching to managed care?

The draft proposal already contemplates a rolling enrollment period that takes place over a year. DREDF supports this process given the numbers of dual eligibles involved. Instead of the arbitrary imposition of enrollment based upon birth date, however, we suggest that it makes more sense to target enrollment based upon health and impairment levels. That is, active enrollment should be solicited first from eligible individuals with fewer complex health needs; any eligible individuals can actively enroll in a plan at any time. Outreach over the course of the enrollment period can culminate in active outreach to individuals with complex care needs, multiple provider teams and/or medication needs, and additional HCBS and long-term supports and services (LTSS) needs. This would enable plans to continue to gain experience meeting the needs of individuals with complex care conditions, learning the intricacies of HCBS and IHSS, and further solidify needed relations with community and advocacy groups. Word of mouth concerning plans that are effectively and appropriately meeting the care coordination and HCBS needs of the dual eligible population can spread, workgroups can continue to work out the details of vitally important beneficiary protections and unified appeal procedures, and California and CMS have more time to meet with, assist, and if necessary delay further enrollment among those plans that encounter difficulty meeting performance target measures for the first waves of enrollees. Passive enrollment should not be considered until dual eligible individuals are actually given the opportunity to see managed care done well for people with complex and multiple health conditions, and an extended period of time to freely voluntarily choose managed Medi-Cal and Medicare.

<u>Opportunities</u>

DREDF is not alone in our concern over the tremendous risks that accompany a transition to managed care for dual eligibles. Colleagues at Disability Rights California, National Senior Citizens Law Center, Western Center on Law and Poverty, and many other advocacy organizations have enumerated detailed concerns and excellent recommendations for the draft proposal. We support their work, and also want to take this opportunity to highlight what we see as two specific opportunities that a managed care transition will afford people with disabilities in the state, in addition to the general goal of improving health care quality and coordination for dual eligibles. These opportunities involve increasing the physical and programmatic accessibility of health care delivery to people with various disabilities, and rebalancing LTSS to ensure the ready availability of HCBS favored and needed by seniors and PWD in California.

Physical and Programmatic Accessibility

The physical and programmatic inaccessibility of smaller practices and clinics owned by a physician or physician group, where over 83% of outpatient facility visits take place, is becoming increasingly documented. One recent large-scale analysis of over 2300 primary care provider facilities in California serving Medicaid-eligible managed care enrollees found that 8.4% of provider sites have a height-adjustable exam table, and only 3.6% have an accessible weight scale.[1] Many people with mobility, balance, and strength impairments cannot receive equally effective examinations without accessible equipment. The need for programmatic accessibility, which involves reasonable modifications of policies, practices and procedures such as providing written information in alternative formats or extended appointment times, is even less likely to be known among, and available from, providers.

DREDF supports the draft proposal's general declaration at p. 9 that "sites must comply with state and federal disability accessibility and civil rights laws, including communicating in alternate formats." However, ensuring actual adherence to accessibility laws by plans and among providers requires more than a declaration, or even contractual language. Legal accessibility obligations in healthcare have existed for decades in California. This fact in itself has not made health care delivery accessible.

Managed care presents another layer of resources and infrastructure that operates among and connects individual providers to one another and to state Medi-Cal funds. As an umbrella entity, a managed care organization can perform 3rd party trained physical and programmatic surveys of its provider network, provide linguistic translations and alternative formats of common health care and self-care information, efficiently undertake contracting and scheduling ASL services within the network, assist members to find accessible providers within a reasonable distance, and foster disability cultural awareness and training among providers. If the state can delegate practical administrative responsibilities for ensuring accessibility among thousands of California providers, then it can focus on committing resources to monitoring and enforcing compliance with accessibility laws and investigating and resolving disability civil rights healthcare complaints. However, the draft proposal must clearly establish these expectations and lay a common regulatory foundation among all demonstration plans, or nothing will change. Plans must be required to establish physical and programmatic accessibility targets for their provider networks – primary, specialist and ancillary – that are periodically updated. The state, including DHCS and DMHC, as well as CDSS, must hold plans accountable for meeting their targets, and must also review each departments own policies, practices, and procedures to ensure that all health care services and public interactions are accessible.

One ongoing example of inaccessibility are the bi-weekly provider timesheets that IHSS recipients must sign under penalty of perjury to initiate provider payments. The timesheets are a centralized state form that providers fill in by hand, and the state forbids any modification to the form. This form is wholly inaccessible to blind and many

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[11] These findings are published in N.R. Mudrick, M.L. Breslin, M. Liang and S. Yee, *Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews*, 5 DISABILITY & HEALTH J. (2012) (forthcoming).

visually impaired IHSS beneficiaries, who nonetheless must "verify" hours that they cannot see for their providers to get paid. Currently county IHSS authorities receive signed timesheets and enter provider hours worked, but the state plans to centralize IHSS timesheet collection and entry functions across California. The timesheet procedure, as well as IHSS informational notices and Notices of Action that are sent to individual beneficiaries, are undeniably inaccessible and are barriers to the equal participation of visually impaired recipients in the IHSS program. This is currently the case, and will remain the case after IHSS benefits are folded into managed care in the demonstration sites. Who bears responsibility for developing and implementing accessible solutions to this issue? The forms come from CDSS. Managed care entities will be responsible for administering IHSS services. County IHSS agencies will be subcontractors of managed care entities, and seem likely to remain the front line representatives for purposes of beneficiary interaction. California's Health and Human Services Agency is the overall coordinating agency for the dual eligibles project.

In the above situation, as in countless others, the complexity of overlapping public-private functions and local-centralized responsibilities make it all too easy for *every* responsible party to simply point fingers and take no action. The draft proposal claims that financial and service integration will simplify service delivery and make the system easier for eligible beneficiaries. This goal must include a guarantee of physically and programmatically accessible service delivery, which requires establishing clear and publicly transparent lines of responsibility and authority for enforcing federal and state disability rights laws. At the same time, plan or state administrative complaint and appeal procedures concerning inaccessibility must not infringe on existing rights to bring a complaint or legal action under current federal and state disability rights laws.

One of the fundamental tenets of the Supreme Court 's *Olmstead* decision was that people with disabilities (PWD) could not be required to endure segregation in a nursing home or other institution in order to receive needed health care services. But the fundamental ongoing inaccessibility of outpatient provider offices makes it extremely difficult or impossible for people with various disabilities to actually receive equally effective healthcare services in their communities. High functional impairment levels among the dual eligible population makes accessibility a core prerequisite for achieving improved health care delivery and services through the coordinated care initiative. Furthermore, another advantage of ensuring that providers in Medi-Cal managed care networks become accessible is that doing so will benefit not only Medi-Cal enrollees and dual eligibles, but also many other PWD of all ages who are plan members or who visit those same providers through Medicare only or private insurance. Ultimately California's entire population benefits when providers, plans, and the state develop and systematize appropriate accommodations and reasonable modifications in response to the needs of the dual eligible population.

Rebalancing LTSS toward HCBS

The disability community and advocates, as well as the state and local counties, have invested time and effort over many decades into building IHSS into a system of HCBS that may not be perfect, but does recognize the critical importance of consumer

direction and independence in such critical aspects as hiring, firing, and supervising personal care assistants. DREDF recognizes that the draft proposal establishes some safeguards for maintaining the best features of IHSS. For example, the proposal states that beneficiaries can choose to limit the role of their IHSS providers on care teams, county social service workers agencies and not medical providers will continue to assess and authorize IHSS hours, and existing grievance and appeals process will remain in place. We strongly advocate for additional necessary provisions that will set the stage for not only maintaining IHSS, but for optimizing HCBS within LTSS. These additional provisions include the state's commitment to:

- Develop managed care capitation rates that pay the same blended LTSS rate wherever a consumer lives so that plans will not be given fewer resources to provide HCBS relative to services in an institution, and full LTSS funding will follow beneficiaries to homes in the community rather than be conditional in any way on nursing facility placement.
- Establish a global budget in which managed care plans will draw out of the same fund for HCBS and institutional care, and accounting mechanisms will enable plans and the state to track and realize savings from providing HCBS to beneficiaries rather than institutional care.
- Prohibit any "carve out" of institutional costs from a managed care plan's budget or costs after plan beneficiaries have passed some arbitrary time period of institutional stay.
- Set rate incentives that will reward plans that consistently and successfully provide HCBS to dual eligible beneficiaries in the community and assist those individuals to avoid hospitalizations and institutional stays. Incentivization should work hand-in-hand with the development of quality care measures that examine whether people with various disabilities receive common preventive tests and treatments in an accessible and equally effective manner, for example, a measure that examines whether dual eligible women who use wheelchairs receiving regular mammograms and pap smears. The development and use of quality measures for individuals with varying levels of functional impairment and medical complexity is important to ensure that no plan is penalized for, or discouraged from, taking on beneficiaries with more fragile or complex conditions, and a potentially higher propensity to require periods of institutional care.
- Ensure that managed care organizations receive all relevant information about beneficiaries receiving institutional care, including reporting requirements placed on nursing homes under Section Q of the Minimum Data Set 3.0, which mandate local agency referrals whenever a resident indicates that she or he wishes to talk to someone about living in the community. DREDF supports the administration's decision to not exclude any beneficiary from the demonstration based on specific diagnostic categories or on institutional residence. This decision must be reinforced by establishing that managed care organizations are now key *Olmstead* players in California, and must reduce fragmentation among, and

improve lines of accountability with, myriad subcontractors to ensure that HCBS fiscal incentives provided to managed care organizations translate into appropriate action at the level of the institutional provider, where fiscal incentives will run in the other direction.

- Maintain regulatory and policy support for full consumer choice of IHSS providers, including the hiring, training, and supervision of non-medical and non-licensed service providers to perform a wide variety of personal assistance and intimate care needs.
- Establish a robustly funded Ombudsman office to provide consumer education, independently investigate individual complaints as well as systemic LTSS issues, and provide information on, and assistance with, rights and appeal procedures, administrative hearings, and court filings. The Ombudsman is also an ideal centralized point for the public to obtain performance data, including physical and programmatic accessibility survey data and complaint data, on such LTSS providers as including HCBS agencies, nursing facilities, and managed care plans. Given the centrality of rebalancing to all of the draft plan's goals, it is vital that the Ombudsman operate completely outside of the service delivery system and be free of conflicts of interest in both fact and appearance.
- Develop a unified LTSS database that includes the demographic data collection requirements established by the federal Department of Health and Human Services under the Affordable Care Act, utilization data according to type(s) of service used (e.g., waiver, IHSS, institutional stay), and assessment and service data (including discrepancies between a beneficiary's assessed needs and the services provided).
- Include the realignment of provider fiscal incentives toward appropriate HCBS for dual eligibles and beneficiaries with disabilities in the development of any managed Fee-for-Service model for less populated, rural areas or counties where there is no operating managed care plan.
- Maintain ultimate accountability for *Olmstead* implementation. California may choose to delegate aspects of HCBS service delivery and LTSS coordination to managed care organizations, but it cannot abdicate its legal responsibility for ensuring that people with disabilities do not endure unnecessary and unwanted segregation outside of their chosen communities because of a medical condition or diagnosis.

Specific Concerns and Recommendations

DREDF's primary recommendations for this draft proposal are to slow down the process and to do it right. Within the parameters of the draft proposal as written, however, we do also have some specific recommendations and questions as follow:

- Page 7- enhanced quality monitoring and enforcement.

The language here should clarify that performance outcomes relate to more than just medical goals, and should encompass outcomes that are important to the individual consumer such as remaining in the community, maintaining maximum

independence, and retaining sufficient functionality to pursue employment, educational opportunities, and family/social relationships.

- Page 7 – exclusion of some beneficiaries in long-term care facilities that actually have to establish meeting their monthly Medi-Cal share of cost.

We are unsure why any long-term facility resident should lose the opportunity to benefit from the demonstration projects' anticipated benefits of care coordination and re-emphasis on HCBS and a return to the community just because of administrative or accounting difficulties.

- Page 11 – provider network requirements.

Provider network requirements must include geomapping standards that address the need for physical and programmatic accessibility from a wide range of providers, including primary, acute, specialist, and key ancillary providers such as DME and wheelchair seating specialists. Consequently, the state should suspend new enrollment of dual eligible beneficiaries into managed care plans that lack sufficient accessible providers. On an individual beneficiary level, if an appropriately experienced, accessible network provider who is actually accepting patients cannot be found in a reasonably proximate location, these should be automatic grounds for the managed care plan's authorization of grant out-of-network provider payments.

- Page 13 – care coordination standards.

Without diminishing the importance public input to developing care coordination standards, we still strongly recommend the state's adoption of some uniform, "bottom line" standards for immediate implementation by managed care plans. Mandatory managed care for dual eligible persons and people with disabilities may be relatively recent, but there have always been people with various disabilities voluntarily enrolled in managed care. The use of an immediate baseline performance standard, with a clear timeline for the development and refinement of additional specific standards with stakeholder input, will greatly assist the state, consumers, and advocates to detect care assessment and coordination issues and support remedial steps sooner rather than later.

- Page 14 – comprehensive health risk assessments and care planning.

Individual care plans must include the member's actual or anticipated physical and programmatic accessibility needs, such as "height adjustable exam table," "fillable forms and information in electronic format," or "extended appointment time for examination." These accommodation or modification needs must be regularly updated. Even if a younger person with a disability is capable of transferring independently for a number of years, that ability can diminish fairly rapidly during periods of illness, after acquiring a secondary condition, or even simply due to aging and repeated stress on joints over years of transfers.

- Page 15 – use of technology.

Electronic health records (EHR) is mentioned here, but not with regard to patient access, which the draft plan should at least address. EHR must be made accessible for patients with various disabilities and/or Limited written English Proficiency to

review, to provide corrections where appropriate, and to obtain copies in alternative formats and in threshold languages without any additional surcharge.

- Page 17 – LTSS only available through Medi-Cal managed care in demonstration counties.

We are concerned for those individuals who strongly wish to opt out of the demonstration in order to maintain long-held relationships with key fee-for-service Medicare providers, but who also require IHSS services and therefore must enroll in Medi-Cal managed care. Will their services and billing/payment procedures in fact be even more fragmented than the current status quo, as there are now additional differential layers of dual eligibles fully enrolled in the demonstration, mandatory Medi-Cal and Medicare opt-out dual eligibles (either initially or at the 6 month mark), and those who will apply for a MER from managed care Medi-Cal and opt-out of Medicare. If enrollment is truly to be optional, at least on the Medicare side, then potential enrollees must be given some clear idea of what happens after opt-out, and the impact of that decision on needed LTSS services which are now imbedded in Medi-Cal managed care.

- Page 18 – evidence based practices.

DREDF favors the use of evidence-based medicine, but also cautions that many people with disabilities, and especially those with low-incidence conditions/ impairments or who have multiple conditions, are simply excluded from the parameters of evidence-based practices. When health plans are educating network providers and staff, they must also indicate that the opinions of established treating physicians and clinical experts concerning best practices and medical necessity can be applied as well or in lieu of general guidelines that were developed without the participation or input of any person with any kind of disability whatsoever. Any state administrative staff involved with medical decision review or appeal should also be provided with this information.

- Page 18 – telephone survey.

We strongly suggest that any telephone survey options in future find simultaneous ways to capture the opinions of beneficiaries who does not have a phone, or cannot use a typical voice line because of voice or speech impairments. We also would like to clarify whether the last key finding is that four percent of *all* beneficiaries scheduled to transition to Medi-Cal managed care under the 1115 Waiver made a MER, or whether it is four percent of the 463 individuals called who actually responded to the phone survey who indicated that they had applied for a MER?

- Page 19 – health plan adjustment to needs of 1115 waiver population.

The best practices described, such as partnering with member advocacy and community groups, budgeting more time for welcome calls, and developing new ways to disseminate information, should be compiled and disseminated among all plans who wish to be a demonstration site, to be incorporated as standard practice for the dual eligible project.

- Page 21 – Other home and community-based waiver programs.

Before community-based waiver program services are integrated or taken over by health plans, the plans need to engage in a thorough analysis of where plan services and waiver services are duplicative and where different services are provided, taking into account the availability, frequency, duration, and quality of the service (e.g.,. experience levels of the service providers, opportunities for beneficiary input, etc.). The plan analysis and any proposed eliminations of duplicative services should be made available to the public, who will have the chance to offer further insight to the services provided under waiver programs.

- Page 25 – notification about enrollment process.

Plans must include in their information concerning benefits and grievance and appeal procedures the name and position of a specific individual who is at least partially dedicated to solving accessibility issues for members.

- Page 28 – performance based reimbursement for providers.

Health plans should be strongly encouraged to provide incentives that motivate network providers to establish practices that combat known health disparities, such as providing reimbursements for physicians and other providers who acquire accessible equipment and offer physically and programmatically accessible services.

- Page 29 - potential improvement targets for performance measurement.

Is there any specific reason why the development of plan performance measures cannot remain an open process beyond January 2013? That is, given the many innovative and duals integration projects happening across the country, and a common need for performance measurement, the state or other stakeholders could learn of good validated performance measurements after January 2013. Including additional or new performance measures may make it more difficult to compare overall performance within one plan over time, but should have minimal impact across plans, and all stakeholders benefit from using the best available performance measures.

- Page 29 – potential improvement targets for performance measurement.

"An increase in the number of beneficiaries with mobility impairments receiving preventive screenings" or "an increase in the number of beneficiaries with communication impairments participating in health risk and behavioral health screening" are some additional potential improvement targets that would also address documented disparities experienced in the disability community.

- Page 31 – state infrastructure/capacity.

The relationships among multiple state departments and agencies remains unclear, especially with regard to projected lines of authority and responsibility for the demonstration project in such important areas as consumer protections, complaint investigation, regulatory authority, data gathering, appeals procedures, and so forth. These basic structural issues must be worked out and clearly documented before the demonstration is initiated, and include any additional relationships with private entities that play a critical role, such as the enrollment agent. DREDF supports the

expansion of HICAP counselors for the open enrollment period in the demonstration counties.

Two final specific concerns are not addressed in the draft proposal. The first concerns the myriad of primarily non-profit service providers that have served beneficiaries through the home and community-based waiver programs. For the most part these are local providers with a wealth of experience who also respect the dignity and autonomy of waiver recipients. DREDF believes managed care plans should be strongly encouraged to enter subcontracts with these providers and preserve existing waiver provider relations wherever possible, thereby minimizing beneficiary disruption and retaining the valuable experience amassed by these providers. One way to encourage these subcontracts would be to require plans to properly weight familiarity and levels off existing contact with the incoming beneficiary population, and not merely seek "the lowest bidder" when seeking subcontractors.

Finally, we do commend California's demonstration and stakeholder process as being among the more open adopted by states interested in duals integration across the country. We would ask that a commitment to transparency, data publication, and stakeholder engagement be retained as the process moves forward and as the state continues to discuss options and details with CMS. If the state, as one public entity, approaches CMS as another public entity, to advance a particular interpretation of either CMS guidance or a consumer protection stated in the state's own draft proposal, affected consumers and stakeholders should be given the opportunity to give feedback on the implications of that particular interpretation. For example, after the 1115 Waiver was granted and CMS terms and conditions were published, California sought CMS approval to 'clarify" its position that only medical doctors were considered "providers" for continuity of care purposes. This clarification has had a negative impact on wheelchair users who rely heavily on the specialized expertise of ancillary providers such as seating experts to avoid dangerous pressure sores and to preserve musculoskeletal functioning. The entire approval process was done behind closed doors and without the input of informed beneficiaries or providers. DREDF would like to avoid a repetition of this process.

Thank you again for the opportunity to comment on this critically important health care transition for dual eligible persons and all Californians with disabilities.

Yours truly,

Susan Henderson,
Executive Director

Thank you for the opportunity to comment.
Our comments will combine a short narrative and notes on your Excel spreadsheet. In both, we will refer to our LTSS Principles document, citing it as DRC Page…. We attach a copy of the document. Please note: we used the large-print version of the proposal, so the items will be on different pages from the smaller-print version.

The proposal conflates what the legislature has authorized in SB 208, aka Duals Pilots, with what the administration proposes in its Coordinated Care Initiative, which the legislature has not authorized. Page one should state that the Coordinated Care Initiative is a proposal, and that many significant components of it are embodied in legislation and trailer bill which are being considered by the legislature but have not been approved.

We suggest that the proposal clearly differentiate which is which.
The state seems to be asking CMS to approve the CCI before it is law, which raises many questions, including the most obvious: if the CCI is not acted on until after the proposal is submitted, how can the timeline be accurate; and if CCI is rejected, what is CMS being asked to approve? Not only do the Duals Pilots and the CCI differ in scope, they differ fundamentally in that the former is voluntary (albeit via passive enrollment) and the latter is mandatory, in terms of Medi-Cal services in managed care.
Here are a few important topics which are missing entirely from the proposal, all of which are included in our Principles:

No Wrong Door/Single Point of Entry

Access to advocate/ombudsman (other than HI-CAP)

Qualifications of assessors and care managers

What assessment instrument(s) will be used

Will members get offered the services indicated in the care plan?

We are greatly concerned about the readiness and capacity of the state to proceed with this program, the readiness of the plans to take on this huge increase in members and to provide services with which most are

unfamiliar, and the consequences of experimenting with the lives of people with disabilities, including seniors.

The problems with the SPD enrollment, which have only recently been acknowledged by DHCS, are not resolved. It is not clear how the state will avoid repetition of the same problems with the duals integration.

We are equally concerned with the quality of the plans overall, especially given the dismal ratings many of them have received in publicly available measures. It is hard to square the state's insistence that the plans went through a rigorous application process, and are of highest quality, when at least two of the largest are under threat of being suspended by Medicare from participating in passive enrollment.

We have supported the concept of integration of long term services and supports for years, and would have welcomed a thoughtful and measured process to achieve that goal, to try different approaches, to start with voluntary enrollment into the plans who are fully prepared. We believe that if it is done right, coordinating services has potential to do great good.

However, we oppose the scope and timeline and many specifics of the CCI; we also oppose starting even four pilots in January 2013, especially in Los Angeles, which contains 40% of the population of duals. The Department acknowledges the number and breadth of unanswered questions and crucial operational details. To fill in those gaps, the Department has organized stakeholder workgroups, who are being asked to start and complete their work in the next several weeks. It is not possible for groups of 150+ to start and finish the complex work required over that time period. It is not the responsibility of stakeholders to help the Department meet a deadline we believe potentially threatens the health and welfare of our constituents.

We respectfully request that DHCS and the Administration re-think the scope and timeline of this project, slowing it down until it can operate at a safe speed.

Deborah Doctor
Legislative Advocate
Disability Rights California
California's protection and advocacy system

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DONALD V. STEVENSON, M.D.

DIPLOMATE, AMERICAN BOARD OF ORTHOPAEDIC SURGERY

ORTHOPAEDIC SURGERY
SPORTS MEDICINE
ARTHRITIS

I am an othopeadic surgeon serving the area of the Inglewood and South Central Los Angeles. I am the only orthopeadic surgeon physically located in this community and dual eligible patients comprise 85% of my practice. These patients are both economically needy and medically disavantaged. I find their need for surgical attention is matched or exceeded by their need for the empathy I have acquired over my 25 years of practice. My colleagues and I essentially engage in a sub-specialty of medical practice optimized to the special needs of the elderly, poor and sick populations. While managed care espouses efficiencies. I find these patients often tripped up and logistically incapacitated by the managed care maze. I often find my hands tied while trying to help them. Health care must change, but the evolution should not remove the patient physically from the community or logistically from their physicians nor contractually from the health care resources which serve them best. This proposed model is flawed and shall result in worse health and higher expense. Input from doctors here in the trenches with our boots on the ground is required.

Sincerely,
Stevenson, Donald M.D.

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April 30, 2012

Director's Office
Department of Health Care Services
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This letter is in response to the current draft to move over 800,000 patient with Medicare and Medi-cal an HMO system. The premise for moving this number of patients to one HMO in less than nine months will be difficult for the communities, the patients and the providers of their care.

The main reason for my objection of this move is that there are not enough <u>contracted</u> primary care physicians, contracted specialists or contracted facilities in HMO setting to care for this increased volume of patient by January 2013.

I want to repeat this message there are not enough contracted primary care, specialist or facilities in HMO to care for this volume of patient by January 2013.

To move this volume of patients without the assurance that the physicians, specialist, And facilities needed to care for this volume of patients is in my humble opinion a train wreck waiting to happen to our elderly and indigent patients.

As the office manager of a private ENT specialist who has and continues to provide specialty care to at least seven Los Angeles County base HMOs I can readily foresee a number of problems with moving our elderly patients into HMO based system.

One place where the HMO system fails miserably is when the patient requires non primary care services - that is specialty care; physicians, surgeons, radiology, oncology etc. The delay of treatment is a reality that fars exceeds the facts of fragmented care.

Office of Lorenzo Brown MD.

I say this because I have personally been responsible for coordinating the care of elderly HMO patients because my physician's practice is well over 40% of medicare and medi-cal. I have personally sought authorization for specialty services for patients and found a host of HMO problems just within Los Angeles County.

1. The first step that must be accomplished before sweeping thousands of recipients into this system MUST be to insure that there are enough contracted physicians waiting and available to accept these patients. The number of current contracted physicians, specialists and facilities cannot begin to absorb the volume of patients that the model indicates in the draft.

2. Primary care physicians, their staff and/or their authorization clerks that do not know, understand or have never trained to coordinate care for patients. This is a long standing and unacknowledged problem that I have seen on a monthly basis.
The State of California spends more time on requiring cultural competency of physician staff rather than **training physician and their personnel on the assessment of the elderly patient's needs and circumstances together with ensuring the actual implementation of all parts of that care.**

3. HMO cannot coordinate care because their administrative personnel do not have the experience, knowledge, training or written guidelines to assist patients particularly elderly patients when serious health problems occur. For example a newly diagnosed patient with cancer of larynx requires oncology, oral surgery (removal of teeth prior to radiation therapy which is not a covered medical benefit), chemotherapy, radiation therapy transportation, lab work)

4. HMO have lists of physicians, specialists, facilities that they show as contracted yet Their lists are full of providers who have withdrawn from the HMO. I now have to call a contracted provider prior to generating any specialist authorization simply because no one removes providers that are no longer contracted or even changed locations or phone numbers. It is my experience that HMO leaves the provider name as current to meet state guidelines when in reality because they cannot find providers and are not actively seeking new or replacement providers to contract.

5. HMOs and primary care physician's offices are leaving patients to the mercy of not being able to obtain services sometimes routine, simple and/or specialty care until they receive a written authorization for services. (Once any provider learns that a patient is in an HMO – this is barrier to care – because physician and their staff know through financial penalty of non-payment NOT to provide care without authorizations.)

Office of Lorenzo Brown MD.

6. HMO system requires written requests for authorization; authorizations require written approval from the HMO. When a patient needs comprehensive and multiple services, as a service by one provider necessitates more requests for services and multiple authorizations – the HMO system becomes overwhelming for the patient particularly the elderly patient. Because for lack of an authorization the patient fails to obtain needed services. But more importantly when you place patients in HMO they have no power

to rectify a missing, incorrect, incomplete authorization. What does the patient do when no one will assist them with an authorization? What does the patient do when authorizations go to the wrong address ???? What does the patient do when their authorizations is to a provider who is no longer contracted and the phone is disconnected?

These are just a few of anticipated problems with moving the patients into HMO. If I had more time I would give many examples why we find that the elderly patients need the freedom to obtain care from providers of their own choosing. What should be created are centers that contain specialist for the elderly to how to obtain and coordinate care.

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Toby Douglas, Director
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Delivered electronically to info@calduals.org

May 4, 2012

Dear Director Douglas:

Genentech appreciates the opportunity to provide comments on California's April 4, 2012 draft application to the Centers for Medicare & Medicaid Services (CMS) to participate in the dual eligible integrated care demonstration program. The comments in this letter address several concerns Genentech has with the proposal as written, and raise additional issues not considered in the proposal.

Founded more than 30 years ago, Genentech is a leading biotechnology company that discovers, develops, manufactures, and commercializes medicines to treat patients with serious or life-threatening medical conditions. The company, a member of the Roche Group, has headquarters in South San Francisco, California. Americans of all ages, ethnicities, and income levels are prescribed our products. Genentech manufactures products used by Medicare beneficiaries under the Part B physician-administered drug benefit. We also manufacture Part B-covered oral drugs, and Part D-covered prescription drugs. Our products are covered by Medicaid[1] and many of the patients who use our medicines are dually eligible for Medicare and Medicaid benefits. Misalignment between Medicare and Medicaid benefits may raise barriers to access for this vulnerable beneficiary population, and as such Genentech is interested in finding ways of better coordinating care to improve access to necessary health care services for dual eligibles and to preserve the strong beneficiary protections of the Medicare program that have evolved over time.

California is proposing to implement the three-year demonstration program in ten counties in the program's initial year (2013).[2] State law currently authorizes conducting the demonstration in four of California's 58 counties, though the State will implement the demonstration in six additional counties in 2013 if the Government's Coordinated Care Initiative is approved by the legislature.[3] These ten counties

[1] Genentech signed the Manufacturer Voluntary Drug Rebate Program agreement with HHS effective January 1, 1991. The full list of participating manufacturers and their NDC-5 labeler codes are available at https://www.cms.gov/MedicaidDrugRebateProgram/downloads/labeler.zip.

[2] Proposal, p. 2.

[3] Proposal, p. 2. See also File 617 to the California State Budget Trailer Legislation, 2012. Care Coordination Initiative for Medi-Cal Beneficiaries. Available at http://www.dof.ca.gov/budgeting/trailer_bill_language/health_and_human_services/documents/%5b617%5d%20Coordinated%20Care%20Initiative.pdf

account for 71% of dual eligibles in the state. By 2015 the program would include all 58 counties if the Governor's Coordinated Care Initiative were enacted.[4]

As estimated by the Governor's office, running the demonstration program in ten counties in 2013 would save $679 million and annual savings from an expanded statewide program would reach about $1 billion once fully implemented.[5] For perspective, saving $1 billion per year is the equivalent of saving 6% on costs for dual eligibles in the state.[6] This is significant savings for the state.

Under DHCS's proposal, dual eligible beneficiaries would be automatically enrolled in a participating Medicaid managed care plan that would manage their Medicare and Medicaid covered health care services. The beneficiaries would be able to "opt out" of the program after being notified of the plan in which they were enrolled.[7] Until actual enrollment begins for coverage effective January 2013, it is unknown how many beneficiaries will opt to remain in their current coverage elections. (DHCS's proposal does not provide an estimate.)

California's Proposal Should Address Outstanding Operational Questions

Of primary importance to us is that California acknowledge that dual eligibles are eligible for two complementary government programs, and that the demonstration should be additive. This demonstration should not result in them having some benefit package that is intrinsically less than, or less generous than Medicare, as that would be to undermine their eligibility in that program. Congress intended the two programs for this population to be additive and coordinated, not that the end result is less than the sum of the independent parts.

While the proposal is comprehensive in its discussion of many issues, it leaves several questions of interest to stakeholders unanswered. We lay out these questions below.

1. **Network adequacy assessments?** Dual eligible beneficiaries represent a diverse group of individuals including many with multiple chronic conditions that require access to a wide range of health care providers, including specialists. Ensuring that these beneficiaries have access to providers capable of meeting their individual needs will depend in large part on the provider networks established by participating health plans. Presently, provider participation in Medi-Cal is low, particularly for specialists.[8] DHCS's proposal indicates that health plans will be required to meet certain requirements related to provider network adequacy. These requirements are a positive first step. However, Genentech remains concerned that shifting responsibility to managed care plans, without providing additional reimbursement to providers, will not be sufficient to improve provider participation in the demonstration. We urge the state to fully evaluate this issue and develop specific beneficiary protections to ensure health plans include strong provider networks, with access to specialists as appropriate. In addition, we note that the network adequacy language indicates that plans will be required to meet "joint state and federal access standards for medical services and prescription drugs." This language should be strengthened to specifically state that plans will be required to meet higher Medicare adequacy requirements

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[4] Proposal, pp. 2, 33, 35.
[5] California Legislative Analyst Office, 2012. The 2012-13 Budget: Integrating Care for Seniors and Persons With Disabilities, at 20-23. Available at http://www.lao.ca.gov/analysis/2012/health/integrating-care-021712.pdf
[6] Per StateHealthFacts.org, Medi-Cal spending is approximately $40 billion per year and dual eligibles in California accounting for 41% of state Medi-Cal spending, or approximately $17 billion.
[7] Proposal, p. 10. It appears that California plans to request such a waiver from CMS to automatically enroll dua eligibles into managed care plans, but has not yet done so. Page 42 of the proposal refers to a "waiver submitted to implement mandatory Medi-Cal managed care enrollment for dual beneficiaries" in "April/May 2012."
[8] Primary care and specialty physician availability for Medicaid enrollees in California is only 66% and 40% of the availability statewide. See Peter Harbage, "Playing Catch-Up: California Can Improve Medi-Cal Access and Coverage By Obtaining Available and Additional Federal Support," February 2007. Available at http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/Playing%20Catch%20Up.pdf.

(ability to see any participating physician) in order to ensure dual eligibles have the same protections available to other Medicare beneficiaries.

2. **Medicare Beneficiary Protections.** Dual eligible beneficiaries participating in the demonstration should be afforded the full array of beneficiary protections provided under the Medicare program. Because dual eligibles are among the most vulnerable Medicare beneficiaries, these protections are critical to ensuring they do not lose access to services that would be covered under Medicare. These beneficiary protections include the ability to see any specialty provider in the network as has evolved under the Part B program without a gatekeeper function, access to protected classes of clinical concern under Medicare Part D formulary requirements, and the most protective aspects of the appeals processes available under the Medicare and Medi-Cal programs.

3. **Coverage for Medicare Part B Self-Administered Drugs.** The draft proposal does not specify whether Medicare or Medicaid coverage requirements would apply in cases where a particular medical service is covered under both programs. For example, there are a number of drugs that Medicaid would typically include in its pharmacy benefit that are also covered by statute under the Medicare Part B program. These include oral immunosuppressants for individuals receiving Medicare-covered organ transplants, oral anti-cancer therapies with an intravenous equivalent, immune globulins for those with primary immune deficiencies,[9] and drugs inhaled through durable medical equipment,[10] among many other categories. These drugs have been added to the Medicare Part B benefit because Congress saw it necessary to do so to ensure access to life-saving medical treatments for vulnerable populations, such as transplant recipients, cancer patients, and those with primary immune deficiency syndrome. Dual eligible beneficiaries should maintain access to these treatments as provided under the Medicare Part B program and should not be subjected to limitations that may exist for these services under the state's Medi-Cal program.

4. **Payment Adequacy for Medicare Part B Services**. The draft proposal indicates that California is also considering a Managed Fee-for-Service (FFS) model for the demonstration beginning in 2015. The following issue is of particular relevance for patient access to Medicare Part B services in the FFS environment. Under current law, Medicare reimburses physicians for Medicare Part B covered drugs based on the average sales price, and beneficiaries or secondary payers like Medicaid owe a 20% coinsurance based on the rate listed in the Medicare rate schedule. However, State Medicaid plans are not required to provide payment for cost-sharing, including coinsurance, to the extent that payment for the service would exceed the payment amount that would be made under the State Medicaid plan. Failure to pay coinsurance for physician-administered Medicare Part B drugs creates a financial disincentive for providers to continue to treat dual eligible beneficiaries, particularly when the reimbursement level falls below a provider's acquisition costs.[11,12] Medi-Cal is one of the state Medicaid programs that does not pay the beneficiary's outstanding 20% coinsurance for Medicare Part B drugs based on its current reimbursement rates. We urge DHCS to address this issue to ensure adequate reimbursement for Medicare Part B drug costs for physicians. Genentech addressed this issue in our letter to the

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[9] See SSA §1861(s)(2)(J), (Q), and (Z) for these categories, and elsewhere within 1861(s)(2) for other categories not named in this paragraph.
[10] See SSA §1861(n).
[11] See HHS OIG, Review of Selected Physician Practices' Procedures for Tracking Drug Administration Costs and Ability to Purchase Cancer Drugs at or Below Medicare Reimbursement Rates, A-09-05-00066 (July 2007, available at http://oig.hhs.gov/oas/reports/region9/90500066.pdf). The likelihood that payment rates are insufficient to cover their drug acquisition costs is higher if payment rates fell below 106% of ASP.
[12] A study by HHS found that reducing the Medicare cost-sharing paid by Medicaid reduced the likelihood that a dual eligible would have an outpatient physician visit and also reduced the number of visits the person would have; a 10% reduction in Medicaid cost-sharing payments reduced by 3% the likelihood of the patient having an outpatient visit. MedPAC, Report to the Congress: New Approaches in Medicare (June 2004), at 87.

Medicare-Medicaid Coordination Office's Request for Information Filed July 31, 2011.[13] Maintaining access to these treatments for dual eligible beneficiaries will help to improve outcomes, particularly for patients with serious, life-threatening illnesses including cancer.

5. **Administration of the Prescription Drug Benefit.** The DHCS proposal does not clarify how Medicare Part D prescription drug benefits will be administered for beneficiaries. The proposal notes that health plans participating in the demonstration will be responsible for the full range of services, including Medicare Part D benefits. However, there are no specifics offered regarding how the existing requirements under the Medicare Part D program will be applied. In order to ensure the new program does not disrupt continuity of care for dual eligible beneficiaries, Genentech urges DHCS to incorporate all Medicare Part D requirements into the program. To the extent that DHCS proposes to make any changes to Medicare Part D requirements, or alter coverage for prescription drugs or administration of the prescription drug benefit from Medicare Part D to Medicaid, the proposal should explicitly outline those changes. We understand the purpose of these programs is not to undo the protections and market mechanisms of Medicare Part D, reduce beneficiary access to covered services including Medicare Part D drugs, or affect manufacturer rebate requirements in order to achieve cost savings. In fact, as the state's budgetary calculations have indicated, savings under these demonstration programs will come from true care coordination, including enhanced access to LTSS.

Conclusion

Genentech appreciates this opportunity to provide comments to DHCS regarding its proposed methods for integrating care for this vulnerable population. If you have any questions or would like further information please do not hesitate to contact Stephanie Dyson, Senior Director for Government Affairs, at 202-296-7272 or via email at dyson.stephanie@gene.com.

Sincerely,

/ ELM /

Evan L. Morris, Esq.
Vice President, Government Affairs

[13] 76 Fed. Reg. 21896-28207, published in the Federal Register May 16, 2011. Available at http://www.gpo.gov/fdsys/pkg/FR-2011-05-16/pdf/2011-11848.pdf

Dear Director:

Due to the fact that time seems to be of the essence, please forgive me for not having the template but it would not download.

I would like to give praise to who ever is the author of the "Invitaiton to Provide Public Comment" document. The goal to implement and monitor a health system which improves health outcomes and promotes efficient healthcare is noble to say the least. However if the plan is to include at the initial start-up all Medicare/Medical patients known as"duals" to be migrated into various HMO systems, I fear this system will fail miserable.

I do not believe there is a system that could possible accommodate this large number of dual coverage patient population being moved into a HMO system all at once and still receive high quality healthcare. I work for a small speciality group of four Cardiologist in a private practice in Glendale California. When Medi-Cal implemented the HMO migration, many straight Medi-Cal patients did not want to be forced to join the HMO system. I suspect that the "dual" patients will have the same response. Most Medi-Medi (dual patients), do not have extra money to pay for the privilege of not being forced to joining an HMO which will not be able to deliver the same quality of care in a timely manner due to needing authorization, eligibility issues, etc.

I fear that the Coordinated Care Initiative: California's Dual Eligibles Demonstration will create a negative impact on quality patient care and to many private physicians who do not currently belong to any HMO's. I wonder if anyone has done any viability studies on the impact of such a move for Glendale California dual patients and physicians who currently are treating them outside of the HMO system?
I have seen a mirage of physicians panic over this issue because of the fear of the negative impact the migration of the dual patients will have on their practices and on patient care.

Since Governor Brown is an advocate for this initiative, perhaps he would be willing to join an HMO in Glendale and find out exactly what he is asking the dual coverage patients to be subjected to.

Sincerely,
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Glendale Internal Medicine and Cardiology

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May 2, 2012

To: Director's Office
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Re: HMS Comments on California Department of Health Care Services' Dual Eligible Integration Proposal

Health Management Systems (HMS) commends the current efforts by California and the Centers for Medicare and Medicaid Services (CMS) to improve the integration of services rendered and quality of care provided for its most vulnerable populations – those served by both Medicaid and Medicare. As the nation's leader in coordination of benefits (COB) and other cost containment solutions for Medicaid programs, we support these efforts and appreciate the opportunity to comment.

HMS Overview

HMS is the nation's leader in cost containment solutions for government-funded and commercial healthcare entities. Our clients include health and human services programs in more than 40 states; commercial programs, including over 150 Medicaid Managed Care plans; the Centers for Medicare and Medicaid Services (CMS); and Veterans Administration facilities. HMS helps these healthcare payers to ensure claims are paid correctly and by the responsible party. Overall, our services make the healthcare system better by improving access, impacting outcomes, containing costs, recovering dollars, and creating efficiencies. As a result of HMS's services, in 2011 our clients collectively recovered over $2.1 billion annually, and saved billions of dollars more by avoiding erroneous payments.

HMS in California

Since 1998, HMS has provided third party liability and worker's compensation identification and recovery services to California's Department of Healthcare Services (DHCS). Over the life of these contracts, HMS has recovered over $550 million on behalf of the State. In addition to these contracts, California DHCS recently awarded the Medicaid Recovery Audit Contractor request for proposal to HMS.

Dual Eligible Integration Initiative: The Capitated Model

In July 2011, CMS announced two new financing models to support efforts to integrate medical, behavioral and long term care services for dual eligibles. Our comments specifically apply to the capitated model, which California selected in their proposal.

The blended capitated model will combine Medicaid and Medicare payments in such a way that there will no longer be a distinction between payors. This methodology fundamentally changes the structural and financial relationship between Medicaid and Medicare. As those relationships change, so will the way States and CMS perform cost containment and oversight activities for this population's claim set. As California finalizes their dual integration plan, we ask you that consider the following:

Net Savings Calculations

How are current cost savings and recovery efforts employed by Medicare and Medi-Cal being incorporated into the evaluation of the model's cost effectiveness?

Today, states have numerous and ongoing cost containment efforts underway for Medicaid, such as utilization review, overpayment recovery audits, coordination of benefit activities, and other types of audits and clinical

review activities that generate millions of dollars annually in prospective savings and cash recoveries to States. Under the current proposal, it is unclear how the state and CMS will ensure that the savings from these activities are maintained as duals move into an integrated model, and how the savings from these efforts will be reflected in premium sharing calculations. The goal of these demonstrations is to provide real savings above current levels. Consequently, these saving should reflect current expenditures net current program integrity efforts. Without this consideration, the old and new program structures are not a true "apples-to-apples" comparison.

Coordination of Benefits (COB)

How will the State proactively identify duals with other coverage?
HMS estimates that approximately 2% of duals nationally have other commercial coverage. For Medicaid, COB rules are governed by payor of last resort status, codified in state and federal law. Contrary to Medicaid, Medicare does not enjoy the same payor of last resort status. Instead, Medicare Secondary Payor rules govern how Medicare coordinates benefits. Appropriate coordination of third party benefits saves government program billions of dollars annually.

The California's Duals Eligible Proposal excludes beneficiaries with other health coverage from the demonstration. HMS believes this structure makes sense in order to preserve Medi-Cal's payor of last resort status. However, the State should give careful consideration to the proactive identification of other insurance at the point of application and enrollment, and then again with frequent ongoing checks.

Will the State disenroll Duals if other health coverage is found after enrollment into the Demonstration?
Other insurance identification is a dynamic and complicated process. For example, a beneficiary may gain access to and enroll in employer sponsored coverage after enrollment into the Demonstration. The assumption for withholding these individuals from the Demonstration is that it is more cost effective to allow the commercial primary carrier to pay for medical services than the State or CMS under the integrated plan. How will the state proactively identify other coverage after the point of enrollment? If credible other coverage is found, will the State disenroll from the Demonstration?

Eligibility

Is retro-eligibility allowable?
On occasion, CMS determines retro eligibility for a Medicare applicant. Today, when retro eligibility for Medicare is determined, Medicaid recovers the cost of claims paid during the identified retroactive period of eligibility through a provider disallowance process. Under the Medi-Cal-Medicare integration capitated model, will a member deemed retroactively eligible for Medicare be retroactively enrolled in an integrated plan? If yes, who is financially responsible for healthcare costs paid during that retroactive period? How will costs be reconciled with fee for service or Medi-Cal Managed Care payments already made within that period?

Is there an eligibility waiting period?
Numerous states impose a 30-90 waiting period for eligibility in Medicaid managed care. In the meantime, Medicaid FFS usually pays the claims incurred during that time. Will the duals integration plan impose a waiting period?

Are Medicare Buy-In populations included?
Medicare buy-in is the management and payment of Medicare premiums by Medicaid. Based on their State Plan, Medicaid agencies pay part B and part A premiums for specific categories of Medicare eligible recipients. How will enrollment in an integrated model impact this group? How would these changes handle recipients within optional buy-in coverage groups? What changes would take place to the buy-in premium payment mechanism?

Program Integrity

What data is available for program integrity activities in this new model?
For Medicaid FFS program integrity activities, claims and eligibility data is often the reference point. Medicaid Managed Care plans use encounter data. HMS recommends that a robust data set be collected to allow for comprehensive quality and program integrity reviews. At a minimum, we recommend states collect the same

encounter data sets required from Medi-Cal Managed Care plans. The data set should also include the patient cost of care and/or any factors used to calculate the cost of care applied to a given claim.

How is patient cost of care for long term care (LTC) services calculated in the integration plan?
In Medicaid FFS, a portion of the recipient's monthly income (pension, social security, etc.), commonly known as the *Patient Cost of Care*, offsets the Medicaid amount paid by the state to the LTC provider.

If patient cost of care is calculated, who is responsible for monitoring it – the State, the care management entity?
Today, in Medicaid FFS, the patient cost of care is typically sent directly to the LTC provider; however, that is tracked by the fiscal intermediary and Medicaid payments to that LTC provider are offset accordingly.

HMS Recommendation

HMS's mission is to improve the effectiveness of the healthcare system. We support efforts to better coordinate care, improve the quality of care, and reduce costs of care delivery for all populations, but especially the costly and most vulnerable dually eligible population. In keeping with the spirit of CMS's initial proposal, and to stay true to our mission, we strongly encourage California to survey, calculate, and account for all costs savings activities already underway for the dual eligible population. This measurement is necessary to calculate the true net savings associated with moving the duals into the integration plans.

Additionally, HMS recommends that CMS and California contemplate the above preliminary comments and questions around coordination of benefits and eligibility prior to the release of a final integration plan.

HMS also encourages the pursuit of program integrity initiatives in this new model. Maintaining the fiscal integrity of programs through fraud, waste, and abuse efforts is a critical piece in meeting the goals of the integration plans. To that end, a robust data set must be collected and analyzed. Furthermore, we encourage the use of proper incentive structures to ensure maximization of program integrity efforts.

We look forward to engaging with you on these topics as you work towards a successful implementation of the program. If you have any follow up questions, please do not hesitate to contact Lori Karaian (415) 738-0758, lkaraian@hms.com.

Thank you again for the opportunity to comment.

Sincerely,

Lori Karaian
Division Vice President State Government Relations
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Sacramento, CA 95014

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healthy is for everyone
www.hpsm.org

May 4, 2012 **SENT VIA ELECTRONIC EMAIL TO:**
info@calduals.org

Toby Douglas
Director, Department of Health Care Services
California Health and Human Services Agency
1501 Capital Avenue
Sacramento, CA 95899

RE: Comments on Proposed Coordinated Care Initiative (CCI)

On behalf of the Health Plan of San Mateo (HPSM) and our county partners, I would like to commend DHCS, the Governor, and CMS for its bold plans to implement dual eligible demonstration pilots and eventual adaptation of proven care integration approaches throughout the State of California. We are tremendously excited to be selected as one of four counties to begin this process. We thank the State for its confidence in San Mateo County and HPSM, and the willingness to partner with us in this important program.

We would like to take this opportunity to comment on the draft proposal to CMS dated March 23, 2012. My questions and comments that begin on page 2 of this letter utilize the template provided and follows the structure of the draft proposal.

HPSM is a County Organized Health System (COHS) serving vulnerable residents of San Mateo County since 1987. HPSM serves more than 100,000 members through multiple coverage programs including Medi-Cal, Healthy Families, Medicare Advantage and other local coverage initiatives. HPSM has participated in the Medicare Advantage Special Needs Program (SNP) program since its inception in January 2006. HPSM's SNP is only one of two Dual Eligible Special Needs Plans (D-SNPs) available in San Mateo County. Approximately 60 percent, or 8,400, of all duals in San Mateo County are currently enrolled in our D-SNP plan.

Again, thank you for your vision and please view this document as a statement of overall support for the State's efforts to improve the quality of care for California's dual eligible population. We look forward to an ongoing dialogue about these critical issues with you and your staff as well as with CMS. I can be reached at maya.altman@hpsm.org or (650) 616-2145.

Sincerely,

Maya Altman,

Chief Executive Officer

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
	7	Population: Share of Cost Beneficiaries	We urge that DHCS include all duals with Medi-Cal Share of Cost as part of the Demonstration, and not limit enrollment to those who are in long term care facilities. Share of cost is a barrier to coordination of Medicare and Medi-Cal benefits which is the very issue that the Demonstration seeks to address. Inclusion of all duals with Medi-Cal Share of Cost for the Demonstration would be consistent with existing CMS D-SNP policy. Currently, some duals convert to share of cost Medi-Cal from full-scope Medi-Cal while they are enrolled in HPSM's D-SNP – this occurs during the annual redetermination process (and is sometimes in error). A beneficiary who does not meet his/her share of cost is at risk of being disenrolled from a D-SNP due to "loss of Special Needs Status." Existing CMS guidelines allow a deeming period for up to six (6) months for beneficiaries who lose special needs status. To accommodate this scenario, the HPSM D-SNP is allowed to enroll duals with share of cost Medi-Cal as long as they meet their share of cost at least once every six (6) months. The following is an excerpt from the Medicare Managed Care Manual, Chapter 2, Medicare Advantage Enrollment and Disenrollment, section 50.2.5: "*A SNP must continue to provide care for at least one full calendar month for a member who no longer has special needs status, as long as the plan can provide appropriate care and the individual can reasonably be expected to again meet the special needs criteria within six (6) months. For example, a dual eligible individual who loses Medicaid eligibility can be deemed to continue to be eligible for the plan if that individual would likely regain eligibility within six months. The SNP may choose any length of time from one month to six months for deeming continued eligibility, as long as it applies the criteria consistently to all members of the plan and fully informs members of its policy."* The six (6) month deeming period would: a) prevent disruptions in care that would result if

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
	8	Population: Children Under Age 18	Please clarify what happens with children in IHSS? San Mateo County data shows that approximately 200 CCS kids receive IHSS hours. The CCS pilot excludes LTSS and the Trailer Bill Language dated 04/04/2012 exempts children in a CCS pilot from the Demonstration. For Demonstration counties, the State is proposing that all LTSS services – including IHSS and nursing facility services, be available only through Medi-Cal managed care plans beginning January 1, 2013. If managed care plans are ultimately responsible for LTSS anyway, we recommend all children be eligible, including CCS kids, for the Demonstration. This would be consistent with the overall goals of integrating all services and finances so that incentives are properly aligned for managed care plans and providers.

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
	8	End State Renal Disease (ESRD)	We understand that CMS is considering excluding individuals with ESRD from the Demonstration. We strongly encourage that these individuals be allowed to remain in the Demonstration. HPSM fully supports the policy that no full benefit dual eligible will be excluded form the Demonstration based on specific diagnostic categories. As a COHS plan, all beneficiaries (including individuals with HIV/AIDS, ESRD, ALS and those who are institutionalized for longer than 90 days) are already HPSM Medi-Cal members, and excluding them from the pilot would be extremely disruptive for the care of these members. Such exclusions do not exist for our D-SNP with the exception of beneficiaries with a *pre-existing* ESRD condition, an exclusion we are forced to follow per Medicare Advantage rules. Yet we see many opportunities for more effective care coordination if beneficiaries with ESRD were included in the pilot. Overall we feel strongly that a more integrated, coordinated delivery system should be available to all beneficiaries; otherwise, there is the danger of pilot sites cherry picking which beneficiaries to manage, often leaving those with the greatest needs to fend for themselves in the fee for service system.
	9	Person-Centered Care Coordination	Please clarify the statement "All sites will offer personcentered care coordination as an essential benefit." This statement suggests that all duals enrolled in the Demonstration will be offered care coordination. It is our understanding that all duals in the Demonstration would receive an initial health risk assessment and be involved in the development of an individualized care plan, but care coordination will be limited to those duals that would benefit form care coordination. Care coordination is a resource-intensive activity and should be targeted to higher risk individuals who could achieve better health outcomes with care coordination.

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
	10	Enrollment Process	The draft proposal states that "Enrollment will be implemented on a phased-in basis throughout 2013." HPSM has the local support and the organizational capacity to handle passive enrollment of all eligible duals in San Mateo County on January 1, 2013. HPSM passively enrolled approximately 9,000 duals in 2006 into our Medicare Advantage Special Needs Plan (SNP); 91 % remained in our plan. Currently, approximately 60% of all duals in San Mateo County are enrolled in our SNP, and as a result, only 6,000 duals will be eligible for passive enrollment as part of the Demonstration. While we support a phased-in approach for other Demonstration counties with a much larger duals population, we believe San Mateo County should be allowed to passively enroll all eligible duals on day one. Current Trailer Bill Language (dated 04/04/2012) gives the DHCS Director discretion to implement the most appropriate enrollment approach. We also support the incorporation of all LTSS services into HPSM's service offerings on January 1, 2013, in conjunction with the start of the Demonstration. We do not support a phased approach in this county, which we believe will unnecessarily confuse beneficiaries and lead to a great deal of administrative complexity and greater likelihood of errors.

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
	11	Medicare Marketing	Please clarify the statement in the second paragraph that reads "health plans may also partner with current providers and case managers to explain the benefits of participating in the demonstration." Current Medicare Advantage marketing guidelines prohibit providers from steering beneficiaries to any specific plan. We believe these restrictions should be modified for the Demonstration. An ability to work with physicians to encourage their patients to join and/or remain with the Demonstration is vital for the overall success of the Demonstration and for ensuring beneficiaries receive comprehensive and timely information about the Demonstration from a source they trust, namely their physicians.
	12	Additional Benefits	It is unclear whether health plans will have the ability to offer appropriate alternative services (which are often much less expensive) and that those expenses will be recognized in capitation rate development, such as is the experience with PACE programs. Please confirm that DHCS intends to work with CMS and plans to explore housing as a supplemental benefit. HPSM and other Demonstration plans should have the flexibility, similar to PACE programs, to provide nonMedi-Cal funded services, or gap services, as needed – such as services provided in residential housing (e.g., assisted living or board and care), home modification services, or any other alternative service that can help prevent institutionalization. This flexibility is critical because appropriate housing is a key factor in unnecessary institutionalization in San Mateo County.

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
	21	MSSP	Please clarify whether current MSSP regulations will continue and remain separate as part of the Demonstration during year one. Please clarify whether the cap and ratios will continue to be required. Please clarify whether Demonstration plans would have the flexibility to provide MSSP benefits (like home modifications) to those under 65 during the Demonstration? It will be difficult for health plans to offer services in a more streamlined fashion if current categorical restrictions and administrative requirements for programs such as MSSP and IHSS do not change. We encourage DHCS to include a goal for all involved state agencies (DHCS, DSS, Department of Aging, etc.) to develop uniform reporting requirements across programs and agencies that eliminate the duplicative, restrictive, and burdensome reporting requirements associated with individual categorical programs.
	34	Data Sharing	We fully support data sharing of both de-identified and member-specific data prior to enrollment. This data is critical to ensure continuity of care and a smooth transition during passive enrollment.
	35	Medicare STAR Ratings	We are concerned that the State intends to replace the Medicare STAR Ratings system for the Demonstration. While we do not think that the STAR system is perfect, Demonstrations plans with D-SNP experience have existing infrastructure to support STAR measurement and reporting. An alternative approach would require at least a full year for stakeholder input, testing and approval. For this reason, we recommend the State: a) builds on and modifies the existing STAR system during the three year Demonstration and b) works toward a new Medicare performance system for implementation in 2016.

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
	35	Quality Measurement and Evaluation	Will there be stakeholder input opportunities in the development of quality assurance measures and development of outcomes dashboard?

HEALTHSOUTH

May 4, 2012

Mr. Toby Douglas
Director
California Department of Health Care Services
1501 Capitol Avenue
Post Office Box 997413
Sacramento, California 958990-7413

SUBMITTED VIA EMAIL: *info@CalDuals.org*

Re: Comments on Dual Eligible Demonstration

Dear Director Douglas:

We are writing in connection with the "Coordinated Care Initiative: California's Dual Eligibles Demonstration" (referred to herein as "draft document" or "demonstration"). We are CEOs of HealthSouth-Bakersfield Rehabilitation Hospital and HealthSouth-Tustin Rehabilitation Hospital, 60 and 48 bed freestanding rehabilitation hospitals, respectively. HealthSouth is the national leader in rehabilitation hospital care and services, operating 99 freestanding rehabilitation hospitals (otherwise known as inpatient rehabilitation facilities, or "IRFs") in 27 states and Puerto Rico. Our 99 hospitals operate approximately 6,500 beds and provide services to nearly 25% of all patients treated in IRFs each year. In California, there are just over 120 IRFs, most of which are hospital-based inpatient rehabilitation units, and they operate approximately 2,100 beds.

We appreciate the fiscal challenges confronting the federal Medicare and California Medi-Cal programs, and welcome the opportunity to work with both programs to achieve the demonstration's goals of improving health outcomes, promoting efficiency, and allowing patients to remain in their homes and communities for as long as possible. California IRFs are well-positioned to make positive contributions toward achieving each of these important objectives, though we have concerns about how this demonstration may possibly impact Medicare beneficiaries' access to IRF care.

The draft document indicates that the demonstration's scope of benefits will include Medicare Part A services (which includes rehabilitation hospital services) and that the networks will be comprised of providers who provide all covered services. However, neither the extent to which IRF services will be a covered benefit (as well as how IRF coverage decisions would be

made) nor a framework permitting post-acute care ("PAC") rehabilitation providers' quality of care to be evaluated are clearly specified within the draft document. It is very important that the demonstration be developed and implemented in a fashion that maintains, and does not reduce, Medicare beneficiaries' access to *medical rehabilitation* services provided by IRFs under Medicare Part A, and that PAC rehabilitation providers be subjected to an appropriate quality framework.

If not properly structured, the demonstration may expose Medicare patients to the risk that critically important distinctions between their needs for "rehabilitation" versus "medical rehabilitation"--and the care-setting in which those needs are most effectively met--could be displaced in favor of simple per-diem cost comparisons without regard to their overall length-of-stay, discharge destination, functional improvement, the intensity of care and services they receive and other important quality measurements.

We therefore respectfully request that: **1)** the demonstration's scope more precisely clarify that IRF services would be provided as a benefit to Part A dual-eligible beneficiaries, just as they are currently provided to such beneficiaries (and that such services continue being reimbursed in accordance with current fee-for-service policies); **2)** that the policies and rules governing coverage of IRF services in the demonstration will be those currently in effect and utilized under traditional fee-for-service Medicare, with a particular reliance upon the role of rehabilitation physicians in determining the medical appropriateness of such services; **3)** that sufficient safeguards permitting expedited review of IRF coverage disputes, and mechanisms encouraging transparency between the plans and providers, be incorporated in order to ensure that Medicare beneficiaries' access to IRF services would not be inappropriately eroded; and, **4)** that the program establish a sufficient framework to evaluate the quality of care provided by PAC rehabilitation providers.

I. Medicare & Post-Acute Care: General Background

Medicare spends nearly $60 billion annually for PAC services through four distinct payment systems, with the bulk of these expenditures occurring in the skilled nursing facility ("SNF," or nursing home) and home health prospective payment systems—in 2010, Medicare fee-for-service expenditures for SNF and home health services were $26.4 and $19.3 billion, respectively. By comparison, expenditures for IRF and long-term acute care hospital ("LTACH") services during the same period totaled $6.4 and $5.1 billion, respectively.

IRF services are a specified benefit under Medicare Part A pursuant to 42 U.S.C. §1395x(b),(e) and are reimbursed through the Medicare Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") established under 42 U.S.C.§1395ww(j). The IRF-PPS is comprised of more than 350 case-specific rates that account for patients' age, functional impairments, and medical comorbidities. Rates are further adjusted at the case level to account for

exceptionally high-cost cases (outliers); transfer cases; interrupted stays; short stays; or patients who expire. The rates are adjusted at the facility level to account for an IRF's status as rural; teaching; the mix of low-income patients it treats; and its physical geographic location. Other Medicare Part A payment systems have similar payment adjustments, though the draft document does not specify how these types of adjustments would be accounted for in the development of provider rates. Providers should continue to be reimbursed under current fee-for-service reimbursement payment systems and various adjustments associated with those systems.

Approximately 70% of patients treated in HealthSouth rehabilitation hospital are Medicare fee-for-service beneficiaries; more than 90% of them come to our hospitals directly upon discharge from an acute care hospital; and their average length of stay is just under 14 days (by comparison, the Centers for Medicare and Medicaid Services ("CMS") has observed that the average length of stay for Medicare Part A SNF/nursing home patients is approximately 30 days). Since 2004, annual expenditures under the IRF PPS have been in the range of approximately $6 billion to $6.5 billion, representing just over 1% of the overall Medicare budget. Medicare's so-called "cost curve" for IRF spending has remained largely flat for the past several years. In short, the IRF sector does not pose as a "growth problem" for the Medicare program.

II. Maintaining Patients' Access to IRF Services

As discussed in more detail below, there are rigorous coverage and medical necessity criteria governing the IRF benefit within the Medicare Part A fee-for-service program, which were updated and implemented by CMS in 2010. These criteria permit Medicare beneficiaries who need IRF services to receive them. When evaluating the PAC rehabilitative care needs of patients within the demonstration and where those needs should be met, the coverage policies and patient admission criteria governing the current Medicare Part A IRF benefit should be applied in the demonstration.[1] In a "Question and Answer" document issued earlier this month in connection with the capitated payment model, CMS addressed the question of coverage and medical necessity, as follows:

> Question. How will a demonstration plan determine whether a certain item or service is medically necessary?
>
> Answer: We expect Medicare criteria to be used for services for which Medicare is primary and Medicaid criteria to be used for long term supports and services not covered under Medicare. More information is to be determined by a given State and CMS as a part of the MOU negotiation process that will follow the State submission of a proposal.[2]

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[1] *See* generally, 42 C.F.R. §412.622(a)(3) *et seq*; *see also*, "Medicare Benefit Policy Manual," Chap. 1, §110 (accessible at: http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf).

[2] "Medicare-Medicaid Coordination Office Financial Alignment Demonstration, Capitated Model Frequently Asked Questions" (accessible at: http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CapitatedFinancialAlignmentDemonstrationFAQs.pdf).

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(Emphasis added).

Ensuring that a sufficient number of IRFs are included in the networks also would be important, but ensuring that Medicare beneficiaries who need IRF services *actually receive* those services would be even more important. Current and historical coverage decisions of Medi-Cal managed care plans for IRF services provide little comfort that dual-eligible Medicare beneficiaries who are currently able to access IRF services under traditional fee-for-service will be able to continue accessing those services on a consistent basis under the contemplated demonstration. Our experience has been that many Medi-Cal managed care patients who need IRF services oftentimes are forced to receive their rehabilitation in SNFs/nursing homes. We are, respectfully, concerned that some Medi-Cal plans simply view SNFs/nursing homes as an acceptable substitute for an IRF level of care, notwithstanding that the intensity and frequency of medical, rehabilitative, and nursing care and services provided in IRFs is fundamentally different than that of SNFs/nursing homes.

It would be important for the demonstration to include a "real time" appeals mechanism that can afford Medicare beneficiaries the right to appeal a "discharge destination" decision for PAC services with which they may disagree. Otherwise, a multi-day appeal process oftentimes (if not always) will result in a patient being discharged to a SNF/nursing home prior to his/her grievance being properly addressed for purposes of determining where he/she should receive rehabilitative care. It would also be important for the demonstration's managed care plans to undergo sufficient training and education activities on Medicare fee-for-service IRF coverage criteria and patient admission policies; to be transparent with the provider community regarding how it would interpret and apply those criteria and policies; and to ensure that coverage decisions are applied consistently across all networks.

Although the draft document indicates that many Medi-Cal managed care plans have experience with administering Medicare Advantage ("MA") plans, many MA plans, similar to the Medi-Cal plans, do not utilize fee-for-service IRF coverage and admission criteria but instead oftentimes simply substitute SNF/nursing home rehabilitation care for IRF care. This practice would be particularly odd in this demonstration, since one of its objectives is to encourage less utilization of SNF/nursing home services.

When considering the quality and costs associated with PAC rehabilitation, it is worth noting that CMS recently disputed the assertion by commenters as part of the FY 2012 SNF PPS rulemaking process that SNFs/nursing homes provide less costly PAC rehabilitation services as compared to IRFs while attaining essentially identical outcomes. CMS refuted the assertion, stating as follows:

> ... shifting IRF patients toward SNF care does not necessarily improve the quality of care provided to the beneficiaries. A March 2005 report in the Archives of Physical Medicine and Rehabilitation found that 81.1 percent of IRF patients were discharged to home, compared to 45.5 percent of SNF residents. Additionally, IRF patients appeared to have shorter lengths of stay, averaging approximately a 13-day stay, compared to the average 36-day stay for a SNF resident. Finally, when patients discharged from each

> setting were reviewed 24 weeks after discharge, IRF patients had consistently better outcomes and displayed a faster rate of recovery. *Given these findings, we do not agree with those commenters who would assume that shifting patients from the IRF setting to a SNF setting is necessarily more beneficial to the patient or the Medicare Trust Fund.*

76 Fed. Reg. 48,486, 48,499 (August 8, 2011) (emphasis added).

Of course, we would anticipate that ongoing data monitoring would occur, such as benchmarking the prevalence of IRF services over time within the markets comprising the demonstration, and that the results of such monitoring would be shared with the provider community and other interested stakeholders. Apart from these types of monitoring activities, however, it would also be important to ensure that IRFs and our rehabilitation physicians not be precluded from evaluating Medicare Part A beneficiaries' potential eligibility for IRF services during their discharge stage from acute care hospitals. As outlined below, a central principle of Medicare's IRF benefit is that rehabilitation physicians are optimally suited to determine whether beneficiaries need an IRF level of care. This principle should not be displaced by patient discharge or care transition strategies or processes within the demonstration that do not effectively permit, or may even preclude, physicians who are skilled and trained in rehabilitative medicine from exercising their informed judgment about Medicare patients' rehabilitative care needs and admitting patients to IRFs based upon that judgment.

III. IRFs and IRF Services Defined By Rigorous Requirements

A.) 60% Rule

IRFs are defined by various regulatory and policy requirements that have been established for the level of care we provide our patients. Chief among these is a statutory-based rule called the "60% Rule," which requires IRFs to treat 60% of all patients (Medicare and non-Medicare) whose condition falls on a specific list comprised of 13 medical diagnoses, including cases involving stroke; neurological disorders; hip fracture; brain injury; spinal cord injury; major multiple trauma; amputation; burns; congenital deformity; certain joint replacement cases; and certain other orthopedic and arthritic-related cases.[3] CMS characterizes this requirement as a means by which IRFs are "distinguish[ed]...from other inpatient hospital settings of care, including acute care hospitals and traditional post-acute care settings (such as skilled nursing facilities). The 60 percent rule specifies that an IRF's patient population must consist of at least 60 percent of the patients who need *intensive* rehabilitation services for one or more of 13 specified conditions." 73 Fed. Reg. 46370, 46388 (August 8, 2008) (emphasis added).

Of course, this policy should not be interpreted to mean that only patients with conditions satisfying the 60% Rule requirement are appropriate for IRF treatment. It does, though, serve as a general reference point when considering the *medically* intensive patient population served by

[3] 42 C.F.R. §412.23(b)(2)(i) (subsequently amended by Sec. 115 of Pub. Law 110-173).

IRFs. No other PAC rehabilitation provider is required to treat a specified percentage of its patients from a particular list of medical conditions or diagnoses.

B.) IRF Coverage & Admission Criteria Driven By Rehabilitation Physicians: The *Medical* Component of "Medical Rehabilitation"

The following discussion highlights several key requirements that IRFs must satisfy under the Medicare program. This list is not all-encompassing--for example, it does not touch upon the various Conditions of Participation requirements that rehabilitation hospitals and units must meet, though they are identical to those of general acute care hospitals by virtue of their status as rehabilitation "hospitals." These Conditions include evaluation, planning and provision of medical care by appropriately trained, competent physicians. Rather, the discussion highlights key elements of particular regulations and policies that demonstrate the *medical* component of the rehabilitation care and services that are provided only by IRFs and that distinguish this level of care from other PAC rehabilitation providers. In short, whereas SNFs/nursing homes and other less intensive PAC providers provide "rehabilitation," only IRFs provide intensive "medical rehabilitation" led by rehabilitation physicians and carried out on a consistent multi-disciplinary basis.

a.) Requirement For Medical Director Specializing In Rehabilitation Medicine

IRFs are required to have medical directors with specialized training in medical management of inpatients requiring rehabilitation.[4] Rehabilitation physicians (whether physiatrists or other doctors and medical practitioners specializing in rehabilitation medicine) recognize and address coexisting medical and functional impairments which oftentimes are not mutually exclusive but rather are coexisting and influence each other. Rehabilitation physicians bridge the divide between medical and functional impairments, monitoring and treating both as warranted. Many medical conditions actually develop as a consequence of injury and are nearly exclusive to rehabilitation, such as autonomic dysreflexia (which may occur following spinal cord injury). The advanced training of rehabilitation physicians permits them to recognize and treat conditions which oftentimes may not be fully understood by many other physicians and medical practitioners who do not have specialized training in rehabilitation medicine. No other PAC rehabilitation provider is required to have a medical director with specialized training in the medical management of inpatients requiring rehabilitation care and services.

b.) Patients Admitted To IRFs Must Be Approved By Rehabilitation Physicians

Patients treated in IRFs must be admitted by rehabilitation physicians. Such approvals must occur prior to or at the time of a patient's admission and must be based upon the physician's review of a pre-admission evaluation of the patient that is conducted by clinicians designated by the rehabilitation physician.[5] No other PAC rehabilitation provider is required to

[4] 42 C.F.R. §412.23(b)(5); §412.29(f).

[5] 42 C.F.R. §412.622(a)(4)(i); Medicare Benefit Policy Manual, Chap.1 §110.1.1.

secure the approval of a rehabilitation physician for each patient prior to the patient's admission to receive rehabilitation care and services.

c.) Rehabilitation Physicians Must Conduct Post-Admission Evaluations For Each Patient

Within 24 hours after each IRF patient has been admitted, the rehabilitation physician is required to conduct a post-admission evaluation documenting the patient's admission status, including a comparison with the pre-admission screening information.[6] No other PAC rehabilitation provider is required to have a rehabilitation physician conduct this type of post-admission review for each patient it admits.

d.) IRF Patients Must See A Rehabilitation Physician At Least 3 Times Per Week

Patients treated in IRFs must have a documented need requiring physician supervision by a rehabilitation physician. Each patient must have a need to be seen, via face-to-face visits, by a rehabilitation physician at least 3 days per week throughout the patient's stay in the IRF. During these visits, rehabilitation physicians must assess the patient medically and functionally, and modify the patient's course of treatment as needed to maximize his/her capacity to benefit from the rehabilitation process.[7] No other PAC rehabilitation provider is required to have their patients seen by a rehabilitation physician or that they see a rehabilitation physician via face-to-face visits at least 3 days per week throughout the duration of their stay.

e.) Rehabilitation Physicians Must Develop Patients' Overall Plan of Care

Each patient admitted to an IRF must have an overall plan of care developed by a rehabilitation physician and documented in his/her medical record. The care plan must detail the patient's medical prognosis and anticipated therapy interventions (including number of hours of therapy per day; number of days per week therapy will be provided; and total number of days therapy will be provided), functional outcomes and discharge destination.[8] No other PAC rehabilitation provider is required to have this level of involvement of a rehabilitation physician in the development of a patient care plan.

f.) Weekly Interdisciplinary Team Meetings Must Be Led By A Rehabilitation Physician

The care and services provided to each patient in IRFs are frequently monitored by rehabilitation physicians. Rehabilitation physicians must lead weekly meetings for each of their patients with professional rehabilitation staff who have current knowledge of the patient, including registered nurses with specialized training or experience in rehabilitation; a social worker or case manager; and a licensed or certified therapist from each therapy discipline

[6] 42 C.F.R. §412.622(a)(4)(ii).
[7] 42 C.F.R. §412.622(a)(3)(iv).
[8] 42 C.F.R. §412.622(a)(4)(iii).

treating the patient.[9] No other PAC rehabilitation provider is required to hold meetings led by rehabilitation physicians at this frequency or with staff participation at this level.

g.) Intensive Therapy Requirements

With few exceptions, all IRF patients, regardless of their diagnosis, must have a need for and receive therapy at least 3 hours per day, 5 days per week (or otherwise receive 15 hours of therapy per week). Therapy must be initiated within 36 hours from midnight of admission day.[10] No other PAC rehabilitation provider is required to provide therapy at this level of intensity and frequency.

IV. Quality of Care & Outcomes

The draft initiative mentions quality in a number of places though does not specify how PAC rehabilitative care providers would be evaluated in the area of quality and patient outcomes. Several of the demonstration's objectives--improving quality and outcomes and allowing patients to spend more time in their homes and communities--array with key quality measures that are central to IRF care. For example, patients' "discharge to community" rates are a core outcome measurement which IRFs follow closely; in 2011, HealthSouth's national discharge to community rate was 75%. Similarly, our hospitals strive to keep transfers to acute care hospitals ("discharge to acute") as low as possible; in 2011, HealthSouth's national discharge to acute rate was just over 11%. [MAY WANT TO INCLUDE HLS-CA SPECIFIC DATA HERE?]. In the area of functional independence measure ("FIM"), or functional improvement, we are national leaders; in 2011, HealthSouth hospitals achieved an average FIM gain of nearly 33 points.[11]

Additionally, our company is currently developing several initiatives in the area of quality improvement, including the establishment of a clinical information system comprised of an electronic medical record. This will provide our hospitals with the ability to coordinate care more efficiently and to have direct linkages with our referral sources, which will prove valuable in an integrated care environment. We have also implemented a comprehensive patient satisfaction program. Finally, we have developed a "Care Management" process, several components of which emphasize quality improvement, operational efficiencies, and more patient involvement in care decisions.

All PAC rehabilitation providers should be evaluated and judged on their demonstrated ability of providing high quality care to patients. Cost considerations are undoubtedly important to the demonstration, though such comparisons should include other costs as well, such as those associated with hospital readmissions. Patients' discharge destinations and functional outcomes should also be appropriately accounted for as well.

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[9] 42 C.F.R. §412.622(a)(5).

[10] 42 C.F.R. §412.622(3)(ii).

[11] FIM gain is the difference between a patient's admission FIM and discharge FIM. FIM is a quantifiable, scaled series of quality/outcome measurements relating to patients' performance on self-care; sphincter control; transfers; locomotion; communication; and social cognition, that are incorporated into the Inpatient Rehabilitation Facility Patient Assessment Instrument, or "IRF PAI."

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V. Conclusion

If properly developed and implemented, this demonstration offers the potential to improve the quality of care provided to California's dual-eligible population and encourage more coordinated care among healthcare providers. As the process moves forward, we recommend that: **1)** the demonstration's scope more precisely clarify that IRF services would be provided as a benefit to Part A dual-eligible beneficiaries, just as they are currently provided to such beneficiaries (and that such services continue being reimbursed in accordance with current fee-for-service policies); **2)** that the policies and rules governing coverage of IRF services in the demonstration will be those currently in effect and utilized under traditional fee-for-service Medicare, with a particular reliance upon the role of rehabilitation physicians in determining the medical appropriateness of such services; **3)** that sufficient safeguards permitting expedited review of IRF coverage disputes, and mechanisms encouraging transparency between the plans and providers, be incorporated in order to ensure that Medicare beneficiaries' access to IRF services would not be inappropriately eroded; and, **4)** that the program establish a sufficient framework to evaluate the quality of care provided by PAC rehabilitation providers.

Thank you for your consideration of these views, please feel free to contact either of us via email (Sandra.Hegland@healthsouth.com or Paula.Redmond@healthsouth.com) should you have any questions.

Regards,

Sandra Hegland
CEO / HealthSouth-
Bakersfield Rehabilitation Hospital

Paula Redmond
Interim CEO / HealthSouth
Tustin Rehabilitation Hospital

Cc. C. Duane Dauner / California Hospital Ass'n

Sandra Hegland

HEALTHSOUTH.

V. Conclusion

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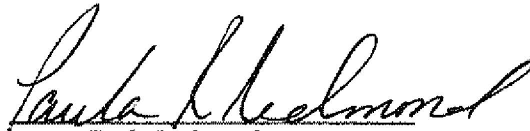
Thank you for your consideration of these views, please feel free to contact either of us via email (Sandra.Hegland@healthsouth.com or Paula.Redmond@healthsouth.com) should you have any questions.

Regards,



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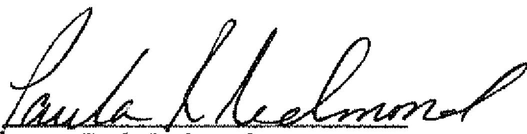

Comment #1 page 6 Regarding HCBS language
Enhanced community based services should specifically include behavioral health services.

Comment #2 page 9 Regarding Person-Centered Care Coordination language
Individual health risk assessments should specifically include language about a behavioral health assessment for every beneficiary.

Comment #3 page 16 Regarding For seriously mentally ill beneficiaries…
There a numerous dually eligible beneficiaries, particularly in the older adult age range who are in need of mental health services but who do not currently access those services due to factors such as stigma, lack of access under Medicare rules, lack of recognition of symptoms on the part of primary care, etc. Serving the behavioral health needs of these beneficiaries will undoubtedly decrease long term physical health care costs. Unfortunately, there are not very many studies currently available that exhibit this cost savings. These beneficiaries need to be served with the full range of mental health services available to their younger dually eligible counterparts **through the county mental health system** and the cost savings needs to be evaluated. The BRIGHTEN project at Rush would be one good model to review.

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May 4, 2012

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

Dear Director Douglas:

On behalf of my organization, thank you for the opportunity to provide input into the department's *Coordinated Care Initiative: California's Dual Eligibles Demonstration* (CCI). I understand that the proposal will be finalized from stakeholder input and submitted to the Centers for Medicare and Medicaid Services with a target start date of January 1, 2013.

My hospital operates a community-based department, Senior Care Network, which has ongoing business with the Department of Health Care Services as a provider of Medicaid 1915(c) waiver programs including the Multipurpose Senior Services Program (MSSP) and the Assisted Living Waiver (ALW). Our MSSP serves 350 frail, nursing home eligible older adults at any given time, and the ALW serves another 130+ individuals.

Our experience with these programs and other community-based services in the San Gabriel Valley of Los Angeles have led to a deep organizational commitment to help people continue to live with dignity and independence in their community while maintaining health and safety. In this context, we provide the following input about the CCI proposal particularly about the long-term services and supports portion of the proposal (enclosed). Further, we have collaborated with our association, the MSSP site association (MSA) and support the MSA Principles for Standards of Care (enclosed).

Please feel free to contact me if you or your staff have questions or if I can be of any assistance, at (626) 397-2011.

Sincerely,

EILEEN KOONS, MSW, ACSW
Director

Enclosures

Sincerely,

Huntington Hospital Senior Care Network
Comments Regarding *Coordinated Care Initiative: California's Dual Eligibles Demonstration*

As a community-based department of Huntington Hospital, Senior Care Network believes strongly in the concept of right time, right place, right care, with regard to acute and emergency department services, and also with community-based services. As such, the hospital has a nearly 30-year history providing community-based programs, resources, services, health education, and caregiver support.

General Comments

We support the stated goals of the demonstration to "...improve health outcomes, promote a more efficient health care system, and allow more beneficiaries to stay in their homes and communities for as long as possible." Further we agree with the stated vision of the CCI proposal to provide seamless access to the full continuum of medical, social, long-term and behavioral supports and services that dual eligible beneficiaries need to maintain good health and a high quality of life.

Concerns

We are deeply concerned that the proposal is largely silent on the intention to ensure that both in and beyond demonstration counties, the vital and struggling safety net of long term supports and services (LTSS) and providers will continue to survive. Although the idealized goal of integration of health and social services can indeed be of great benefit to the residents of California, the delivery systems of health care and social services have never been successfully blended on this scope and scale, particularly in an area as large, populated, and diverse, as Los Angeles County. The complexity of such an endeavor causes us great concern about ensuring that the LTSS safety net continues to exist during the time that the state experiments with how to deliver these services more effectively and cost efficiently. To this end, I would implore the administration to protect the ongoing existence of the Medicaid 1915(c) waivers during the duration of the demonstration, and adopt strong quality of care and consumer protection standards that protect the recipients of services. I ask you to consider and adopt the enclosed MSSP Site Association's *Principles for Standards of Care* (attached).

In addition, in reading, listening to, and engaging with health plans in California who have applied to be demonstration providers, I am greatly concerned that they are overwhelmed enough just trying to integrate the large medically-based programs and services they would be charged with, let alone the LTSS services. For this reason I urge the administration to reconsider its timeline for implementation and delay the January 1, 2013 start date for one year or until sufficient discussion, planning, agreement, and safeguards are in place.

Thank you.

Multipurpose Senior Services Program Site Association
1107 9th Street, Suite 701, Sacramento, CA 95814 Phone: 916. 552. 7400 ~ Fax: 866.725.3123

DHCS Coordinated Care Initiative Trailer Bill Additional Language Principles for Standards of Care

The Multipurpose Senior Services Program (MSSP) has a 30-year history of targeting its services to functionally impaired older adults with co-occurring multiple chronic conditions, preventing costly acute and long-term institutionalization. MSSP is a proven, cost effective alternative to institutionalization as recognized when CMS approved its transition from a demonstration project to a 1915 (c) waiver program. MSSP is a network of conflict-free assessment and care management providers who have worked closely together throughout the program's history to continually refine and adapt the model of care in response to industry-recognized best practices, cost pressures, and changes in the health and social services safety net.

The MSA provider network will work closely with DHCS, CDA, CMS, managed care providers and other stakeholders to integrate the existing intensive, person-centered care management model. The goal is to maintain the integrity and efficacy of the current waiver model while eliminating non-essential administrative burdens within the context of Medi-Cal Managed Care.

As the state implements the duals demonstration pilot and transfers financial and operational responsibility for long term supports and services to managed care organizations, DHCS must ensure the continued availability and proactively guard against the dismantling of the established, trusted safety net of providers including the MSSP network and other HCBS waiver service providers, upon which community-dwelling individuals have come to rely. To ensure the health of medically fragile, low income older adults and their ability to remain safely at home, MSA asserts that providers in the administration's proposed statewide Coordinated Care Initiative Network must meet the following basic principles for standards of care for delivery of long term services and supports:

1. Provide the individual choice in who provides their care management services, and ensure that individual providers are qualified to serve the target population and provider agencies have a demonstrated history of delivering high-quality services.

2. Ensure the ongoing availability of in-home-based conflict-free care management services for any consumer who qualifies and voluntarily opts to receive these services. "Conflict-free" is defined as follows:
(a) the provider does not provide any other long-term services and supports to the individual, and does not receive different incentives based on individual need and thus is free of any appearance of conflict of interest in determining eligibility for services and programs for which the individual qualifies; and
(b) the provider is not related to the consumer by blood or marriage and is not financially responsible for the individual.

3. Ensure that a social service-based care manager is included as part of the individual's coordinated care team.

4. Target provision of care management to individuals based on risk for preventable acute and long term institutionalization (emergency department, acute hospital, nursing home) rather than age or other arbitrary criteria.

5. Assure that care management includes the provision of person-centered bio-psychosocial assessments by organizations that have expertise in providing culturally diverse services to older and disabled adults by qualified teams of registered nurse and professional social worker that comprehensively assess strengths, needs and preferences, health and safety using a standardized format.

6. Develop an individualized plan of care that reflects the needs and preferences of the individual and is responsive to the health and safety issues identified.

7. Care manager contact with the individual and their self-identified informal network at least monthly by telephone or in person, and regular periodic in-home visits at least quarterly to assess ongoing status and additional needs.

8. Reassessment and care plan revision at least annually or sooner upon significant change in condition, including care plan approval by the individual or their authorized representative.

9. Utilize the expertise of the existing MSSP network to screen for eligibility and make referrals to other programs and services for which the individual may qualify, including but not limited to IHSS, CBAS, PACE and Assisted Living Waiver.

10. Maintain or increase availability of purchased services/supplies/equipment through contracts with a network of qualified, licensed, and insured vendors to address care plan needs that are not available through other informal or formal sources. The array of services may include, *at a minimum*, social day care services and other forms of respite care for unpaid/family caregivers, non-medical home equipment, emergency move/temporary lodging, emergency utility payment, minor home modifications, personal care items, gap-filling care (personal care, chore, in-home health care and consultations, protective supervision), escorted transportation as needed to medical appointments, nutrition services, social support, therapeutic counseling, money management, emergency response systems, medication dispensing systems, and other communication services and devices.

11. Establish and ensure adherence to reasonable caseload ratios of clients to care manager based on relevant, recognized standards.

12. Provide adequate funding to maintain quality of care.

13. Ensure that individuals continue to receive needed care management if they move to or from a demonstration county and remain a resident of California.

For more information, contact Denise Likar, MSA President at (562) 637-7138 or Erin Levi of Lehman, Levi, Pappas and Sadler at (916) 441-5333.

IHSS Consumer Protections
May 1, 2012

The In-Home Supportive Services (IHSS) program is a time-proven, cost-effective, exemplary model of person-centered care. In order to live independently, everyone would appreciate having consumer-directed, in-home care and assistance as an alternative to costly institutionalization. The California IHSS program has served as a beacon for all who age or acquire a disabling condition. Because the Disability Rights Movement has always been devoted to self-determination, the following protections are necessary:

INDIVIDUAL PROVIDER (IP) MODE FOR SELF-DIRECTING IHSS CONSUMERS

- **The Right to Use the IP Mode**: Some IHSS consumers prefer staying with the method they currently have, while others **may** want to choose case management.
- **Independent Relationship:** No entities shall interfere in the independent relationship between the consumer and their IP.
- **Employer:** IHSS Consumers retain their authority as the employer with the right to hire, fire, supervise, schedule, train and retain any IP, including family and community members and not limited to any person listed with a registry or agency.
- **Right to Schedule Hours:** Scheduling must conform to the IHSS Consumer's life: work, school, personal needs and preferences rather than any medical agency's shifts or procedures. Family members or significant other IP providers should not be made to give up portions of their attendant hours to strangers coming into their home if publically funded programs will not pay overtime.
- **Emergency help:** A system of 24/7 response services are essential for emergencies scheduling providers and equipment failures (ie, wheelchairs, oxygen etc.)
- **Paramedical Services:** As it has been in the IHSS program for decades IP paramedical tasks which could include daily injections of medications (i.e. insulin, inserting suppositories, digital stimulation, catheter insertion, routine wound, ostomy, and catheter care) will continue to be safely administered by a family member or attendants of the consumer's choice.
- **Provider Training:** Self directing IHSS consumers have the right to train their own IPs in the personal-care methods they prefer. Stipends should be paid to incoming IPs being trained by the consumer. IPs wanting additional non mandatory training to improve their skills and employability may receive that training in educational settings, outside of the self directing consumer's home.
- **Violation of Our Self-Determination and Civil Rights:** No care team, managed-care entity or IP has any standing or authority to monitor, inform on, or determine the self-directing IHSS consumer's decisions. Self Directing IHSS consumers view this as patronizing and a flagrant violation of our self-determination and civil rights.

MANAGED CARE

- **Service Delivery Disruption**: Regardless of the mode of service, immediate attendant and medical services must not be disrupted**. If any misunderstandings occur with enrollment, immediate services must continue seamlessly with Aid Paid Pending while other matters are resolved**. To do otherwise is to endanger the person with a disability or irreparably destabilize their independent living situation.
- **Real-Time Solutions:** Access to ombudsman to address immediate, same day solutions for medical treatment when plans are not ready to deliver it. If that fails, consumers must be permitted to access original fee for service providers.
- **Nothing About Us Without Us.** Self-Directing IHSS Consumers must be included in policy making bodies that discuss or suggest changes.
- **Care Coordination Team:** Recognizing there is a wide diversity in the capacities of IHSS consumers and that "One-Size-Does Not-Fit-All," Self-Directing IHSS Consumers who do not request case management must not be burdened with multiple visits by IHSS workers, case managers, nor required to have a care coordination team.
- **Access to our Disability and Chronic Disease Treatment and Specialists**: during and after pilots.
- **Continuum of Care:** Personal care or homemaker services offered by any entity must not be stopped after it is offered in the initial agreement.

- **Right to Active Enrollment:** Non mandatory, active, informed enrollment respects "Person Centered Care."

ADMINISTRATIVE COSTS and PROFITS: These must NOT be at the expense of Consumer hours.
- **Legal Protections:** Rights to same ADA litigation, resources, and legal protections as we have under State and Federal Law.
- **Diligent Oversight:** administering entities must have diligent oversight by both the State of CA & CMS (federal). Data collecting, tracking, outcomes, stats, and monitoring must be thorough, transparent and readily available to the public. The cap of administrative costs and profits must be upheld.
- **Invest In Direct Service:** As funds become available from reduced E. R., hospital, institutional care and profits, etc, these monies must be invested in direct service rather than administration and profits.

UNIFORM STANDARD OF REHABILITATION: Access to an adequate universal standard of rehabilitation approved by the National Institute on Disability and Rehabilitation (NIDR)
- **Adequate Acute Onset Rehabilitation**: Our brothers and sisters can get as little as two weeks of rehabilitation for serious injuries and be sent directly to skilled nursing facilities and **their active lives extinguished.** It is currently totally random whether one will get adequate rehabilitation or not.
- **Discharge Planning:** must require planners to secure a hospital trained family or community provider and connect the PWD with IHSS, Independent Living Centers, Assistive Technology, California Community Transition program, Linkages, MSSPs or other ongoing community supports.
- **Housing:** People with newly disabling conditions who cannot return to inaccessible housing should be transferred to step-down, transitional housing until accessible housing can be acquired.

HEALTH CARE ACCESS:
- **Assistance:** with accessing examination tables and disrobing as is required by the ADA.
- **Access to Examination Tables and Fittings:** Providers must have access to a Hoyer lift in the building where they work to give persons with disabilities access to examination tables and fittings for durable medical equipment.
- **Communication Access**: to translators for languages, sensory and developmental disabilities and in formats the consumer needs. Accessibility includes physical and programmatic access.

DURABLE MEDICAL EQUIPMENT (DME):
- **Emergency DME:** loaner equipment and other means of immediate emergency DME needs must prevent an IHSS Consumer from being stranded, deprived of basic mobility, and endangered medically.
- **Individualized Equipment Choices**: Consumers must be allowed to select and/or determine what type of wheelchair/scooter best fits their individual needs, because most people cannot use the same type of equipment. Some people require customized seating support systems that allow them to function in safety and comfort.
- **Basic Freedom of Movement**: We find the "Home Bound" rule extraordinarily egregious. No other citizen is required to be under "house arrest" for the basic right to go anywhere. There cannot be any restrictions of movement on how a person uses whatever equipment they have.
- **Choice of Provider**: Consumers must be able to obtain whatever maintenance, or repair, their DME requires. Consumers must also be given a choice about which vendor provides their maintenance and repair.

"**Nothing About Us Without Us!**" (**Latin: "Nihil de nobis, sine nobis**") is a slogan used to communicate the idea that no policy should be decided by any representative without the full and direct participation of members the group(s) affected by that policy. This involves national, ethnic, disability based or other groups that are often thought to be marginalized from political, social, and economic opportunities.

IHSS CONSUMERS UNION Face Book group:
http://www.facebook.com/groups/IHSS.ConsumersUnion/ or ihss.consumers.union@gmail.com, 213-537-4477

I am interested in the "handoff" between IHSS social workers and health plan or other representatives as it relates to community-based care. It makes sense to me to ask the IHSS social workers to perform assessments for more holistic services (as added beyond current IHSS authorized services by the health plan(s)). I am wondering if CMIPS/CMIPS II will incorporate "supplemental" IHSS-type services or if those services will be assessed and tracked by the health plan or other entity instead. Many have expressed concern about new layers of administration/bureaucracy in the Duals Pilots. I just believe it would be a best practice to leverage the IHSS program as it relates to LTSS provided by Individual Providers (Personal Assistants/caregivers).

I also want to join the voices of those who called out the fact that IHSS Public Authorities are generally excluded from the Draft Proposal. Trainer Bill Language (TBL) clearly addresses Public Authorities and I believe that this critical proposal to CMS should also highlight Public Authorities (PAs). I know that the PAs have become "hot political potatoes" but we are not just the employers of record. We operate Registries, we train consumers and providers, in most counties we handle the provider enrollment process; our staff conducts home visits to assist consumers with their employer related responsibilities. Many PAs operate urgent services programs. We also handle Payroll, Verification of employment, liens and garnishments, initial Worker's Comp paperwork, etc. In general, we handle the unique needs (at a minimum duties required by statute) of our counties. I think that CMS would be impressed that we have a statewide network of PAs in CA doing a lot of great work.

I noticed that Centers for Independent Living (CIL) are mentioned multiple times in the Proposal and as a previous CIL director I think that's great. CILs aren't mentioned in the TBL and are relatively prominent in the Proposal so this leaves me very frustrated about the lack of mention of PAs. I encourage you to add PAs to the Proposal as a key partner in the Duals Pilots projects. Even if PAs become irrelevant after year one, they will be around for at least three years as the projects roll out around the state. I am of the opinion that PAs should be kept around for a long time to continue the great work we do locally and statewide through CAPA.

Please feel free to contact me if you have questions. My mobile phone number is 619-249-9150.

Thank you for the work you are doing; I know it must be extremely challenging.

Bud Sayles

Albert G. "Bud" Sayles
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780 Bay Boulevard, Suite 200
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The list of Medi-Cal State Plan Core Service Providers set forth in Appendix 2 (page 39) omits Medical Transportation and, specifically, Non-Emergency Medical Transportation (NEMT) upon which many dialysis and other disabled dual eligible patients to get to and from treatment locations.

Our client in this regard is the California Medical Transportation Association (CMTA) that consists of private firms that are duly enrolled Medi-Cal providers that meet the requirements of Title 22.

Bill Barnaby

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Hi Peter -- Checking in with you regarding the language related to technology included on page 15 in the 4/4/12 draft Duals Demonstration Proposal. It is much more narrow and limited to EHRs and similar functionality vs. the more comprehensive language and questions included in the RFS. We were very pleased to see the breadth of responses to the three RFS technology questions by applicants, and we look forward to working with plans to encourage their work in this area.

To my question --- is the much more limited language included in the Draft Proposal (quoted below) for CMS inadvertent or overt? In other words, does this language represent a decision by the Department to limit it's focus on technology to EHRs and the like and not any eCare technologies/innovative care models?
"Use of Technology. Demonstration sites will leverage effective use of technology, although technology will not replace critical in-person care coordination activities. Current health plan efforts and proposals include:

- Greater use of electronic health records throughout the provider network, including web-based sharing of care management plans and updates. These applications allow primary care providers and specialists, including behavioral health specialists, to securely share clinical information, services approved or initiated, and ongoing updates. Electronic consultation between primary care providers and specialists offers improved collaboration, increases efficiency of specialty care visits, and facilitates resolution of members' unmet needs and issues.
- Electronic notices and reminders to primary care providers to help them target certain patients for preventive or follow-up care.
- A provider portal to provide interactive features permitting individualized physician reporting on quality reports.
- Individualized pay-for-performance tools for physicians to report progress in meeting organizational quality goals; these reports serve, in effect, as disease-specific registries for physicians to use in ensuring appropriate diabetes care and other preventative care interventions.
- A new system being developed to integrate data elements from the health plan, and county home-and community-based services and behavioral health agencies to capture a full picture of the medical, social, and behavioral health needs of each beneficiary. "

Please let me know, and offer any insight on whether we should seek to address in the comment process or if this is something that can be simply addressed at the staff level.

Thanks much,
Scott

Scott Peifer
Executive Director

AgeTech California
1315 I Street, Suite 100
Sacramento, CA 95814
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speifer@agetechca.org

www.agetechca.org

Dear Director's Office, Department of Health Care Services:
The Dual Eligibles Demonstration causes incredible concern for many patients and practitioners in California.
When California enacts this Coordinated Care Initiative on January 1, 2013, all Medi-Medi patients, within Los Angeles, San Mateo, San Diego and Orange counties, who were seeing doctors will be siphoned to a new HMO doctor. This HMO doctor will be seeing many more patients for less pay and may likely deliver care in a different manner than these patients have become accustomed. These patients will lose continuity of care and will suddenly be required to obtain pre-authorization for visits and procedures. Lastly, they will not have a choice. These are early details with which my patients are concerned.
Practitioners who were previously treating Medi-Medi patients will suddenly be required to become an HMO provider. HMOs typically require much more computer work, paperwork and telephone calls and pay for considerably less. This system will afford an office less staff but expect more work. Lastly, if a practitioner seeks to become an HMO provider, getting on the HMO's panel is challenging and often is impossible.
California already has a medical specialist shortage and I fear that this conversion to HMOs will only increase the problem of limited patient access. I regret to inform you that I am already exploring practice opportunities outside of the state of California, as my predominantly Medi-Medi practice will dissolve after California places the patients in an HMO. I am confident that I am not an isolated case.

Sincerely,
Rebecca Moellmer, DPM
Fellow, American College of Foot & Ankle Surgeons
Fellow, American Academy of Podiatric Sports Medicine

I am writing in opposition to the Governor's State Budget Proposal to expand the existing Duals Demonstration from four to ten counties, and to mandatory enroll all duals into Medi-Cal managed care.

The Duals Demonstration would significantly change how seniors and persons with disabilities access their health care services in those pilot counties. In the pilot counties all health care services would be coordinated by a managed care plan. Integrating programs and funding streams for up to 1.3 million beneficiaries will be a significant challenge.

The proposed system will be disruptive to patients as it separates beneficiaries from their traditional providers of care. Such a system is not in the best interest of dual eligible beneficiaries who are often medically fragile.

The program, should it go forward, must begin with a meaningful pilot or demonstration. The purpose of a pilot or demonstration program is to test assumptions and operations, and to determine whether the program goals before moving forward with it. It is not known whether there are other models which would do the same or better.

I believe it is critical to ensure that the savings come from reductions in hospitalizations and skilled nursing and not from deferred treatment of patients.

I believe this dramatic change in the delivery of healthcare deserves full consideration and scrutiny of a stand-alone bill and not be dealt with solely the budget process. Additionally, the choice of counties should be based on those best prepared and those which will give meaningful data instead of an assumed large saving.

It's a shame that the government is forcing the dual eligible to these managed care programs, without any say by them. Obviously, the poor are being taking advantaged again.

Sincerely,

Stuart Codron
6547 McClennan Ave.
Lake Balboa, CA 91406

Maggie Dee

Using a Excel template is irresponsible, user-unfriendly, in fact down right offensive!

Using Excel font for those who are print impaired, congnitively disabled will become victimized lead to unwanted isolation from the facts about fantacy and the rush to crush the health care system by the lack of user-friendly information, access to the "Comment Period" in a basic method. It should be simple to use, answered "Received" and know comments are under consideration and how they used incorporated into any/all final plan models useage. There must be common threads to each plan to accommodate people moving from one part of CA to another.

How you can simplify:
- Keep a list of "Interested parties" and their e-mail addresses. Send out meeting dates and keep the dates given--don't change the meeting times.
- Meetings should always be held in the early afternoons after people's long "Morning Routines" are over for those with more severe disabilities
- Allow for plenty of time, **a hour and a half for meeting times is nothing more than a poor attempt of saying meetings are being held. Hold a four hour meeting so there can be good debate, information sharing and people can get reasonable responses from the Dept!; how this is being done is wholly inadequate leaving many of those who have spent their energy and time to attend left without the ability to participate. A person is limited to a few minutes and may only be able to speak once. This is nothing more than an insincere effort "to meet with the beneficiaries"! Spend the money to REALLY answer questions and debate the needs of PWDs! How can you hear from 900 people which are claimed to have registered?**
- KEEP IT SIMPLE, EASY TO USE forget the registrations, let people e-mail or call in their interest to participate. Use a steady phone number for people to use when teleconference calls are made. Then more people will participate...and want to participate. Interest wanes when you call in are so limited to time and multiple questions one may have.
- Send out timely material in any format requested if the request comes in a 3-day requirement. This the Dept has not always done; receiving material a few hours before a meeting does not allow for study time digesting new material. Materials coming AFTER the fact/meeting! This is useless to the participating member. More people may need accommodations to participate; what is available? Some people cannot or will not open links on their computer in fear that "cookies" will open the door to their computer information.
- Require any/all plans to provide their material in accessible formats and in a

timely manner so the material can be sent or e-mailed in advance of the meeting or it is NOT ACCESSIBLE! This has not been done. We have been told that the Department cannot make this request to private for profit "stakeholders". Is this trust building?

Suggestions and or huge holes that seem at best inadequately or totally missing are:
- NOTHING!!! is mentioned how a person who chooses to divide their Medicare and Medi-Cal into Medicare for continued Medicare Services/Fee-for-Service and those Medi-Cal Services such as long term care *"SERVICES"* which must remain in the managed care system. How does a person split their health care choices from each plan and in regulation which plans must follow.
- There should be common expectations/"same as" of all health plans from county to county so if a person must move that their health care can be a smooth tranistion and easily moved into the new county's health care "plan". Medical needs may be important such as kidney treatments, cancer treatments, surgeries post care (injury post injury care/rehabilitation). This seems to be missing in all plans: transitioning from one health plan to the next for those moving from one county to the next. If a person moves <u>into</u> a county chosen for the Dual Eligible experiment from a county that is not chosen (out years of either the 3-year experiment or if the 10-county is adopted by the legislature and statewide by 2015). There MUST be the ability to move people from one plan (a choice plan if the county is under the Two Plan Model information) with adequate and informative information about the Two Plan Model at either end of the transition/ move. Nothing indicates this in any plan of those submitted.
- There is no indicator that any plan or county will have an effective housing component which will have absolute oversight and data collected to prove the state, county and plan ability to help case managers find appropriate and accessible housing, Vouchers and actual housing units appropriate for the user; case managers need to know and understand how an annual housing re-certification is done for those who will need help to re-certify their unit THIS IS NOT MENTIONED ANYWHERE, transportation component at start-up. This is essential to get people who are new to a system to the facilities, clinics and rehabilitation sites or treatment sites.
- We must make participation in planning and development in new avenues of useage like Meals on Wheels program, Senior Center Without Walls and other programs that will get the word out in the simple fashion of telephone use...especially to those unsuspecting Dual Eligibles! This information needs to come from consumers and participants so they came become part of the dialogue...IF "the system" wants to reach the same group of people then it should ONLY be done with a balanced view from consumer lead discussion group so people will learn what others think of the progress. Hearing from only one side is NOT access or "readiness"!
-There is not one mention of disaster planning when/if an earthquake or some other disaster (fire) hits a county. Where ARE THE PLANS and specifically how do they cope with such matters. Nothing mentioned in this state of earthquakes and wild fires, flooding, avalanches, etc. Just how prepared are the plans to move

pwds in such highly charged circumstances especially if health facilities are directly on earthquake faults as in Hayward Fault loaded with medical centers, nursing homes and treatment centers!
-People in rural areas do not have an emergency transportation system at all or a para transit system...many pwds w/o vehicles. What are the plans to transport people from their homes to medical appointments? Nothing is mentioned in any of the plans how to move people to medical appointments and/or treatment sites when para transit does not exist or has a limited service area which does not cover rural home, apartment complexes yet mandates a person into a system
- Rural areas have the least accessibility standards in place. What are plans offering to deal with this lack of access? Nothing mentioned thus, isolation and poor outcomes for medical needs.
- There is little mention of how to teach new participants how to use a health plan taking this information to the people where they live, senior center sites, low-income residential complexes, city halls, malls conference centers and other sites like Welfare and IHSS offices, Food Stamp/CalFresh office sites, State Appeal sites offices conference rooms which people are familiar.

I do not support mandating a "Passive enrollment with a lock-in for 6 (six) months". This should be an "opt-in". If it is as good as touted people will want to participate...providers will want to join the network.
-Many providers will not join and providers do not want to become "gatekeepers" as they are specialists and do not see them self or their staff of dealing with the endless tasks of filling forms, POTS(Plans of Treatments) to satisfy the demands of the "seamless" medical system.

There are not enough "primary care" physicians to handle the current number of SPD...many are stepping down from their practices because of this rush to adopt a medical system/plan that will require huge sums of money to participate, train their staff in new technologies and proceedures and patient care limitations.

I look forward to anyone who has other matters of concern...or those who do not agree with my comments to comment back to me. We need to engage our community as simply and easily with basic communication. If you know people who do not use computers get their names, contact info so we can bank their information to keep them informed! We cannot overlook those who do not have means to use or do not want to use a computer, informed.

First off, this whole attempt at putting Medi/Medi's on a managed lack of care plan is appalling. I know those of you working on this project believe you will never be in this situation, but neither did I. And yet, here I am, a proposed victim of this plan.

Molina is the applicant for this atrocity. They will only make it 10 times worse. Molina is well known in Sacramento to provide little to no care in addition to extremely poor care when a person can get any. The idea that we may be forced into their system, I can not describe the dread.

I can not believe the State will force me to abandon my Internal Medicine doctor that I have been with for *18 years.* I trust her implicitly and am a full partner in my care. I am treated with respect and she knows

the limits of her expertise and will refer me to a specialist when that is in my best interests. This will end with managed lack of care. It will most assuredly end with Molina.

With this nightmare I can assume I will no longer be referred to my immunologist who is the best in the area and beyond. With out him I would not have access to the only treatment that keeps me from being chronically ill, which of course would not be looked at by a state dictated clinic as it would look bad for their numbers for any future contract. Both companies and the State continuously ignore long term savings for short term costs.

Then the section in your email referencing provider disincentives for providing necessary care. I know it has become a standard for any State controlled plan but honestly, I can not believe it is legal. You are requiring doctors to go against the Hippocratic Oath. As it is, MediCal providers lose money on each patient they see. And now you want a doctor to deny care so they can at least get that pittance.

Like I said earlier I know that the creators of this nightmare do not believe they will ever be here. It can happen. I used to be the Executive Director of a battered women's and rape crisis center. I never anticipated a disability that will never allow me a full time job again or being with out health insurance. Life can change dramatically with out notice. Those who came up with this idea obviously do not believe that.

I read in your emails that this mess is an attempt to basically *lower the costs to the taxpayers and the State*. When a person has Medicare that means either they or a spouse have worked, we were or are still taxpayers! *Only a small portion of our medical cost are born by the State or taxpayers. MediCal is not the primary payer.* Medicare is and that is a system that we have already paid into. It costs neither the State or the taxpayers a dime. Medicare picks up *80%* of our medical costs. *So, what is the actual excuse?* My guess is that it is a ploy to make the lawmakers look good to those that are either not on Medicare yet or those that can afford the MediGap policies.

I do hope that all of you never end up in this ship you are building. But, there is a part of me that does so that you can decry what you have done.

Pam Meadows
3500 53rd St., B
Sacramento, CA 95820
916-456-7494

Dinda Evants
April 20, 2012

I am currently a recipient of a caregiver through ihss and I am under Health Net manaaged care plan so I am aware of how inept, indifferent and potentially dangerous the HMO and it's workers are. I was switch in January. It took a month to get Health Net to give me an inhome oxygen concentrator and over 3 months to get any form of portable oxygen. My wheelchair was damaged in dec in an accident and to date it has not been repaired or replaced. The HMO requires pre authorization so some patients used their rent and food money to cover medical devices or medicine while waiting for an HMOauthorization. They found that the HMO didn't have to reimburse them for any unauthorized expenditures although they had been on the medicine and devices for years under Medi-cal. These are poor and often elderly people.

The HMO pretends that the doctor or clinic is to cover all patients' needs but they are not

specialists and do not have access to equipment and tests to diagnose symptoms. I have been having my left leg and foot swell up. My HMO case manager told me to suck it up..when you get old things swell..it's nothing. The clinic will have to ask for permission for me to see an outside doctor whereas under medi-cal I could contact a doctor (if I could findone taking medi) on my own or go to ucla harbor... By 64 I know when I need more help than a gp or nurse practitioner can give..

I had to contact the dept of insurance managed care dept 2x to get my medicine..medicine my life depends upon. The HMO system in CA in Mismanaged Care..with constant requirements of paperwork and codes etc. that doctors can't keep up with. I had hearings but in the hearings the HMO said they had provided equipment they had not, said it adn't been denied but was under consideration (for four months), etc., etc.

I put in for a hearing to go back to medical andd was told that 1. the doctor signing the form can't be the one in the HMO system (i.e. we must come up with money to hire outside physicians)..The new system is insulting to adults and dangerous to all patients with extreme illnesses. I understand CA said it was broke and that was why they were cutting benefits etc but in reality CA stayed a sanctuary state and voted to give illegal aliens college degrees. Obvious CA doesn't want any elderly or disabled but then it should offer Kavorkian options for those that would prefer to die wit;h dignity and without too much pain or distress..

This said, obviously putting IHSS under the HMO system that is failing so many patients is ludicrous.One the HMO wants to control vendors, etc... do My local oxygen supplier wasnt accepted and they only let me use one all the way in the San fernando valley. By forcing seriously ill people to have to use vendors or physicians or hospitals far from their area, the HMO insures that they will go less. I wonder how many people will die under this system before the suits start rolling in... we want to be able to choose our vendors,hospitals and doctors..Under medi cal it was tough because so few physicians took medi cal but harbor ucla, etc. would and the doctor could refer to a specialist at a higher rate than usual I guess. I would not want THE HMO controlling who is my caregiver, et.c.. My doctor shudders that I am alone for most of the day and all night..We don't need any cuts in hours or HMO control over our caregivers..IHSS doesn't pay well and screws up their pay as it is..we are lucky to have anyone to help us..we don't need the hmo system to make matters worse.

April 29, 2012

Dear Cal Duals....

Here are my thoughts on the subject...and I do realize that I might be wrong on every point mentioned...but I hope that somehow the new program might be helped even a little by my input. I am 81 and disabled and a dual eligible..

.

I am concerned with the plans to move all of California's dual eligibles directly into an HMO with out their consent. I think this might be more difficult than it looks .

I went to a few of my neighbors who are dual eligibles (who are old and

sick) and tried to explain to them in the softest way possible the change that is coming. I was shocked to see the indignation, fear, anxiety and even horror when I mentioned that they might soon lose all or most of precious and trusted doctors.

They could not even comprehend such a thing.

To try to explain to an old sick dependent person that they soon will not be able to see their precious and trusted doctors of many years, seems to bring out anger and disbelief.

If this goes through, someone is going to have a BIG job trying to explain to all of these angry and upset old people why they can no longer see their trusted eye doctor for their macular degeneration when they are almost blind. etc etc

I am a dual eligible myself ... I have worked all my life...36 years as an Registered Nurse......until I got disabled.

After I got disabled my retirement money went fast and I had to go on Medicare with Medi-Cal as secondary

Do I deserve to be moved into the same HMO programs as Medi-Cal only patients? I dont think so..

All the people with Medicare have WORKED, many for all their lives.
All the people on Medi-Cal only have NOT WORKED, at least they have not worked enough to earn Medicare.

Now do I really deserve to be moved into the same HMO program for people with Medi-Cal only people? I dont think so.
I feel that this is indeed unfair. I think I deserve to keep my power of choice just like all the the other Medicare patients are currently doing.

One more issue that I have is why is it that none of the doctors that I have talked to have any idea that this HMO change is happening Why is that?
I feel each and every doctor in these 4 counties should have been notified long ago that this new plan is coming down the pike (so to speak.)

This way it looks as if the plan is somewhat secretive. Also troublesome to me is that when it does get introduced to everyone, the doctors and public have only 30 days to respond.

I believe that 30 days is not long enough for the doctors and the patients

to receive this plan, read this plan, then study this plan, then form focus groups to discuss this plan and how to implement it, and then write up their response, their ideas, their questions, their suggestions, and then get it typed up and approved and then sent to you....I believe it at a minimum should be 60 days...or longer.

My last comment is many of our oldest and sickest belong to MSSP (Multi Purpose Senior Services). This is the Independence at Home plan (a division of Scan Health Plan) for people who might otherwise end up in a nursing home.

If MSSP patients have not already been excluded from the present dual eligible plan, I think it would be a good idea.

This way the dual eligible program could go forward with a smaller target group and could get set up and running well. And then perhaps could take on the patients that are the oldest the sickest and the most resistant to any changes in their lives. (MSSP patients) if that was absolutely necessary at that time.

So in summary, I have 4 points.

1. It may be extremely difficult to get the old and sick to even comprehend the
extent of these changes and to deal with their emotional reaction to losing their precious and trusted doctors.. This looks like to me that it will be a trauma for them that will need to be addressed carefully. And could even cause PTSD in a few vulnerable patients

2.Why are dual eligibles targeted for HMO when they have earned their right through life long work to keep their right to have choice of medical care?

3.Why have so few doctors been notified about this so far and is 30 days of feedback really enough time???

4. Wouldnt it be easier to implement a smaller target group to get things rolling and then do MSSP later if at all???

I do send my blessings and prayers and hope that we all can have the best medical care possible without breaking the bank.

Kindest regards,
Carol

Multipurpose Senior Services Program Site Association
1107 9th Street, Suite 701, Sacramento, CA 95814 Phone: 916. 552. 7400 ~ Fax: 866.725.3123

Comments in Response to California's

Draft Proposal to the Center for Medicare and Medicaid Innovation
Coordinated Care Initiative: State Demonstration to Integrate Care
for Dual Eligible Individuals
(Issued April 4, 2012)

Submitted May 4, 2012

On behalf of the 39 community-based providers of the Multipurpose Senior Services Program (MSSP) and the nearly 12,000 low-income, medically fragile older adults served across the state, the MSSP Site Association (MSA) is pleased to submit the following comments to the California Department of Health Care Services in response to the state's proposed Coordinated Care Initiative for Medicare and Medi-Cal dually eligible seniors and individuals with disabilities.

The "Coordinated Care Initiative: California's Dual Eligibles Demonstration" (CCI) is an undertaking of ambitious scope and scale, but is weakened by the lack of clear beneficiary protections and a lack of specific details on many critical aspects of the initiative. While many concerns with which MSA concurs have been raised by other advocates and providers, these comments will focus primarily on Long Term Supports and Services (LTSS) and the potential disintegration of the state's social services safety net.

While MSA and agencies within the network are taking active roles in the Duals Stakeholder Workgroup process, and appreciate that opportunity to engage on these important issues, we are deeply concerned that many of the critical, defining issues for LTSS integration are left unresolved in the proposal to CMS with vague statements about issues to be determined through the workgroups. The outcomes and decisions that are reached are crucial to determining whether or not the proposal will satisfactorily protect at-risk older adults with multiple chronic conditions.

MSA supports the overarching goal of more integrated and coordinated care, and our provider network is committed to working closely with DHCS, CDA, CMS, managed care providers and other stakeholders to build upon the extensive, existing expertise to deliver intensive, person-centered care management in California. We believe it is critical to maintain the integrity and efficacy of the current MSSP model and to maintain the soundness of the existing MSSP provider network, while eliminating non-essential administrative burdens within the context of Medi-Cal Managed Care.

<u>Specific Comments</u>

1. The draft proposal refers to "care coordination" but does not define the components or necessary level of care to ensure that the most frail of the dual eligible population have access to the intensive level of services needed to keep them safe and healthy at home. We think it would strengthen the proposal to incorporate MSA's "DHCS Coordinated Care Initiative Trailer Bill Additional Language: Principles for Standards of Care" (Attachment) into the revised, final proposal. This captures the core principles and standards of practice of MSSP and will ensure that the medically fragile seniors included in these pilot programs will retain critical consumer protections including self-direction, choice, health and safety, as well as access to their existing home and community-based providers.

2. MSA supports the statement on page 20 that:

> *"The State intends to renew the MSSP waiver before its expiration in 2014, to provide for continued waiver services for recipients in counties without managed care. Other waivers were recently renewed for five years, and will be reexamined at a later time in the context of the demonstration."*

MSA will work closely with the State to ensure the MSSP waiver renewal proceeds efficiently. The CCI proposal, however, currently lacks protection for the quality of care and network of providers to ensure the waiver's ongoing viability. One of the historic strengths of MSSP has been the strong statewide network, linking providers in rural and urban areas to best practices, shared resources and collective communication with state and federal partners. If providers in demonstration counties are de-linked from those in counties without managed care, there is a potential loss of access and information for providers small and large.

3. MSA is concerned that on page 34, the document states:

> *"Note also that the Coordinated Care Initiative provides that if the California Department of Finance 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, after fully offsetting implementation administrative costs, then the State will discontinue the provisions of the Initiative."*

As currently drafted, there are no protections in place to ensure that should the demonstration be discontinued, the community-based safety net would survive to resume care for the fragile patients such as those served by highly-skilled MSSP care managers. The initial trailer bill and draft proposal essentially propose to eliminate MSSP and the provider network, a network of highly committed and skilled providers and subcontractors built over more than three decades, and for managed care to recreate a new "like" service? The MSSP Site Association proposes that rather than eliminate the program in demonstration counties, as the CCI and administration officials have proposed, it is more cost-effective to instead explicitly state the intention to leverage the existing provider network by requiring managed care organizations to partner with existing community based resources.

<u>Conclusion</u>

We believe the proposal needs to be revised so that enhanced care management, as reflected in the "Standards of Care," can be provided in an integrated manner for medically fragile dually eligible individuals while ensuring long-term viability of the safety net, access to services in non-pilot counties and access to well-established services and highly regarded community providers, while reducing acute hospital, emergency department, and long term care institutionalization costs.

MSSP is a time tested and proven model that is a natural fit to serve as the foundation for California's ambitious coordinated care effort. We are committed to working together with the California Legislature as well as the administration and other stakeholders to maximize the potential for the demonstration project's success by leveraging the MSSP system of care for the benefit of California's most vulnerable, at risk residents.

For more than thirty (30) years, MSSP has targeted its services to functionally impaired older adults with co-occurring multiple chronic conditions, preventing costly acute and long-term institutionalization. MSSP is a proven, cost effective alternative to institutionalization as recognized when CMS approved its transition from a demonstration project to a 1915 (c) waiver program and in multiple subsequent waiver renewals. MSSP is a network of conflict-free assessment and care management providers who have worked closely together since the initial

pilot in 1978 to refine and adapt services in response to industry-recognized best practices, cost pressures, and changes in the health and social services safety net.

The MSSP Site Association appreciates the opportunity to provide comments on the draft Proposal to the Center for Medicare and Medicaid Innovation, Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals.

For more information, contact Denise Likar, MSA President at (562) 637-7138 or dlikar@scanhealthplan.com or Erin Levi of Lehman, Levi, Pappas and Sadler at (916) 441-5333.

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DHCS Coordinated Care Initiative Trailer Bill Additional Language
Principles for Standards of Care

The Multipurpose Senior Services Program (MSSP) has a 30-year history of targeting its services to functionally impaired older adults with co-occurring multiple chronic conditions, preventing costly acute and long-term institutionalization. MSSP is a proven, cost effective alternative to institutionalization as recognized when CMS approved its transition from a demonstration project to a 1915 (c) waiver program. MSSP is a network of conflict-free assessment and care management providers who have worked closely together throughout the program's history to continually refine and adapt the model of care in response to industry-recognized best practices, cost pressures, and changes in the health and social services safety net.

The MSA provider network will work closely with DHCS, CDA, CMS, managed care providers and other stakeholders to integrate the existing intensive, person-centered care management model. The goal is to maintain the integrity and efficacy of the current waiver model while eliminating non-essential administrative burdens within the context of Medi-Cal Managed Care.

As the state implements the duals demonstration pilot and transfers financial and operational responsibility for long term supports and services to managed care organizations, DHCS must ensure the continued availability and proactively guard against the dismantling of the established, trusted safety net of providers including the MSSP network and other HCBS waiver service providers, upon which community-dwelling individuals have come to rely. To ensure the health of medically fragile, low income older adults and their ability to remain safely at home, MSA asserts that providers in the administration's proposed statewide Coordinated Care Initiative Network must meet the following basic principles for standards of care for delivery of long term services and supports:

1. Provide the individual choice in who provides their care management services, and ensure that individual providers are qualified to serve the target population and provider agencies have a demonstrated history of delivering high-quality services.

2. Ensure the ongoing availability of in-home-based conflict-free care management services for any consumer who qualifies and voluntarily opts to receive these services. "Conflict-free" is defined as follows:
   (a) the provider does not provide any other long-term services and supports to the individual, and does not receive different incentives based on individual need and thus is free of any appearance of conflict of interest in determining eligibility for services and programs for which the individual qualifies; and
   (b) the provider is not related to the consumer by blood or marriage and is not financially responsible for the individual.

3. Ensure that a social service-based care manager is included as part of the individual's coordinated care team.

4. Target provision of care management to individuals based on risk for preventable acute and long term institutionalization (emergency department, acute hospital, nursing home) rather than age or other arbitrary criteria.

5. Assure that care management includes the provision of person-centered bio-psychosocial assessments by organizations that have expertise in providing culturally diverse services to older and disabled adults by qualified teams of registered nurse and professional social worker that comprehensively assess strengths, needs and preferences, health and safety using a standardized format.

6. Develop an individualized plan of care that reflects the needs and preferences of the individual and is responsive to the health and safety issues identified.

7. Care manager contact with the individual and their self-identified informal network at least monthly by telephone or in person, and regular periodic in-home visits at least quarterly to assess ongoing status and additional needs.

8. Reassessment and care plan revision at least annually or sooner upon significant change in condition, including care plan approval by the individual or their authorized representative.

9. Utilize the expertise of the existing MSSP network to screen for eligibility and make referrals to other programs and services for which the individual may qualify, including but not limited to IHSS, CBAS, PACE and Assisted Living Waiver.

10. Maintain or increase availability of purchased services/supplies/equipment through contracts with a network of qualified, licensed, and insured vendors to address care plan needs that are not available through other informal or formal sources. The array of services may include, *at a minimum*, social day care services and other forms of respite care for unpaid/family caregivers, non-medical home equipment, emergency move/temporary lodging, emergency utility payment, minor home modifications, personal care items, gap-filling care (personal care, chore, in-home health care and consultations, protective supervision), escorted transportation as needed to medical appointments, nutrition services, social support, therapeutic counseling, money management, emergency response systems, medication dispensing systems, and other communication services and devices.

11. Establish and ensure adherence to reasonable caseload ratios of clients to care manager based on relevant, recognized standards.

12. Provide adequate funding to maintain quality of care.

13. Ensure that individuals continue to receive needed care management if they move to or from a demonstration county and remain a resident of California.

For more information, contact Denise Likar, MSA President at (562) 637-7138 or Erin Levi of Lehman, Levi, Pappas and Sadler at (916) 441-5333.

NATIONAL ASSOCIATION OF CHAIN DRUG STORES

May 4, 2012

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

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

Dear Mr. Douglas:

The National Association of Chain Drug Stores (NACDS) appreciates the opportunity to comment on the State of California's Coordinated Care Initiative: California's Dual Eligibles Demonstration**.** We look forward to working with the state as this matter moves forward.

NACDS represents traditional drug stores, supermarkets, and mass merchants with pharmacies – from regional chains with four stores to national companies. Chains operate more than 40,000 pharmacies and employ more than 3.5 million employees, including 130,000 pharmacists. They fill over 2.6 billion prescriptions annually, which is more than 72 percent of annual prescriptions in the United States. Chain pharmacies fill the majority of Medicare Part D and Medicaid prescriptions, making them a critical access point for healthcare services for dual eligibles.

The goals of the CMS "State Demonstrations to Integrate Care for Dual Eligible Individuals" initiative are to improve performance of primary care and care coordination for individuals eligible for both Medicare and Medicaid and to eliminate duplication of services for these beneficiaries, expand access to needed care, and improve the lives of dual eligibles, while lowering costs. Under the program states are eligible to share in the savings their demonstration produces.

Successful outcomes for a coordinated care program are dependent upon coordinating care provided by multiple provider types, including the services provided by pharmacists as part of the health care team. NACDS applauds California for recognizing in their proposal the value of utilizing pharmacists who regularly see their patients to improve medication adherence. Pharmacists play a key role in helping patients take their medications as prescribed and offer a variety of pharmacist-delivered services, such as medication therapy management (MTM) to improve quality and outcomes.

Including community pharmacists as a part of the coordinated care models for dual eligible beneficiaries is one of the many ways of using a pharmacist's clinical skills to improve patient outcomes. Accessible in virtually every community, pharmacists are medication experts with the ability to identify patient specific medication-related issues

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and communicate those issues to the patient and their provider. In addition, pharmacists have the ability to educate the patient with the necessary information to improve patient compliance, outcomes and overall quality of care.

NACDS believes the appropriate utilization of pharmacist-provided medication therapy management (MTM) services can play an important role in helping states meet these goals, improve the lives of dual eligible beneficiaries and allow the state to share in the savings achieved. Research has shown that only 50 percent of patients properly adhere to their prescription drug therapy regimens. Poor medication adherence costs the nation approximately $290 billion annually – 13% of total health care expenditures – and results in avoidable and costly health complications, worsening of disease progression, emergency room visits and hospital stays. This inadequate medication adherence rate is associated with about $47 billion annually for drug-related hospitalizations, an estimated 40 percent of nursing home admissions.

Reasons for patient non-adherence to a medication regimen are multiple, including costs, regimen complexity and patient beliefs. This is especially true for the dual eligible population whose care is fragmented between the Medicare and Medicaid programs. The fragmentation of care can often lead to beneficiary confusion and increase the possibility that a beneficiary may not adhere to his or her medication regimen.

We commend California for recognizing the value of pharmacy medication management services at various points in the proposal. We note the recognition that medication management services will help to reduce hospitalizations. We applaud the acknowledgement of the benefits of disease management programs and the recognition of pharmacist expertise. Community pharmacist provided medication management programs for persons with chronic diseases are recognized for helping to improve health outcomes and reduce use of more costly healthcare services. We urge California to also incorporate the benefits of medication management services provided by community pharmacists, in addition to those of primary care physicians. Community pharmacists are part of the healthcare team and look forward to this collaborative effort to improve the healthcare outcomes of dual eligibles.

Pharmacists are the most highly trained professionals in medication management. They receive a minimum of six years and in many cases eight years of college, with four years enrolled in a College of Pharmacy where they study medication uses, dosing, side effects, interactions and patient care. As highly trained and accessible healthcare providers, pharmacists are uniquely positioned to play an expanded role in ensuring patients take their medications as prescribed. MTM services provided by community pharmacists improve patient care, enhance communication between providers and patients, improve collaboration among providers, optimize medication use for improved patient outcomes, contribute to medication error prevention and enable patients to be more actively involved in medication self-management. Pharmacist-provided MTM services are one of the many ways of using a pharmacist's clinical skills to improve patient outcomes.

Pharmacists already have the training and skills needed to provide MTM services and currently provide many of these services in their day-to-day activities.

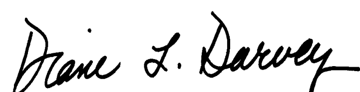
In order to be effective in improving outcomes for the dual eligible population through increased medication adherence, MTM services should be provided in a setting that is convenient and comfortable for the beneficiary; this is especially true for beneficiaries transitioning from the inpatient hospital setting or long-term care setting. Because most patients obtain their prescription drugs and services from their local pharmacy, the convenience of pharmacist-provided MTM services is not only logical, but is a cost effective way to increase patient access to MTM services and coordinate the beneficiaries medication.

In the pharmacy setting, MTM includes services such as review of the patient's prescription and over-the counter medications, reconciliation with medications received in the hospital, development of a personal medication record for a beneficiary to share with his/her physicians(s) and a medication-related action plan to achieve specific health goals in cooperation with his/her pharmacist. To perform the most comprehensive assessment of a beneficiary, personal interaction with direct contact between a pharmacist and a beneficiary is optimal. A face-to-face interaction optimizes the pharmacist's ability to observe signs of and visual cues to the beneficiary's health problems. A recent study published in the January 2012 edition of *Health Affairs* demonstrated the key role retail pharmacies play in providing MTM services to beneficiaries with diabetes. The study found that a pharmacy-based intervention program increased beneficiary adherence and that the benefits were greater for those who received counseling in a retail, face-to-face setting as opposed to a phone call from a mail order pharmacist. The study also suggested that the interventions, including in-person, face-to-face interaction between the retail pharmacist and the beneficiary, contributed to improved behavior with a return on investment of 3 to 1.

For these reasons, NACDS encourages the state to maximize the promotion and utilization of MTM services provided by community pharmacists as a means for improving the heath benefits in its initiative to integrate care for the dual eligible population. In doing so California should also consider increasing access to MTM for those beneficiaries eligible for Medicare for the first time and those beneficiaries transitioning from hospitals and other long-term-care settings.

Thank you again for the opportunity to provide you with this information. We look forward to partnering with you in the future on issues impacting retail pharmacy.

Sincerely,



Diane L. Darvey, Pharm.D., JD
Director, Federal and State Public Policy

National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

May 4, 2012

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Delivered via e-mail to: info@CalDuals.org

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

Dear Director Douglass,

Thank you for providing this opportunity to comment on the draft proposal for California's Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals. The National Senior Citizens Law Center has been an active participant in the dual eligible demonstration stakeholder process. We participated in the 1115 dual eligible technical workgroup, served on the Dual Eligible Technical Assistance Panel, currently co-lead a stakeholder workgroup on beneficiary enrollment, notification and appeals and have been involved in numerous meetings and conversations with Department staff and contractors.

We support the goals of the Demonstration and have had high hopes that the Department of Health Care Services would use the opportunity presented by the Demonstration to develop innovative, person-centered systems of care that would simplify the existing system and improve access to care for dual eligibles.

Unfortunately, we do not believe that this proposal will accomplish these goals. We have concerns about the following components of the plan. Our comments below and the attached comment chart provide more detail about our concerns.

1. **Implementation Schedule:** The proposal lacks detail on a number of important elements including: rate setting, readiness and network adequacy standards, appeals system design, assessment tool, beneficiary notices, evaluation criteria and more. Time is running out to finalize these details before the demonstration is slated for implementation. The Department proposed an implementation schedule that will force the state and stakeholders to rush these important policy decisions. It will also not provide enough time to properly notify beneficiaries of these immense changes or to expand existing medical networks and develop new long term services and supports networks.

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Recommendation: Finalize important details like appeals processes, network adequacy standards and the uniform assessment tool before implementing the demonstration.

Recommendation: Join the growing list of states that are pushing implementation back to 2014 and implement the four county demonstration over a two year period.

2. **Enrollment Process:** The Department proposes mandatorily enrolling dual eligibles into Medi-Cal managed care, passively enrolling them into the demonstration and then locking them into plans even if when the plan is not meeting their needs. This enrollment process represents a significant weakening of consumer protections and cannot be justified as necessary to complete the goals of this project.

   Recommendation: Opt-in enrollment is the most appropriate enrollment vehicle for any demonstration. Leaving one's established care delivery network to participate in an experiment should be an entirely voluntary choice.

3. **LTSS Integration**: The Department proposes integrating long term services and supports as part of the demonstration. We support the goal of integrating LTSS in order to maximize the ability of dual eligibles to remain in their homes and communities. More details and consumer protections are necessary,however, to ensure that the demonstration leads to greater, not worse, access to home and community based services.

   Recommendation: Add additional consumer protections to ensure that access to home and community based services is improved under the demonstration.

4. **Plan and Site Selection:** The fact that the Department has selected several plans that have poor quality ratings in the Medicare and Medi-Cal programs is a major concern. We are particularly worried about the two plans that have below average ratings in the Medicare program and the one plan that has a recent history of significant Medicare enrollment and marketing sanctions. We are also concerned that the plans selected are currently serving too small a number of dual eligibles to take on the increased enrollment targeted by this proposal.

   Recommendation: Select only plans with strong performance records in both Medicare and Medi-Cal. Do not allow plans with below average Medicare quality ratings or plans with a recent history of sanctions in the Medicare program to participate.

Los Angeles County, in particular, is not an appropriate place to launch such a complicated and difficult demonstration. The dual eligible population is larger and more diverse in Los Angeles County than any other in the nation. The plans that were selected in Los Angeles County have poor performance records in the Medicare and Medi-Cal programs and are currently serving just 7,500 of the County's 373,000 dual eligibles.

Recommendation: Select counties of a manageable size with quality, experienced plans. Do not include Los Angeles County in the demonstration. If Los Angeles County is included, prohibit the selected plans from utilizing passive enrollment.

5. **Number of counties:** The proposal includes expansion of the number of counties participating in the demonstration beyond the originally authorized four. There are not more than four counties with high quality plans ready to implement the demonstration. Including more counties, plans and beneficiaries will make the demonstration more difficult to prepare for, explain to the community and oversee and monitor. If the goals of the demonstration are not met, it will be harder to make adjustments or reverse course.

   Recommendation: Focus the demonstration on no more than four counties that have demonstrated the capacity to take on this difficult task. Wait to learn from those counties before expanding.

6. **Beneficiary Protections and Improvements:** The proposal does not include many new protections nor guarantee any new benefits or services for dual eligibles. The care coordination it offers is already available to dual eligibles through existing Medi-Cal and Medicare managed care organizations and, for some, through home and community based services like CBAS and MSSP. Other potential benefits the proposal purports to offer – for example, dental and vision benefits the state has cut in recent years and expanded access to home and community based services – are theoretical and contingent upon financing. The proposal must guarantee that beneficiaries will get something they cannot get now.

   Recommendation: Require the inclusion of additional benefits like dental and vision in the plan benefit packages. Create specific requirements related to the enhanced provision of home and community based services.

Thank you for the opportunity to submit these comments. Please let us know if you have and questions or would like to discuss our comments further.

Sincerely,

Kevin Prindiville
Deputy Director

Georgia Burke
Directing Attorney

EXPANDED COMMENTS ON MAJOR ISSUES OF CONCERN

1. IMPLEMENTATION SCHEDULE

The Department is proposing to start the notice process to beneficiaries in October 2012 and to begin enrollment in January 2013. Passive enrollment would be phased in based on birth month.

We oppose the timetable as unrealistic and unsafe for dual eligibles.

As the Department is well aware, most of the details of the demonstrations are still being decided. They include such critical items as:

- Rate setting
- Readiness and network adequacy standards
- Care Coordination Standards
- Uniform assessment tools
- Appeals system design
- Beneficiary notices
- Evaluation criteria
- Enrollment procedures, disenrollment, marketing rules and more.

In light of their complexity, the need for stakeholder input and CMS consultation, none of the designs for these elements are likely to be in place until late summer or early fall. All must be operationalized by January 1, and enrollment procedures need to be operationalized by October 1.

Our first concern is that the forced speed of the design phase will lead to poor policy decisions. Merging elements within Medi-Cal that have operated separately is itself a huge undertaking. Merging Medicare and Medi-Cal in addition is doubly challenging. Though the Department has set up workgroups for some of the biggest issues, the compressed timeframe does not allow for as much detailed analysis as is needed. Errors on the front end can lead to serious disruptions in implementation.

Our second concern is implementation. Each element must be operationalized, which involves coordinating data systems, setting up new procedures and protocols, training, scripts, notices, etc. To be done right, these all take more time than the three or four month window between finalizing contracts and going "live."

Plan provider networks need to be developed. In Los Angeles County, for example, the chosen plans currently provide Medicare benefits to only 7,492 (2%) of the County's duals. Together they will enroll as many as 30,000 duals each month under the demonstration. The growth needed in providers with expertise to serve the chronic conditions and special needs of duals is substantial. And simply signing up more providers is only the start. If the

demonstrations are to fulfill their promise, new providers need to be trained in the care coordination protocols of the plan, and systems need to be in place for the sharing of records, collecting encounter and evaluation data. Making all this happen with a large number of new providers again takes more time to do right than the current schedule would allow.

The appeals system is another example. A coordinated appeals system has not yet been designed. Yet by January 1, that system needs to be operational. Procedures must be devised to implement the new systems; beneficiary explanations of procedures need to be written; procedure manuals for internal and external decision-makers need to be developed; model notices must be written; and most importantly, reviewers need to be trained in how to apply both Medicare and Medicaid standards to any claim.

We also have serious concerns that the relentless pace of the demonstration will lead to shortcuts in readiness reviews. There will be pressures from many fronts to provisionally approve plans, proceed even if data systems have not been fully tested and otherwise cut corners in order to start enrollment on schedule. The experience with the transition to Medicare Part D in January 2006 provided a vivid lesson in the harm to beneficiaries when they are thrust into a system that is not ready to meet their needs. The risks to beneficiaries are simply too high to justify a race to meet an artificially imposed deadline.

As importantly, beneficiaries and the community need to be educated and prepared for the demonstration. Under the proposed timetable, it will be impossible to provide the needed groundwork with providers, beneficiaries and their families, community organizations and the public at large so that they can understand the significant changes that the demonstrations will represent. It will be difficult and will take time to prepare clear beneficiary notices in multiple formats and languages within the proposed timetables – an essential task given the diversity and need for alternative formats in this population.

We also have serious concerns that the timetable in inadequate for the training that will be needed for the many players who will be involved in assisting beneficiaries through the process, including but not limited to enrollment brokers, choice counselors, current providers to beneficiaries, state, federal and plan CSRs and many other parties.

The need to properly lay the groundwork in the community and particularly the provider community cannot be overstated. Advocates are already hearing from beneficiaries that their doctors are saying that they will no longer be able to treat the beneficiary if the beneficiary is in managed care. This is causing confusion and distress among beneficiaries. The providers are acting in many cases out of misinformation or, at least, lack of information. One lesson from the SPD enrollment experience and from the move of CBAS to managed care has been that significant time and effort are needed to prepare providers and beneficiaries for a significant change. Many of the problems that SPD

beneficiaries have had in transitioning to the new system have arisen because, despite transition policies, their current providers have been fearful, misinformed or simply so wary of the new system that they refuse to continue treatment. The lead time for informing providers in the SPD program was 9 months and that was insufficient.

The problem is repeating itself with the CBAS program. Currently many CBAS enrollees are telling advocates that they fear they will have to leave the CBAS program because their Medicare providers are telling them that they are unwilling to be part of managed care, even though in fact, those providers do not need to join a managed care plan in order to continue to provide Medicare services to their patients. This is discussed in more detail below.

Without effective outreach to providers about the duals demonstration, the problems encountered in the SPD and CBAS transitions are likely to be magnified in the demonstrations, which are broader in scope and impact. As the SPD experience shows, such outreach takes time and effort. Yet dual eligibles will be receiving letters about their choices starting in October and will be looking for advice from their providers then. Since the full contours of the demonstration will not be available until late summer or early fall, it simply is not possible to get accurate information into the hands of diverse and independent providers, answer their questions and ensure an understanding of the demonstration's parameters.

> **Recommendation:** Join the growing list of states that are pushing implementation back to 2014 and implement the four county demonstration over a two year period.

> **Recommendation:** Finalize important details like appeals processes, network adequacy standards and the uniform assessment tool before implementing the demonstration.

2. ENROLLMENT

The proposed enrollment process does not pass the test of creating a simpler system that includes strong consumer protections and will be easier for beneficiaries to understand and navigate. Instead, the proposal weakens current consumer protections and introduces new complexity and confusion to the system. As a result, beneficiaries risk losing access to current Medicare and Medi-Cal providers and services.

The Department is proposing to change both the Medicare and Medi-Cal enrollment rights of dual eligibles in several significant ways. It currently has state legislative authority to make some of these changes, but not others. All of the proposed changes would require new federal authority. The various layers of the proposed enrollment process and the fact that the proposed policies have not yet been authorized by the Legislature makes the proposal difficult to

comment on and nearly impossible to explain to community based organizations and providers, not to mention individual dual eligibles. Misinformation about the enrollment process is already spreading through the community. Below are comments on each distinct change to the enrollment system.

Mandatory Medi-Cal Managed Care Enrollment

The Governor's Coordinated Care Initiative (CCI), which is pending before the state Legislature and will likely not be acted upon before submission of this proposal to CMS, proposes requiring all dual eligibles to enroll in a Medi-Cal managed care plan to receive their Medi-Cal benefits. Dual eligibles in the demonstration counties would be included, but so would dual eligibles in all other Medi-Cal managed care counties. Currently, dual eligibles in County Organized Health System counties are required to enroll in Medi-Cal managed care, but those in Two-Plan and Geographic Managed Care counties are not. The Department does not have authority from the state Legislature or CMS to expand mandatory managed care enrollment to all Two-Plan and GMC counties. The proposal does not specify what authority would be sought to get approval for this change from CMS or when.

When the Department developed its 1115 Bridge to Reform Waiver less than two years ago, it could have requested authority to mandatorily enroll dual eligibles in all managed care counties into Medi-Cal managed care. It wisely refrained from doing so. For dual eligibles, Medicare is the primary payer for most services. Medicaid wraps around the Medicare benefits providing additional coverage of long term services and supports.

A managed care plan responsible for only the Medi-Cal benefits will have little incentive or ability to manage the care of the individual since most of the medical care is being provided by another program and payer (Medicare). There is, however, a serious risk that access to Medicare providers and services will be impeded. We are seeing this dynamic play out now in the transition of dually eligible CBAS recipients into Medi-Cal managed care plans. As stated above, beneficiaries are being told by their Medicare providers that they will refuse to continue to see patients that enroll in a Medi-Cal managed care plan. The Department has indicated to CBAS providers that there is nothing they can do about this problem. In addition, some plans have told beneficiaries that they need to select a new primary care physician that is a member of the Medi-Cal managed care plan network, even though it is Medicare that will be the primary payer for services provided.

We oppose the Department's proposal to mandatorily enroll duals eligibles into Medi-Cal managed care in Two-Plan and GMC counties.

Passive Enrollment into the Demonstration Plan

In addition to requiring dual eligibles to enroll in managed care plans to receive Medi-Cal benefits, the Department proposes passively enrolling dual eligibles into those same plans to receive their Medicare benefits.

Under current law, dual eligibles, like other Medicare beneficiaries, have to right to choose their own providers. Since Medicare managed care plans restrict beneficiary choice to a network of contracted providers, in almost all cases, Medicare beneficiaries are defaulted into Original or Fee for Service Medicare where their freedom of choice rights are preserved to the full extent. With limited exceptions, Medicare beneficiaries must actively choose to enroll in a Medicare managed care plan.

The proposal would change the default enrollment for dual eligibles from FFS Medicare to a private managed care plan. The accompanying restrictions on provider access represent a weakening of a key consumer protection – freedom of choice of providers. As a result, many beneficiaries will lose access to current Medicare providers and will have fewer options for Medicare providers than they have now.

We oppose the Department's passive enrollment proposal.

Lock-In Enrollment

Going even a step further, the Department would require individuals that enroll in a plan, either by their own choice or through the passive enrollment process, to receive their Medicare benefits from the plan for 6 months.

This proposal goes beyond MMCO's 'preferred enrollment' standard and represents a significant weakening of current consumer protections. In recognition that dual eligibles are a particularly vulnerable population with changing health needs that may require a disenrollment from a Medicare prescription drug or managed care plan that is not able to meet those needs, dual eligibles can currently change plans at any time. Even non-Medicaid eligible Medicare recipients have the right to disenroll from a Medicare Advantage plan during the first 45 days of a new plan year. The Department's lock-in proposal would leave dual eligibles with less protection then they have now and less protection than other Medicare beneficiaries have.

The lock-in proposal is particularly problematic when combined with a passive enrollment process. Many dual eligibles will end up enrolled in plans by default since the affirmative selection rate for this population is historically low. For these dual eligibles, by the time they realize they have been enrolled in a plan and understand the impact the enrollment will have on their access to providers and services, they will be stuck in the plan.

If the lock-in period were ultimately pursued, many questions about how the lock-in enrollment period would work in the context of a phased enrollment process and current Medicare enrollment periods would need to be addressed.

We oppose the Department's lock-in proposal.

D-SNP Enrollment and PACE

While not discussed in the proposal, the Department recently released guidance for existing Dual Eligible Special Needs Plans. Under the guidance, D-SNP's in the demonstration counties will be encouraged to contract with the Demonstration Plan to meet MIPPA requirements. These contracts may or may not include requirements for the D-SNP to provide Medi-Cal covered services including LTSS. If a contract is signed, enrollees in the D-SNP will not be subject to passive enrollment into the duals demonstration.

While we do not have a particular proposal for how to handle existing D-SNPs, we note that the current guidance only creates a more complicated set of enrollment options and possibilities that will be extremely difficult to explain to beneficiaries and those that serve them. It will also be extremely difficult to monitor the quality of services provided under these subcontracts. The Department's inability to spot this issue earlier and design an easy to understand policy to address it, raises serious concerns about whether it has the resources and expertise necessary to implement this proposal properly.

The draft indicates that PACE would remain an option, but fails to recognize the impact an "opt-out" model would have on PACE enrollment. Without an independent assessment and screening tool done in conjunction with enrollment, there is a risk that this proposal could harm California's (and the nation's) most successful model for integration.

Insufficient Enrollment Protections

To address some of the concerns above, the Department offers a care continuity provision which would allow individuals to continue to see current Medicare providers for up to 6 months, even if those providers are not part of a plan's network. While very important, the proposed care continuity provision is an insufficient protection for a passive enrollment model as it relies on a provider's willingness to accept payment from the demonstration plan. The CBAS and SPD transitions have made clear that many providers are unwilling to continue seeing patients once they have enrolled in a managed care plan. The Department is aware of this problem and there is nothing in the proposal that will remedy it. The care continuity provision included is very similar to the one which is exists and, according to reports from the field, has not been effective in the SPD process.

We do not fully understand the providers' reluctance to accept payment or enter into contracts with the managed care plans, but we expect that it is based in part on concerns about rates and administrative complexities. Regardless of whether these concerns are valid, it is the beneficiary who will suffer. An alternative approach would be to allow the out-of-network provider to continue to receive payments directly from Medicare and Medi-Cal during a transition period.

The Department also commits to designing and implementing an enrollment process that provides seamless transitions with no disruptions in care. While we agree with that goal, we note the lack of details provided at this point as to how this would be achieved. We also note the short timeframe available to develop a successful process for transitioning such a large number of beneficiaries, especially in a county as large, diverse and complex as Los Angeles.

Finally, the proposal indicates that plans may partner and contract with local advocacy organizations, providers and case managers to assist with outreach and enrollment activities. While the need for local advocacy organizations, providers and case managers to assist beneficiaries in understanding their enrollment choices is clear, support for this work must not come in the form of direct contracts with plans where incentives will exist to enroll individuals into the demonstration even if the enrollment would not be in their best interest. Consumer assistance must be both conflict-of-interest free and funded. If plans are funding the assistance, the money should be administered by an independent entity and without any targets or incentives for enrollment.

Medicare Advantage plans, including some of the plans selected to participate in the demonstration, repeatedly violated and exploited Medicare marketing rules during the years following the creation of the Medicare Advantage program. The demonstration must not weaken important protections which were created to protect dual eligibles from these abuses.

In addition to providing enrollment assistance, the proposal must include a plan for developing a dedicated, independent Ombudsman to monitor the enrollment process and ongoing performance of the plans. The Ombudsman must have expertise in Medi-Cal, Medicare and long term services and supports. The Ombudsman will be most effective at assisting individuals and identifying systemic problems if it is housed in a strong advocacy organization with a history of advocating for this population. In Wisconsin, which is often held out as a successful model for managed integrated care, Disability Rights Wisconsin receives funding to serve as the Ombudsman. We recommend a similar approach, utilizing Disability Rights California and the Health Consumer Alliance.

Beneficiary Reaction to the Proposed Enrollment Process

It is important to note that there has been limited, if any, beneficiary support for the enrollment process the Department has outlined. Even when the proposal was limited to a passive enrollment with full and open opt-out rights, beneficiaries objected. When the Department surprised stakeholders by including a lock-in proposal in a draft document in January, opposition to the enrollment model specifically and the proposal generally escalated significantly.

The reaction of beneficiaries may be based in part on the Department's continued inability to explain how the proposed enrollment process represents an increased consumer protection. The Department claims that passive enrollment with a lock-in is necessary "to ensure a sufficient volume of enrollees over the demonstration period," but has failed to define publicly what "sufficient volume" would be. As mentioned above, the two plans selected to serve as demonstration sites in Los Angeles County currently serve, collectively, about 7,500 dual eligibles in their D-SNPs. There are over 370,000 dual eligibles in Los Angeles County. How many of these dual eligibles would need to enroll in the demonstration to make it successful and sustainable? How many new enrollees could these plans realistically absorb over a year? In San Mateo County, nearly 60% of all dual eligibles in the County are already enrolled in the health plan. How many more are needed to have a sustainable model?

The Department has also asserted that the lock-in is necessary to "encourage beneficiaries to establish a relationship with a plan and providers, so beneficiaries can adequately evaluate this care model." In meetings, the Department has framed the issue differently, asserting that plans need the lock-in to be properly incentivized to provide good care. The implication is that if beneficiaries have the opportunity to opt-out of the demonstration or change plans at any time, they will do so frequently, making it impossible for a plan to prepare to meet the needs of the population. But again the Department provides no evidence to support this implication. Experience in Medicare Part D, Medicare Advantage and PACE indicates that this population does not opt-out of or change plans at a high rate. Nationally, disenrollment rates for PACE (a completely voluntary program that beneficiaries can leave at anytime) are just 5%.[1] Disenrollment rates for non-Private Fee For Service Medicare plans are below 9%.[2] When individuals do disenroll from Medicare managed care plans they do so because of problems accessing providers and services or because

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[1] MedPAC analysis of 2009 data from the MBD/CMS Medicare Entitlement File, 2009 Medicare Denominator File. http://www.medpac.gov/transcripts/Duals%20presentation_Public%20slides_final.pdf

[2] Government Accountability Office, Characteristics, "Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans," December 2008. http://www.gao.gov/new.items/d0925.pdf

they were misled into joining the plan in the first place.[3] It is in the best interest of the state, CMS and beneficiaries that they have the right to leave a plan that is not working for them. Plans that provide quality services do not and will not struggle to retain enrollees.

> **Recommendation:** Use a truly voluntary "Op-In" process for both Medicare and Medi-Cal benefits; including the right to disenroll at anytime.

We have repeatedly indicated our desire for a truly voluntary, opt-in enrollment process. Such a system would honor the autonomy, independence and choice of the individual. A voluntary enrollment process for Medicare benefits preserves for low-income dual eligibles the same right to provider and delivery system choice that exists for middle and higher income Medicare beneficiaries. Preserving that choice is key to maintaining continued access to specialists and other providers that may not participate in the integrated model, particularly for those with complex medical conditions. Maintaining a voluntary Medi-Cal managed care process in the Two Plan and GMC counties allows beneficiaries to avoid disruptions to Medicare provider relationships that may occur as a result of the Medi-Cal managed care enrollment.

Voluntary, "opt in" enrollment processes have been used by integration models that are generally regarded as positive, beneficiary-centered programs. For example, the Program for All-Inclusive Care for the Elderly (PACE) is an "opt in" model. Massachusetts' Senior Care Options, Minnesota's Senior Health Options and Wisconsin's Family Care Partnerships all use an "opt in" enrollment model. An "opt-in" enrollment mechanism ensures that participating plans attract and retain enrollees by offering each enrollee a higher quality, more coordinated experience than the one they have in the fee-for-service system. The "opt in" model also ensures that program participants are committed and willing to use the care coordination services that the model is designed to provide.

Opt-in enrollment is the most appropriate enrollment vehicle for any demonstration. Leaving one's established care delivery network, however imperfect, to participate in an experiment should be an entirely voluntary choice.

3. LTSS Integration

We support the proposal to integrate long term services and supports into the demonstration in an effort to improve access to and delivery of home and

[3] Medicare Rights Center, "Why Consumers Disenroll from Medicare Private Health Plans," Summer 2010. http://www.medicarerights.org/pdf/Why-Consumers-Disenroll-from-MA.pdf

community based services. The process of integrating LTSS is difficult and complex and must be undertaken with great care to ensure compliance with the Americans with Disabilities Act and Olmstead. Additional details and protections must be added to the proposal to ensure that beneficiaries are properly protected.

IHSS Integration

We are heartened by much of the language in the proposal and the Department's proposed trailer bill, including that IHSS consumers will retain the ability to "select, engage, direct, supervise, schedule, and terminate IHSS providers" and that processes for assessing and approving hours will be based on current statutory authority. However, we are concerned that the administration's proposal stops short of guaranteeing the preservation self-directing IHSS. Here are some of our major concerns:

The purpose of maximum inclusion and integration is not yet a meaningful part of the managed care plan's obligations. The Department relies on the idea of inclusion of all long term care into a single capitated rate as providing sufficient incentive for plans to provide IHSS and other home and community based services, which are generally much less expensive than nursing home or hospital care. To the extent that IHSS serves to prevent unnecessary hospitalizations and nursing home stays, we agree. However, IHSS does not exist merely to prevent hospitalization. It also serves the purpose of allowing independent living in the most integrated setting possible. The Department has not shown how it will require plans to take into account this value when calculating their bottom line. In fact, plans who are paid a single capitated rate for all LTSS will have an incentive to keep hours as low as possible, so long as the resulting deterioration in the consumer's condition stops short of hospitalization or nursing home care. While the administration claims it will prevent this by refusing to allow plans to cut existing IHSS hours, it has not explained how it will ensure that plans' incentives to cut costs do not gradually erode the availability of IHSS and its support for independent living, especially for new consumers.

Second, the proposal does not explain how it will ensure that managed care plans have the necessary expertise to play a meaningful and appropriate role in IHSS needs assessment and coordination of care. For consumers whose care coordination needs are very high, a great deal of expertise and care coordinator direct involvement is required, often in social or non-medical arenas outside the competence of mainstream managed care plans. Research shows that existing successful models of managed care for dual eligibles with integrated LTSS rely on strong ties to the local community, have extensive experience dealing with particular populations of duals, and evolve slowly and gradually over time. These qualities are not easily replicated by the vast majority of the plans that have been selected. Meanwhile, consumers who self-direct IHSS independently may find their autonomy undermined if a plan becomes involved in either care

coordination or assessment in any substantial capacity.

Third, the Department has not guaranteed that consumers' rights will be preserved. For instance, the Department's trailer bill states that IHSS would still be subject to "a grievance and appeal process," but it falls short of explicitly guaranteeing that consumers will continue to enjoy all the rights that they currently have. Over decades of existence, the IHSS program has developed a rich system of regulations and rules that serve to protect consumer rights ranging from a prohibition on forced "volunteer" care providers to language access for the limited English proficient.

> **Recommendation:** Affirm the maximum inclusion and integration principle of the IHSS program, add requirements for plan competence and include strong, specific consumer protections.

The most important consumer protection is the right to choose not to join or to opt-out of managed care for IHSS consumers who wish to maintain or develop their own provider networks rather than join a plan. The above discussion provides more details on the enrollment process, but we wanted to note here that the denial of a right to opt-out and/or institution of a lock-in period are particularly inconsistent with the Olmstead plan principle of self-determination, and duals' rights to freedom of choice of providers.

For those who do choose to join or remain in a plan, yet who are self-directing and receive services through the IP mode, self-determination should be preserved by making plan involvement in IHSS available a la carte, allowing self-directing consumers to design integration to make sense for their particular circumstances. Areas where a consumer may exercise choice should include, for instance: determining whether IHSS providers are involved in the consumer's care team, and the extent of that involvement; determining necessary qualifications for IHSS providers; determining necessary training for IHSS providers.

In order to avoid undermining the role that IHSS plays in implementing Olmstead, the legislature and the administration should take all feasible steps to ensure that the current IHSS program remain a minimum floor for benefits and consumer protections. This can be accomplished in part by:

- Keeping counties responsible for independent needs assessments, providing a benchmark for evaluating the added value of plans.
- Requiring that each plans' LTSS expenditures, as a percentage of total expenditures on duals, remain at or above the current percentage, and that community LTSS expenditures, as a percentage of total LTSS expenditures, remain at or above the current percentage.
- Incorporate the Hourly Task Guidelines, which reflect years of careful stakeholder process, in both implementing legislation and plan contracts.
- Guarantee consumers who get IHSS through managed care all of the

rights (including for judicial review) they enjoy under the current system. State legislation and plan contracts should make clear that plans are responsible for complying with the Americans with Disabilities Act, and that they share in the state's liability.

- Enshrine the Olmstead purpose of IHSS in statute and in contracts.

Other LTSS Programs

We are particularly concerned about the proposal to completely integrate MSSP into the managed care plan's operation. The MSSP program has a long history of successfully providing intense case management services for nursing facility eligible persons so they can remain in the community. This is an infrastructure that should be preserved and built on, not destroyed in favor of a system administered by plans which have never done this type of work. The better model would be to require plans to contract with MSSP for case management of these high need individuals who are nursing facility eligible and express a preference for living in the community.

> **Recommendation:** Require plans to contract with MSSP for case management of dual eligibles who are nursing facility eligible and express a preference for living in the community.

4. SITE AND PLAN SELECTION

We doubt, for the following reasons, the proposal's claim that the Department conducted a 'rigorous selection process' to select plans that 'demonstrate a proven track record of business integrity and high quality service delivery.'

First, only one plan that responded to the Request for Solutions (RFS) did not receive an approval letter. That one plan happens to be under investigation for Medicare and Medi-Cal fraud. All plans not under investigation for fraud were approved. Two plans received approval letters even though they were the only plan to apply from a Two-Plan or GMC county (the RFS clearly required that more than one plan apply from those counties).

Second, many of the plans selected have records of poor performance in both the Medicare and Medi-Cal programs. NSCLC recently released a report summarizing the Medicare plan performance ratings and Medi-Cal CAHPS scores of the plans that were selected to participate in the four initial Demonstration counties.[4]

On the Medi-Cal side, seven of the eight plans received a global health plan rating of 1 out of 5 stars. On the Medicare side, two of the plans selected have a below average rating and have received a notice of non-compliance from the

[4] National Senior Citizens Law Center, "Assessing the Quality of California Dual Eligible Demonstration Health Plans," May 2012. http://dualsdemoadvocacy.org/wp-content/uploads/2012/02/Plan-Ratings-Report-May-2012.pdf

Medicare program. One of those has been marked as a low-performing plan for three consecutive years and is at risk for termination of its Medicare contract. Another plan was recently sanctioned by Medicare as a result of beneficiary access problems. Medicare continues to restrict the enrollment of dual eligibles into that plan's Part D products. All eight proposed demonstration plans were found to be low-performing on at least one composite Medicare quality measure.

Finally, a review of the publicly available plan applications revealed that many of the plans failed to comply with the requirement in the RFS that they provide three years worth of data on all Medi-Cal and Medicare quality performance indicators. At least two of the plans failed to provide any performance data at all. We question how a plan could be approved at all if it failed to comply with the application requirements found in the RFS. We also wonder how the Department could verify the quality of these plans without reviewing quality performance results.

The proposal includes a concern that Medicare star ratings may not accurately capture the performance of plans serving dual eligibles. We note that several of the plans selected for the demonstration have average plan Medicare ratings and several plans serving dual eligibles in California and across the country have above average and excellent ratings. If the Department believes that the star rating system is not sufficient, another measure should be offered to demonstrate the high quality of plans selected to participate.

> **Recommendation:** Select only plans with strong performance records in both Medicare and Medi-Cal. Do not allow plans with below average Medicare quality ratings or plans with a recent history of sanctions in the Medicare program to participate.

Los Angeles County

Los Angeles County's size, diversity (a large number of LA County dual eligibles speak a language other than English at home) and complex publicly-funded health system make it one of the most difficult places in the country to conduct a dual eligible integration demonstration. The plans selected to participate in the county have poor performance records and currently serve a very small portion of the county's dual eligibles.

The NSCLC report indicates that Health Net's Medicare plans have a very recent history of Medicare enrollment and marketing sanctions. Due to problems providing access to prescription drugs, the plan was barred for nearly all of 2011 from enrolling any new members. While these sanctions were lifted in late 2011, the plan is still prohibited from auto-enrolling dual eligibles into its Part D benchmark plans. On the Medi-Cal side, the plan received very low scores including the second lowest score statewide on the measure of "Getting Needed Care."

According to the NSCLC report, LA Care has a below average rating from Medicare and has received notice from Medicare that it is out of compliance with the Medicare program. A plan that is rated below average three years in a row is at risk of termination of its Medicare contract. LA Care has only been below average for one year, but in previous years the plan has been too small to receive any rating at all.

Combined, Health Net (4,632) and LA Care (2,860) serve fewer than 7,500 of Los Angeles' 373,941 dual eligibles. We do not see how receiving an additional 175,000 or more enrollees each via a passive enrollment process would help either plan cure their current performance problems.

> **Recommendation:** Select counties of a manageable size with quality, experienced plans. Do not include Los Angeles County in the demonstration. If Los Angeles County is included, prohibit the selected plans from utilizing passive enrollment.

San Diego County

While San Diego County has shown a commitment to improving care for dual eligibles over the last several years, we have concerns about several of the plans selected.

Molina is one of the lowest performing Medicare plans in the state of California. As a plan that has received a below average rating for three years in a row, it is now identified as a 'low performing plan' on the Medicare.gov website. Medicare has told 'low performing plans' that they are at risk of termination of their Medicare contract and has granted a Special Enrollment Period to all current members allowing them to leave the plan. Molina also received low ratings on the Medi-Cal side of its business.

Our concerns about Health Net's Medicare plans are summarized above. Health Net's San Diego Medi-Cal plan raises additional concerns as it is ranked lowest in the state for in Rating of Health Plan (Adult) and Getting Needed Care (Adult). It is third lowest in the state for Rating of all Health Care and fifth lowest for Shared Decision-Making (Adult).

Care 1st had an average overall Medicare ranking, but was below-average in several key areas. On the Medi-Cal side, it has a low overall rating and was among the state's lowest plans for Shared Decision-Making and Rating of All Health Care.

Community Health Group serves too small a number of dual eligibles to receive an overall Medicare rating, but received a below average ranking for several individual measures. The plan received low ratings in the Medi-Cal program.

Combined, Care 1st (2,086), Community Health Group (1,071), Health Net (2,318) and Molina (1,252) serve just 6,727 of San Diego's 75,724 dual eligibles. We do not see how receiving an additional 18,000 or more enrollees each via a passive enrollment process would help any of these plans to cure their current performance problems.

> **Recommendation:** Move forward with the demonstration in San Diego County, but without passive enrollment. If passive enrollment is used, prohibit Molina and Health Net from receiving passive enrollments. Enrollment of members into the remaining two plans should occur over at least a two year period to ensure that the plans can handle the increased enrollment.

Orange and San Mateo Counties

The performance records of the plans in these two counties, while clearly demonstrating room for improvement, raise fewer concerns. We are concerned, however, about each plan's ability to handle the large influx of new members that a passive enrollment process would bring. CalOptima currently provides Medicare benefits to just 13,400 of Orange County's 71,588 dual eligibles. The Health Plan of San Mateo County currently provides Medicare benefits to 7,925 of the county's 13,787 dual eligibles (the highest percentage of any plan by far).

> **Recommendation:** Move forward with the demonstration in these counties, but without passive enrollment. If passive enrollment is used, enroll members into CalOptima over a two year period to ensure that the plan can handle the increased enrollment.

5. NUMBER OF COUNTIES

Under the CCI, the Department seeks authority to enroll into the demonstration up to 750,000 dual eligibles in ten counties in 2013 and over 1 million dual eligibles in 28 counties by 2015. This reflects a significant departure from California's plan in early 2011 to enroll just 150,000 dual eligibles in up to four counties and poses significant risk to beneficiaries and the state of California.[5] The decision to expand the scope of the demonstration appears to be driven primarily by the desire to save money, as a reasonable policy rationale for the change has not been provided. We oppose the proposal to expand the demonstration beyond four counties and object to the inclusion of Los Angeles County (see more information on Los Angeles County above).

The more beneficiaries that are enrolled in the demonstration in the first year, the more difficult it will be to notify them about and assist them through the

[5] California DHCS Response to Request for Proposal, State Demonstrations to Integrate Care for Dual Eligibles, January 28, 2011. http://www.dhcs.ca.gov/Documents/State%20Demonstrates%20to%20Integrate%20Care%20for%20Dual%20Eligibles.pdf

transition. Identification of sufficient numbers of providers to serve higher numbers will be a challenge as will the creation of enrollment and data management systems capacity. Implemented on too large a scale, it will be difficult to correct problems that arise.

Implementing the demonstration for more beneficiaries in more counties in 2013 also means involving more health plans. As discussed in more detail above, we do not believe that there are sufficient plans prepared to take on this complicated project at this time.

Enrolling that many dual eligibles into these new models before we know whether and how they will work also puts the state of California at risk. Despite not mentioning cost savings as a goal of the demonstration, it is obvious that the Department is making decisions primarily based on their budget impact. If savings are not realized, however, or the quality of care is not maintained or improved as imagined, the state will have few options for laying out a new course of action.

> **Recommendation:** Focus the demonstration on no more than 4 counties that have demonstrated the capacity to take on this difficult task. Wait to learn from those counties before expanding.

6. <u>BENEFICIARY PROTECTIONS AND IMPROVEMENTS</u>

As mentioned above, there are many important areas where consumer protections have not been fully developed and where time is running short do so. Enrollment process, care continuity rules, appeals and grievances, network adequacy rules, language and disability access rules are just a few. These protections must be detailed well in advance of implementation so that beneficiaries understand their rights, plans understand their obligations and the Department and CMS have in place mechanisms for ensuring the protections are working.

We also note that while the proposal provides the Department and Medicare savings and managed care plans new enrollment and expanded business, it includes no guarantee of any new benefits or services for dual eligibles. The care coordination it offers is already available to dual eligibles through existing Medi-Cal and Medicare managed care organizations and, for some, through home and community based services like CBAS and MSSP. Other potential benefits the proposal purports to offer – for example, dental and vision benefits the state has cut in recent years and expanded access to home and community based services – are theoretical and contingent upon financing. The proposal must guarantee that beneficiaries will get something they cannot get now.

> Recommendation: Add more details on consumer protections including care continuity, appeals and grievance, ombudsman, the enrollment process, network adequacy and language and disability access rules.

Recommendation: Require the inclusion of additional benefits like dental and vision in the plan benefit packages. Create specific requirements related to the enhanced provision of home and community based services.

Comments on other elements of the proposal are provided in the comment response form attached to this letter.

Taxpayers watchdog since 1945

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May 1, 2012

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

Dear Director Douglas:

On behalf of the San Diego County Taxpayers Association (SDCTA), I appreciate the opportunity to comment on the Draft Coordinated Care Initiative: California's Dual Eligibles Demonstration. Over the past few years, we have offered the County of San Diego feedback on the performance of In-Home Supportive Services (IHSS).

Consistent with our mission of promoting accountable, cost-effective and efficient government, we recognize that identifying appropriate metrics in the early stages of government programs is critical for accountability.

SDCTA respectfully requests the opportunity to participate in the stakeholder process to develop the statewide HCBS Universal Assessment Process. In addition, following are proposed modifications to the draft initiative.

Comments on the Draft Coordinated Care Initiative: California's Dual Eligibles Demonstration

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
1	17	"Beginning January 1, 2015, managed care health plans and counties will utilize the new universal assessment process described below for IHSS. The new universal assessment tool will be built upon the IHSS Uniform Assessment process, Hourly Task Guidelines and other appropriate home- and community-based assessment tools, and will be in addition to the health risk assessment process used by managed care health plans when beneficiaries initially enroll in managed care. All other IHSS processes described above will remain the same."	"Beginning January 1, 2015, managed care health plans and counties will utilize the new universal assessment process described below for IHSS. The new universal assessment tool will be designed to measure outcomes rather than process and may utilize the IHSS Uniform Assessment process, Hourly Task Guidelines and other appropriate home- and community-based assessment tools, and will be in addition to the health risk assessment process used by managed care health plans when beneficiaries initially enroll in managed care. All other IHSS processes described above will remain the same."

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
2	17	"Starting in June 2013, the State will lead a stakeholder process to develop a statewide HCBS Universal Assessment Process. This process shall be implemented no earlier than January 1, 2015. Providers, counties, and managed care plans will use it to assess the need for home- and community-based services. It will incorporate the current array of LTSS assessment tools, including the assessment tools used for IHSS. As noted above, this tool will be separate from and will not replace the Health Risk Assessment process used by managed care plans when beneficiaries initially enroll."	"Starting in June 2013, the State will lead a stakeholder process to develop an outcome-based, statewide HCBS Universal Assessment Process. This process shall be implemented no earlier than January 1, 2015. Providers, counties, and managed care plans will use it to assess the need for home- and community-based services. It will incorporate the current array of LTSS assessment tools, including the assessment tools used for IHSS. As noted above, this tool will be separate from and will not replace the Health Risk Assessment process used by managed care plans when beneficiaries initially enroll."

We appreciate your consideration of our comments as well as our request to participate in the State-led stakeholder process to develop the statewide HCBS Universal Assessment Process.

Sincerely,

Lani Lutar
President and CEO

LL/sdk

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May 4, 2012

Mr. Toby Douglas
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Sacramento, CA 95899-7413

SUBMITTED VIA E-MAIL to info@CalDuals.org

Re: Comments on California Coordinated Care Initiative

Dear Mr. Douglas:

SCAN Health Plan ("SCAN") is pleased to submit comments in response to the *Invitation to Provide Public Comment* on the Coordinated Care Initiative: California's Dual Eligibles Demonstration (the "demonstration"). SCAN commends California's proposal to enroll all Californians who are dually eligible for Medicare and Medi-Cal ("dual eligibles" or "duals") in high-quality, integrated health plans, as we agree that dual eligible individuals deserve seamless access to the care and social supports and services that will help them maintain good health and a high quality of life in the setting of their choice.

SCAN has provided high-quality, integrated, person-centered care to dual eligibles since shortly after our founding by community activists nearly 35 years ago. SCAN has extensive experience in coordinating Medicare, Medicaid, and home- and community-based services (HCBS) benefits, as well as supplemental services. Today, SCAN is the nation's fourth largest not-for-profit Medicare Advantage plan, serving nearly 130,000 individuals, and is the only fully-integrated dual eligible special needs plan (FIDE SNP) in California. Nearly 20,000 of SCAN's enrollees are nursing home eligible. This frail and elderly population benefits from SCAN's close partnerships with health care providers that engage with plan members to provide the right care in the right setting at the right cost, while maximizing their ability to maintain their independence. As a result of this highly integrated network, SCAN has kept more than 100,000 seniors in the community and out of costly nursing homes since 1985.

We are pleased to once again submit comments as DHCS proceeds with its proposal to the Centers for Medicare & Medicaid Services (CMS). As SCAN is committed to ensuring high-quality care for the dual eligible population in California, we have participated in every step of the demonstration's development, including submission of comments in response to the June 2011 request for information, the October 2011 framework documents and the December 2011

draft Request for Solutions, as well as submission of applications to participate in the demonstration in four counties.

Below, SCAN has provided comments on the following topics:

- Future of specialized care management under the demonstration;
- Future of the PACE program;
- Integration of long-term services and supports (LTSS);
- Integration of mental health, behavioral health and substance use services;
- Quality measurement and evaluation of demonstrations and existing programs.

I. FUTURE OF SPECIALIZED CARE MANAGEMENT

SCAN is very concerned that the demonstration, as proposed, does not appropriately provide for access to specialized care for individuals with complex care needs. In particular, the demonstration as drafted makes it unlikely that certain special needs plans (SNPs) will continue to be available to Californians in demonstration counties, and unclear whether the years of experience possessed by SNPs will be built upon after the transition.

SNPs are health plans that have been specifically designed to provide coordinated, continuous care to individuals who require targeted interventions and monitoring to address their significant health care needs. In the years since SNPs were first opened to Medicare beneficiaries, many have become increasingly skilled in developing and delivering specialized plans of care to individuals with multiple chronic conditions, varying degrees of frailty, and other risk factors. In particular, certain dual eligible SNPs (D-SNPs) have developed effective models of care that address the unique needs of the duals population and seamlessly combine their Medicare and Medicaid benefits through a single point of access. Similarly, chronic condition SNPs (C-SNPs) have implemented models of care that are tailored to individuals with severe or disabling conditions such as diabetes, congestive heart failure and end-stage renal disease (ESRD). However, upon implementation of the demonstration, these plans may no longer be an option for dual eligible individuals in California.

As proposed (and pursuant to All Plan Letter 12-001), the demonstration would require that D-SNPs subcontract with a demonstration plan or contract with the State in order to participate and not lose their enrolled membership. D-SNPs that do not subcontract with a demonstration plan in a given county or are not awarded a direct contract with DHCS will lose their membership in the passive enrollment process under the demonstration and, presumably, would cease to exist in that county. This will result in a reassignment of D-SNP members to plans that are likely not as experienced in or capable of managing the health of frail seniors, thereby reducing the quality of care they receive. Under the proposal, the State is defaulting to the exclusion of the plans that are most familiar with the target population and most experienced in coordinating their care. It is also important to note that current D-SNP enrollees made an affirmative choice to enroll in the D-SNP—a choice that will be disregarded under the demonstration.

Furthermore, the State appears to be assuming that D-SNPs and other experienced plans will be willing to subcontract with the demonstration plans in order to have sufficient capacity to serve the expected number of enrolled duals. As proposed, the demonstration plans will need to take on a significant number of duals in a very short timeframe and will undoubtedly need additional capacity in the form of other plans' provider networks and internal care management teams to successfully meet their enrollees' needs. Many SNPs, including SCAN's, have spent years developing and refining their models of care and may not be willing to subordinate their processes and systems to those of the demonstration plan with which they may contract. If potential subcontracted plans are not given full responsibility for their enrollees and are required to perform their care management role in the context of the demonstration plan's model, quality is likely to suffer.

The State also does not appear to have considered what will happen to duals who are currently enrolled in C-SNPs. Many C-SNPs include dually eligible individuals who are only enrolled in Medicare. For example, SCAN's Village Health program is a C-SNP for ESRD and post-transplant patients. Eighty (80) percent of Village Health members are dually eligible but have chosen to enroll in the C-SNP in order to receive the highest quality care for their condition. If these individuals are moved to a demonstration plan, how will the State ensure that they can receive the medical care they need, and that there is no disruption to their care? Many demonstration plans are not likely to have the capacity, nor the desire, to provide the best possible care for these individuals.

In sum, SCAN opposes the State's proposal to default to a one-size-fits-all model that disregards D-SNPs' and C-SNPs' years of experience working with this population and the lessons learned along the way. SCAN recommends, similar to the State's decision regarding PACE and AHF enrollees, that D-SNP and C-SNP enrollees *not* be included in passive enrollment in the demonstration and that they be allowed to remain in the plans they affirmatively chose and that are serving them well. Of course, should the State's demonstration proposal be adopted, SCAN urges the State to work closely with SNPs to ensure that reassigned duals are transitioned safely in order to prevent disruptions to their care that could jeopardize their health.

II. FUTURE OF THE PACE PROGRAM

The Program of All-inclusive Care for the Elderly (PACE) is a proven model for delivering high-quality care to nursing facility eligible individuals and should be preserved to the greatest extent possible under the demonstration. As such, SCAN supports the State's proposal that PACE enrollees would not be passively enrolled into a demonstration plan. However, DHCS must go further to ensure that PACE is presented as a plan choice in the same manner as other health plans for duals and that individuals understand that they will take both their Medicare and Medi-Cal benefits with them under PACE. For those individuals who wish to choose PACE, the State must ensure that they are not forced into a confusing process of opting out of a demonstration plan, then choosing a managed care plan for their wrap-around benefits and LTSS, and then being disenrolled from the plan if they are later found to be eligible for PACE. In

order to prevent beneficiary confusion and disruption in care, individuals who choose PACE should remain in fee-for-service Medi-Cal and Medicare until they are assessed for PACE eligibility. Furthermore, PACE-eligible individuals should not be locked into a demonstration plan for any period of time. Instead, PACE-eligible individuals should be a category of beneficiaries who may opt out at any point during the 6-month stable enrollment period so that they always have access to a proven care model that is structured to meet their needs. Finally, to maintain the integrity of PACE and to prevent barriers to access for eligible individuals, the demonstration should not include any provisions that would require that PACE programs contract or subcontract with demonstration plans.

III. INTEGRATION OF LONG-TERM SERVICES AND SUPPORTS (LTSS)

The demonstration proposal leaves a number of open questions regarding the integration of LTSS by the demonstration plans and makes no assurances that the individuals currently served by these programs will be served as well or better than they are at present.

First, the proposal does not address eligibility for the LTSS benefits that will be integrated into the demonstration plans. Under the current system, each LTSS program has different eligibility requirements and definitions. For example, "nursing facility level of care" (NFLOC) is interpreted differently among the programs, limiting to varying extents which beneficiaries are eligible for which service. Once a beneficiary is enrolled in a demonstration plan, however, there do not appear to be clear eligibility requirements for qualifying for the different benefits. The demonstration provides for a "statewide HCBS Universal Assessment Process" that will be used to assess the need for HCBS, but that process will not be in place until 2015 at the earliest. In order to prevent confusion among plans and enrollees, there need to be clear protocols and triggers for the provision of LTSS benefits to different subsets of the demonstration plans' enrollees. Clear guidelines will also prevent plans from arbitrarily setting limits and thresholds that may be financially beneficial to the plan.

A related issue is the capacity of demonstration plans to serve members who are newly able to receive HCBS. It is conceivable that many individuals who are enrolled into demonstration plans and assessed for HCBS services will for the first time become aware of their need for such services, resulting in a larger pool of individuals than is currently served by each waiver program. It is critical that demonstration plans have the capacity to serve this potentially large number of individuals who have to date not received such services under the existing fragmented system. Similarly, the proposal is not clear as to whether additional individuals would become eligible for Multi-Purpose Senior Services Program (MSSP) services, as compared to the current budgeted availability. For example, Los Angeles County currently serves approximately 3,500 NFLOC individuals at 7 sites, due to the current system of budgeting and waiting lists. However, there are tens of thousands more individuals in the county who are in fact eligible for MSSP but are not served by the program due to the restrictive budget. The State's proposal does not indicate how such individuals will be served by demonstration plans, nor does it provide any standards of care or core operating principles to ensure that demonstration plans adhere to the key tenets of the program. The proposal also does not

provide sufficient assurances that MSSP functions can be absorbed by the demonstration plans in years 2 and 3 of the demonstration and that the infrastructure to care for NFLOC individuals will be sufficient to meet the demand.

Finally, plan payments for LTSS services are also not clearly explained in the proposal. Currently, MSSP sites receive a set payment for a set number of individuals. It is unclear how the sites will be compensated throughout the demonstration, as plans will receive a capitated rate intended to cover all services, and services will be gradually incorporated into the plan.

IV. INTEGRATION OF MENTAL AND BEHAVIORAL HEALTH AND SUBSTANCE USE SERVICES

Duals are an incredibly heterogeneous population when it comes to mental health and the State must ensure that each individual maintains access to the services he or she needs, without disruption. As drafted, the proposal lacks a significant amount of detail regarding the integration of mental and behavioral health and substance use services into the demonstration plans so as to ensure continuity of care. The proposal states that county-administered mental health services will not be included initially under the demonstration plans' capitation rates, but will be integrated eventually, and that plans will be responsible for providing enrollees seamless access to services covered by Medicare and Medi-Cal. While this is a fine starting point, the details around the integration of services need to be far more fleshed out before the start of the demonstration in order to ensure that all parties are aware of their responsibilities and that Federal, State and plan funds are appropriately disbursed. In particular, duals receive mental health coverage via three separate channels: Medicare, Medi-Cal and programs established pursuant to the Mental Health Services Act (Proposition 63). The proposal focuses on the collaboration with county mental health agencies and does not indicate how the other channels will be integrated, and does not contain any quality assurance expectations. Finally, it is unclear what respective roles will be played by the State departments of mental health and substance abuse under the demonstration. In order to preserve the existing infrastructure for mental and behavioral health and substance use treatment, the State must be specific about the roles and expectations of all parties.

V. QUALITY MEASUREMENT AND EVALUATION

The proposal in its current form lacks detail regarding quality measures that will be applied to demonstration plans and does not indicate that demonstration plans will be selected based on past performance. Although they should be the *first* consideration for a population as vulnerable as dual eligibles, no specific quality metrics are included in the demonstration proposal. Rather, the proposal includes only generalized "potential improvement targets". There needs to be a single set of well thought out and transparent quality metrics that will apply to dual demonstration plans so that the plans know how they are performing, the State knows whether improvements are being made in quality care as well as plan value, and the enrolled beneficiaries are assured that they are receiving the highest quality care. To that end, the State should work with plans to develop a set of metrics for LTSS performance, which do not currently exist, and integrate such metrics into the overall performance measurement

system. These metrics should be considered not only on a prospective basis, but also, to the extent possible, retrospectively to inform the State's selection of demonstration plans.

On a larger scale, the State (in collaboration with CMS) should undertake a full and impartial evaluation of the impact of each of the different State and Federal programs that care for duals in California. In addition to the duals demonstration, there are SNPs, ACOs, PACE and fee-for-service duals, all of which will employ different systems of care delivery and different payment methodologies. As part of the demonstration, in order to determine what truly works to deliver the highest quality and highest value care for duals, the State should compare the performance of duals demonstration plans—in terms of quality metrics, health outcomes and beneficiary satisfaction—to the other existing and developing care delivery programs.

* * *

SCAN Health Plan appreciates the opportunity to provide feedback in response to the State's demonstration proposal. Please contact us if we may provide any additional information.

Sincerely,

Chris Wing
Chief Executive Officer

Timothy Schwab, M.D.
Chief Medical Officer

May 4, 2012

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

RE: Comments on the *Draft Coordinated Care Initiative: California's Dual Eligibles Demonstration*

Dear Mr. Douglas,

Thank you for the opportunity to comment on the state's draft demonstration proposal to integrate care for Californians who are eligible for both Medi-Cal and Medicare. As expressed in a recent policy brief,[1] The SCAN Foundation believes that bridging medical care and long-term services and supports (LTSS) is critical to meeting the unique needs of dually eligible individuals who often live with chronic health conditions and functional limitations. We believe this effort can positively impact both person- and system-level outcomes when accomplished thoughtfully. This letter provides comments to specific areas in the draft proposal.

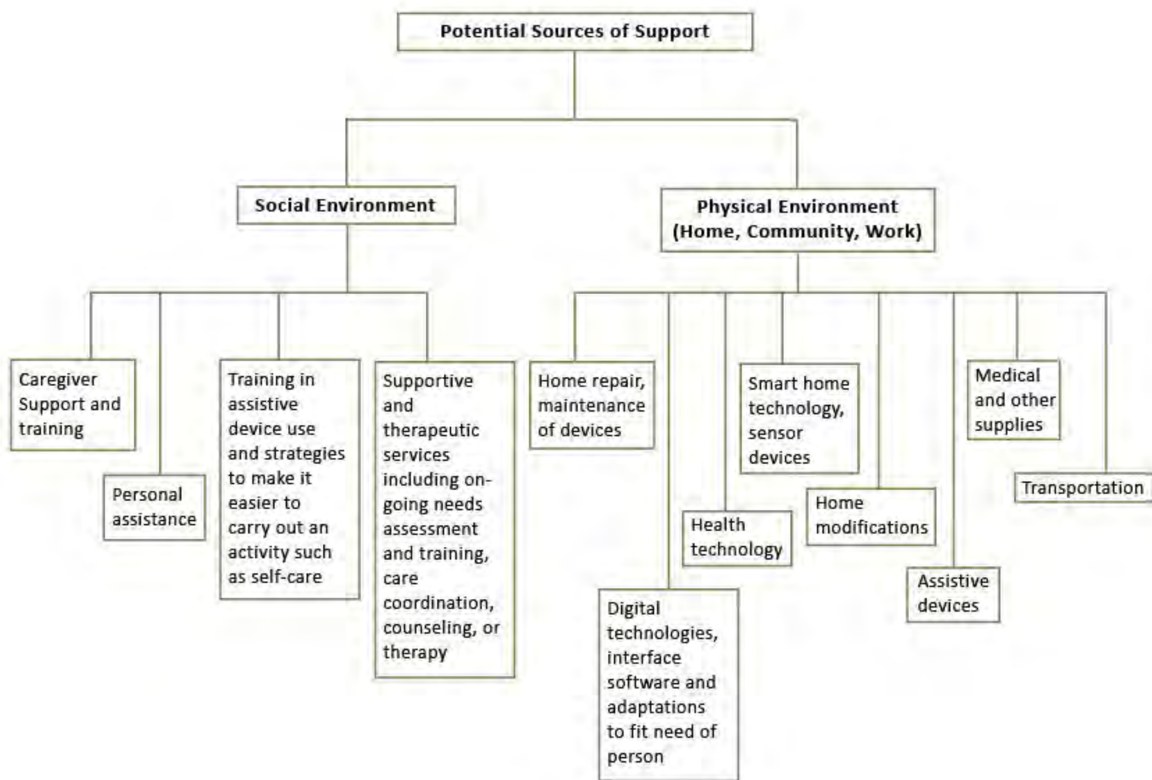
Specific Areas for Comment

- **Passive and Stable Enrollment Process (page 10, 32):** Education and outreach is a critical component to assisting beneficiaries with understanding their options and choices in the demonstration. This process is even more vital given that beneficiaries will be passively enrolled in plans with a six-month lock-in period. We recommend that the Department provides demonstration health plans with a clear, overarching beneficiary outreach and education strategy that includes all legally required communication elements for plans to adhere to, and then ensures that health plans execute the outreach and education strategy consistently with local advocacy organizations through partnership or contractual arrangements (page 11). In addition,

[1] The SCAN Foundation. Policy Brief No. 6: Bridging Medical Care and Long-Term Services and Supports: Model Successes and Opportunities for Risk-Bearing Entities. 2012; http://www.thescanfoundation.org/foundation-publications/policy-brief-6-bridging-medical-care-and-long-term-services-and-suports-mode. Accessed May 1, 2012.

the Health Insurance Counseling and Advocacy Program run by the Department of Aging (HICAP; http://www.aging.ca.gov/hicap/) should be engaged by health plans in all demonstration counties. HICAP has a track record of providing unbiased counseling and education for Medicare beneficiaries on health insurance options. Additional training on Medi-Cal should be considered for HICAP programs in the demonstration counties to assist with beneficiary education.

Figure 1: Outline of Potential Sources of Support for Individuals with a Disability



Source: Gitlin L, Szanton S, DuGoff E. CLASS Technical Assistance Brief No.1: Supporting Individuals with Disability Across the Lifespan at Home: Social Services, Technologies, and the Built Environment. 2011; http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/TSF_CLASS_TA_No1_Supporting_Individuals_At_Home_FINAL.pdf. Accessed April 25, 2012.

- **Benefit Design and Supplemental Benefits (page 12):** The proposal provides the state an opportunity to focus funding on providing services based on an individual's needs and preferences, rather than being centered on particular programs and Medi-Cal waivers. Individuals with functional impairment who wish to live in the community often need a variety of supports and services, as described in the domains listed in Figure 1 above. The proposal notes that "*Demonstration health plans will be responsible for the full range of services under Medicare*" and that "*states will also be responsible for all Medi-Cal State Plan benefits and services, including long-term institutional, and*

home- and community-based services (HCBS) including IHSS, CBAS, MSSP, and other Section 1915 (c) HCBS (waiver) services." While much emphasis has been on existing Medi-Cal State Plan or waiver programs (e.g., IHSS, MSSP, CBAS), there has been little discussion on how individuals will access the broader range of *services* they may need, many of which are currently authorized under various Medi-Cal HCBS waivers (appendix 3, page 40-41). Such services include but are not limited to: habilitation; respite; community transition; personal emergency response system; caregiver training and support; environmental accessibility modifications; private duty nursing; communication services (device, translation); housing assistance (restoring utilities, emergency move, non-medical home, temporary lodging, non-emergency minor home repair/maintenance); and assisted living or publicly-subsidized housing. We recommend that the Department describe how health plans will ensure access to the full range of LTSS without wait lists in order to enable individuals to live in the most person-centered, integrated setting possible.

- **Person-Centered Care Coordination: Care Coordination Standards (page 13):** The proposal indicates that "*New care coordination standards will be developed in collaboration with public stakeholders"* but does not indicate the time frame for the development of these standards. Given that implementation of this demonstration is slated for January 2013, we recommend that the Department initiate this activity by July 2012 to ensure standards are ready in time for implementation on January 2013.

- **Comprehensive Health Risk Assessments and Care Planning (page 13):** The proposal indicates that "*Demonstration plans will be responsible for an in-depth risk assessment process capable of timely identification of primary, acute, LTSS and behavioral health needs."* In order to best ascertain an individual's needs, it is important that the assessment include both health and functional status measures, including those related to cognition and risk for cognitive impairment. We recommend that the Department define functional measures to include in the health risk assessment. We understand that the state intends to pursue a universal assessment to be implemented across plans, which will not be available until January 2015 at the earliest. In the interim, the state should work with plans to implement a core set of functional assessment measures that are common across plans to inform demonstration quality monitoring and evaluation.

- **Behavioral Health Care Coordination (page 15):** The proposal indicates that "*health plans will be providing enrollees seamless access to the full range of mental health and substance use services currently covered by Medicare and Medi-Cal… Health plans will develop plans with stakeholder input to enhance screening and diagnosis…including*

Alzheimer's disease and related dementias." We applaud the Department's mention of Alzheimer's disease and related dementias. Individuals with Alzheimer's disease or related dementias typically cannot access services through county mental health systems, and often, the medical community lacks the knowledge to identify or treat these conditions. We recommend that the Department require health plans to develop and implement a strategy to identify and treat individuals with Alzheimer's and related dementias among their members, including opportunities for mental health treatment and family caregiver support.

- **No-Conflict Case Management (page 17; 21):** The proposal indicates that the Department will require health plans to contract with counties to conduct an assessment and determine eligible hours for IHSS consumers. Additionally, the Department will require health plans to contract with MSSP organizations for case management functions. To ensure access to conflict-free case management for all LTSS, we recommend that the entity that will assess an individual's health and functional status, as well as develops the care plan based on her/his needs and preferences, should not be financially at risk for the outcomes of the assessment and care planning process.

- **Universal Assessment (p. 17):** The proposal describes a mechanism to develop a statewide HCBS universal assessment that will be used in all areas of the Coordinated Care Initiative. Below are comments to specific aspects of this process.

    a. *Before Implementation of a Universal Assessment Tool:* Selecting and implementing a universal assessment tool will take time and resources. In the near term and for the purposes of supporting this initiative's evaluation efforts, the state should require health plans to collect and report to the state a set of standardized measures that reflect quality of care and other desired outcomes. These measures should be considered for inclusion in the final universal assessment.

    b. *Time and Stakeholder Process*: The Department estimates that the universal assessment tool will be implemented in January 2015, with the stakeholder process commencing in June 2013. This timeline provides an 18-month window for the stakeholder process, tool development and implementation. In a recent analysis of selected states with uniform assessment tools, the state with the shortest stakeholder process still spent approximately three

years in this effort.[2] The process entails engaging stakeholders, selecting/refining the tool, reviewing system stability, developing the statewide rollout strategy, determining the impact on the testing site, and evaluating the impact on assessed individuals. We recommend that the state develop a stakeholder engagement process that ensures the meaningful engagement of consumers, HCBS providers, health plans, and other stakeholders. Sufficient time should be built into the process to ensure a complete and fully-engaged stakeholder effort.

c. *Selecting the Tool:* The state has indicated that it will use the IHSS assessment as the platform for the universal assessment. There is merit in this approach because the IHSS assessment is a known tool and already in use for the majority of individuals accessing Medi-Cal-funded LTSS. However, the IHSS assessment was designed with the specific purpose of determining the number of IHSS hours an individual may receive and was not designed to identify a broader set of LTSS needs nor develop a care plan based on an individual's functional and health status. We recommend that the state consider selecting an "off the shelf" assessment tool with strong validity and inter-rater reliability and one that was designed to support broader care planning for physical, cognitive, and behavioral needs. State officials should examine tools adopted by other states, and consider tools that have features that can meet the assessment and care planning needs of California's diverse population served through the Medi-Cal program.

d. *Identifying the Assessor:* We recommend that the assessment be performed by trained and experienced personnel, with no financial stake in the outcome of the assessment. Upon adoption, health plans should be required to use the state-selected uniform assessment tool to ensure consistent assessment of needs and preferences of individuals across the state. Furthermore, health plans should be required to report assessment data to the state to support evaluation of these initiatives.

e. *Quality Measurement and Quality Monitoring:* Quality outcomes should be identified and translated into measures that can be included in the universal assessment. Automating the assessment system is critical to capturing the

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[2] Black P, Leitch K. Analysis of State Approaches to Implementing Standardized Assessments. 2012; http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/Standardized_Assessment_CE_Reed-4-12.pdf. Accessed May 1, 2012.

data needed to produce quality measures. The system should be designed to link assessments for an individual over time as well as link assessment data to other data systems, such as Medi-Cal administrative data, to capture outcome measures such as service utilization. This could be accomplished through a secure "cloud" mechanism. Furthermore, an analytic team should be positioned to access all necessary data across departments to produce the outcome measures and identify areas for improvement.

- **Timely and Accurate Data Sharing (p.19):** The proposal states that "*The state is working to develop better processes and protocols for timely and accurate data sharing…*" As the Foundation has learned through the efforts of the California Medicaid Research Institute (CaMRI) to evaluate HCBS in California, data sources that inform service use, population characteristics, and other key metrics currently live in multiple departments (e.g., Health Care Services, Aging, Public Health, Social Services). These data systems operate independently and presently cannot be linked easily or be made available in "real time" to inform system monitoring and timely evaluation.[3] We recommend that the state consolidate data sources into a single entity, preferably housed at the Agency level, which can support efforts to achieve timely and accurate data sharing pursuits.

- **Institutional Transition to the Community (page 20):** The proposal states that "*To the extent that federal funding for the Money Follows the Person Demonstration is available, a one-time resource to re-establish household will be available to demonstration health plans that successfully transition eligible beneficiaries in institutional settings back into the community."* During a transition from a nursing home, residents (often with assistance) arrange for the move and receive the services they need to be as independent as possible. The community setting may be an apartment where they live by themselves or with others, a group home, a residential care facility, or another location. We recommend that the Department expand its requirements under this section and ensure health plans provide the opportunity for individuals to transition from institutions to the community, in accordance with their needs and preferences. The Department should require health plans to identify individuals in institutions who wish to transition and consult with the appropriate entities to facilitate this transfer.

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[3] Stone J, Newcomer R, Chattopadhyay A, et al. Studying Recipients of Long-Term Care Services and Supports: A Case Study in Assembling Medicaid and Medicare Claims and Assessment Data in California. 2011; http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/CaMRI_Data_Case_Study_Report.pdf. Accessed May 1, 2012.

- **Accessing the Range of LTSS Provided Previously by Waiver Programs (page 21-22):** The proposal indicates that "*During the demonstration, current recipients of these waivered programs will be eligible for enrollment in the demonstration, and will at least be enrolled in Medi-Cal managed care, according to the Coordinated Care Initiative.*" In addition, the proposal states that "*…Integration of these waiver programs…will include (*among other provisions*) integration of waivered services as part of supplemental service offering of the demonstration plans…the state is considering whether waiver programs would cease to take on new beneficiaries and all waivered services and care coordination would be undertaken by the demonstration plans.*" Based on this language, it is unclear how individuals who have needs in alignment with the service offerings of existing waiver programs, whether or not they are enrolled in 1915(c) waiver programs currently, will be addressed. This is particularly true for services that have been provided by some of the smaller waivers, such as the Acute Hospital waiver (Nursing Facility waiver component), which has been plagued by long waitlists. To address these issues, we recommended that the Department clarify what LTSS will be included in the health plan's essential benefit package and how individuals will access these critical services in the demonstration. Should the Department determine that some LTSS included in smaller Medi-Cal waiver programs are supplemental only and not required, we recommend that this decision is expressly stated, along with the latitude that health plans have from the Department and CMS to provide these services.

- **Potential Use of Risk Sharing and Risk Corridors (p. 28):** The success of LTSS integration is highly dependent upon the rate setting process, which in ideal circumstances, should provide incentives for health plans to increase access to HCBS in lieu of more costly institutional care. This goal can be accomplished by strategies that include risk sharing among providers and risk corridors based on individual/population characteristics. In a recent policy analysis conducted by the Center for Health Care Strategies,[4] *"states can strategically design financial incentives to help…programs foster community-based care, including supporting transitions from nursing facilities to community-based settings and promoting discharges to the community from acute care settings."* As described in the report, strategies include paying the same reimbursement rate regardless of care setting, rewarding plans for appropriate transitions to the community, and providing incentives for HCBS. We recommend that the Department consider these strategies employed by other states to incentivize health plans toward increasing access to HCBS in alignment with an individual's needs and preferences.

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[4] Gore S, Klebonis J. Medicaid Rate-Setting Strategies to Promote Home- and Community-Based Services. 2012; http://www.thescanfoundation.org/sites/scan.lmp03.lucidus.net/files/CHCS_Incentivizing_HCBS_in_MLTS-5-12.pdf. Accessed May 2, 2012.

- **Performance Measurement (p. 28, 29):** The proposal states that *"California certifies that it 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."* To ensure a reliable evaluation, we recommend that measures included should be clear and collected regularly by all health plans consistently and with sufficient response rates where collected by survey. Ideally, this effort should include measures of functional status, care transitions, and beneficiary satisfaction to identify plans that may do well on clinical measures but do not succeed in adequately matching beneficiaries with needed LTSS. The proposal also states that *"California will finalize the performance measures…only after significant input from multiple stakeholders,"* and that performance metrics must *"be implementable by the state in time for initial enrollment in January 2013."* While clinical measures are more readily available, measures related to LTSS and high-quality care coordination and care transitions in integrated systems are still under development and may not be ready by January 2013. We recommend that the Department work actively with health plans to include performance measures that span across clinical, functional, and beneficiary experience domains as these become available and ensure timely data collection from the health plans so that quality monitoring and evaluation can occur on a rapid cycle basis. We also recommend that all evaluation results be made available to the public in a timely fashion.

Thank you for your consideration of these comments. Please do not hesitate to contact me if you have any questions.

Respectfully,

Gretchen E. Alkema, Ph.D.

Vice President, Policy and Communications

Coordinated Care Initiative: California's Dual Eligibles Demonstration

State Independent Living Council

Comments – May 2012

The State Independent Living Council (SILC) in cooperation with the Department of Rehabilitation prepares the State Plan for Independent Living which sets the policy and funding levels for the state's network of Independent Living Centers (ILCs) and services.

California established the SILC in 1996 because the Federal Government requires that all states establish and fund SILCs as a condition of receiving federal funding. California receives more than $5 million for Independent Living annually from the Federal Government. The SILC monitors and advises the state regarding the distribution of funding to ensure funding levels meet the needs of the ILC network.

The SILC is also responsible to monitor the implementation of the State Plan while coordinating with similar agencies and councils at the state and federal levels. Additionally, the SILC monitors state and federal legislation to identify and create new policies that will maximize the ability of people to live independently.

The comments below address the Coordinated Care Initiative's impact on the ability to live independently.

General Statements

The Coordinated Care Initiative is a significant change in the way healthcare is delivered in California to dual eligible beneficiaries. The integration of Medicaid and Medicare is on an extremely fast timeline and currently there are more questions than answers. The stakeholder workgroups that are being conducted by the Department of Health Care Services are a good start; however it is doubtful that state staff and the advocates will resolve all of the complex issues that are part of payor integration prior to January 2013.

Is recommended that the timeline be pushed out for one year in order for more detailed planning and analysis can occur.

Provider Networks

Stronger assurances that beneficiaries with disabilities will be able to access providers in the network must be made. California has more stringent access requirements than the Americans with Disabilities Act. By not applying California statute and regulations, health providers could be in compliance with the Initiative without meeting the access needs of some beneficiaries. There were reasons and analysis done when California added additional requirements that go beyond the ADA. The ability to access health care is critical for beneficiaries with disabilities. At a minimum they must have access to, exam tables and diagnostic equipment.

Person Centered Care

The list of agencies that plans should work with under the "Person-Centered Care Coordination" **should include Independent Living Centers**. Independent Living Centers are required, in federal statute, to provide individual advocacy training which includes training and assistance in the navigation of services, and includes enrollment. It is critical for consumers and health plans that ILCs be part of their coordination network.

In fact, ILCs may assist beneficiaries in their selection of plans to enroll.

Payment structure – Tiered payments based on risk

If payments are tiered based on patient risk, it is unclear how beneficiaries will move from one tier to another as their health status changes. What will trigger the move? Change in condition? Significant health event? Will there be any barriers or caps on services received based on their tier?

Appeals and Grievances

Medicare, Medicaid and IHSS currently have separate processes for managing beneficiary appeals and grievances. Unification of the grievance process ensures that beneficiaries know where to call to file a grievance. Procedures must be established that allow for the existing processes to manage the grievance or appeal, without forcing beneficiaries to be bounced around to multiple entities. Additionally, a unified process at the front in will assist in the data collection process that used for quality measures.

The ability for beneficiaries to file grievances and appeals is critical to ensuring that the right medical services and supports are accessible in a timely and satisfactory manner.

Standardized Assessment Process

The development of a standardized HCBS assessment tool should not begin six months after implementation of managed care. The tool used for screening for HCBS needs should be available with the launch of the waiver. Medical providers and the plans should be working together now in a workgroup facilitated by the state.

In order for this waiver to be successful, and for beneficiaries to receive the right care, they must to be assessed correctly, at the start of the program.

In-Home Supportive Services

The ability of consumers to maintain the ability to hire/fire their aides is critical in maintaining their independence. We support and appreciate the commitments made to integrate IHSS into the waiver without making structural changes.

The SILC also supports the ability of health plans to authorized additional IHSS hours, above the statutory limits, through funding under the capitation payment.

Opt – Out

The passive enrollment process ensures participation in the waiver, but does not ensure beneficiaries are in the appropriate plan. The six month lock-in does not provide beneficiaries an option if their health plan and network are unable to meet their medical needs. Additional clarity is needed regarding how the beneficiary categories that may opt-out is determined. Information on how to submit a request to opt-out must be provided to beneficiaries. When a beneficiary is denied the request to opt-out, will there be an appeal process?

How will pre-approved services transition over to the new plan? For example if a hip replacement was scheduled, after the transition, will the beneficiary be able to have the surgery as scheduled, or will they have to go through an

additional assessment and approval process? Clarity on this process is critical as this was an issue with the SPD managed care waiver conversion.

How will the use of out-of network providers be addressed for pre-enrollment approved services?

No beneficiary's care should be delayed or denied due to their passive enrollment into a new health plan.

Long Term Services and Support Integration

The integration of LTSS waivers and the Money Follows the Person Demonstration funding to allow beneficiaries to receive services in the community and/or their homes rather than in an institutional setting is supported by the SILC.

The use of a third party uniform assessment process, with the service integration, is the recommended approach. How managed care plans will determine and schedule services for beneficiaries in a fair and equitable manner without one is unclear at this time.

Recommendations

That State should coordinate with CMS to make grant funding available for community organization to provide community education and enrollment events. This would provide beneficiaries an opportunity to meet with someone to learn about the changes in their counties and what options they have. ILCs, AAAs, CBAS, MSSP and others would be able to host such events, but would need funding to cover their staff costs if the events were held on the weekends or in the evenings.

This type of grant funding was available during the roll-out of the Medicare Part D benefit and was very helpful in assisting seniors select and enroll in the most appropriate drug plan.

Reinvestment

Any savings achieved through Coordinated Care Initiative should be reinvested into the home and community based network. State statute should specify that the savings received from Medicare will not be deposited

into the State's General Fund. This will ensure that the home and community based network will increase to service more beneficiaries.

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Comments on California's Draft Duals Proposal

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
1	9	Care Model Overview	At least sixty days prior to entering into any contract with a manged health care plan, the State should make available for comment and review by stakeholders and the Legislature the language of the proposed contract.
2	10	Enrollment Process: Stable Enrollment Period	With careful attention to continuity of care issues, passive enrollment with the option to opt-out of receiving benefits and services under managed care will ensure a reasonable balance between the needs of the plan and the success of the Demonstration with consumer choice and protection. However, the six-month stable enrollment period unnecessarily curtails consumer choice and infringes on the protection opting-out gives beneficiaries in deciding where and how they receive their care, and it should be eliminated from the demonstration proposal.
3	10	Enrollment Process	In the passive enrollment process, where beneficiaries do not affirmatively choose to opt out, the state should establish a formula for automatic enrollment that prioritizes enrollment into a public health plan where available.
4	14	Person-Centered Care Coordination: Person-Centered medical homes and interdisciplinary care teams (ICT)	Health plans must honor the beneficiary's choice whether or not to have their IHSS services coordinated through their managed care plan as well as whether or not to integrate their IHSS provider onto their ICT. If a consumer opts to have their IHSS provider on their ICT, the consumer should play an active role - with their IHSS provider - in designing and implementing their care plan. IHSS providers, particularly those who participate on the ICT, should have access to training to help them provide better, more individualized, care for their consumers. All trainings should be developed with consumer input.
5	14	Care Transitions	Health plan care transition interventions must always prioritize the beneficiary's choice of setting regarding where they receive care and must include every possible benefit to ensure the beneficiary's social and medical needs are met in that care setting. Beneficiaries must be presented will all available care options so they can make a choice about what setting they prefer to receive their care in.

Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
6	17	LTSS Care Coordination: IHSS program structure under the demonstration	The California Department of Social Services (CDSS) must ensure that under the demonstration IHSS services are provided to all eligible recipients. Further, CDSS and the Department of Health Care Services (DHCS) must ensure that in implementing IHSS integration into the demonstration that all requirements of the Medicaid Act (Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code), the Americans with Disabilities Act (Chapter 126 (commencing with Section 12101) of Title 42 of the United States Code), Section 504 of the Rehabilitation Act of 1973 (Subchapter 5 (commencing with Section 794) of Chapter 16 of Title 29 of the United States Code), regulations implementing these federal laws, and all other applicable federal and State laws and regulations are met. These responsibilities should include but should not be limited to ensuring that provider payments satisfy the requirements of Section 1396a(a)(30)(A) of Chapter 7 of Title 42 of the United States Code.
7	17	LTSS Care Coordination: IHSS program structure under the demonstration	County social services must always 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 Medi-Cal managed cared health plans. At no point, during the demonstration or after it is completed, should Medi-Cal managed care health plans take over those functions from County social services.
8	17	LTSS Care Coordination: IHSS program structure under the demonstration	Outside of existing waiver services, all personal care and home care services provided by the MCOs must be provided through the IHSS program for those who are eligible.
9	17	LTSS Care Coordination: IHSS program structure under the demonstration	It is important that heath plans have the ability to authorize additional home- and community- based services, including IHSS hours, above the statutory limits in order to ensure that beneficiaries are able to remain safe, healthy and independent in their homes and communities. However, it is equally important that health plans be prohibited from reducing IHSS hours beyond those hours that have been authorized by a county.
10	27	Beneficiary Protections: Appeals and Grievances	Regardless of what the final "unified" grievance and appeals process entails, existing rights as currently provided under federal and state law must be maintained.

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Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
11	27	Financing and Payment: Health Plan Payments and Financial Incentives	Rates for participating health plans should be developed in a process that is transparent and open to influence from stakeholders and the Legislature.
12	28	Expected Outcomes: State's Ability to Monitor, Collect and Track Data on Quality and Cost	The State should establish a program branch in the Department of Managed Care Services that is specifically focused on Long Term Supports and Service (LTSS) integration as a managed care benefit. This branch should enforce legal sanctions, including, but not limited to, financial penalties, withholding of Medi-Cal payments, enrollment termination, and contract termination, to penalize any managed care health plan that consistently fails to meet performance standards provided in statute or contract. The department should work with stakeholders to develop violations relating to non compliance. The Department should provide complaint management, clinical review, and oversight for LTSS as managed care benefits. The department should oversee health plan compliance with all state and federal disability accessibility and civil rights laws. The department should develop strict financial penalties for plans who fail to comply with existing law. The state should establish an Ombudsman specific to LTSS as a managed care benefit, which should assist in monitoring and evaluating plan performance, assisting recipients with enrollment decisions, appealing denials and other plan decisions regarding service, as well as navigating other problems.
13	29	Potential Improvement Targets for Performance Measures	Performance measures and improvement targets should be monitored and evaluated throughout the demonstration. In addition to those listed, potential improvement targets should also include the following: (1) Improved quality, adequacy, and impact of LTSS (2) Improved Health, functional, and health-care related outcomes (3) Improved family and unpaid caregiver outcomes and (4) Improved paid personal assistance worker and workforce related outcomes.

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Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
14	30	F. Expected Outcomes: Expected Impact of Demonstration on Medicare and Medicaid Costs	In addition to working with CMS and its evaluation contractor, RTI, for the evaluation of the demonstration, the State must hire its own independent evaluator to ensure the demonstration is meeting its objectives and the needs of the beneficiaries. Further, DHCS, in collaboration with CDSS, the Department for Managed Health Care, and stakeholders, must establish its own monitoring and evaluation system for not only the impact of the demonstration on Medicare and Medicaid costs, but also the state's progress to achieving the goals of the demonstration.
15	30	F. Expected Outcomes: Expected Impact of Demonstration on Medicare and Medicaid Costs	There should be legislative informational hearings regarding the transition of Medi-Cal long-term supports and services (LTSS) into managed care at the end of each demonstration year. Further, continuation of each year of the Duals Demonstration (as well as Medi-Cal LTSS integration) should be contingent on approval by the Legislature.
16	30	Expected Impact of Demonstration on Medicare and Medicaid Costs	The State should invest savings accrued as a result of the demonstration back into Medi-Cal home and community based programs in order to continue to promote better care and health outcomes for consumers, and to reduce costs for those who are dually eligible for Medicare and Medicaid, resulting in further savings in both programs.
17	31	Infrastructure and Implementation: State Infrastructure/Capacity	The draft proposal states that "CDSS will administer a revised quality monitoring program for the IHSS program in the demonstration counties." What is this referring to? IHSS currently has a multi-faceted integrity and quality assurance monitoring program, as established under the IHSS/PCSP Quality Assurance Initiative (WIC Section 12305.71). These quality assurance measures are already administered by multiple entities (county, state and federal). In order to avoid additional fragmentation and/or duplication, any new or expanded efforts relating to quality assurance must be streamlined and coordinated with what currently exists. Funding for quality assurance should not compete with general program funding. Additionally, if the goal of expanding quality monitoring is to seek savings, there must be a process to monitor and measure those outcomes.