NSCLC
National Senior Citizens Law Center
PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

June 1, 2011

Toby Douglas, Director
Greg Franklin, Deputy Director for Health Care Operations
Jane Ogle, Deputy Director of Health Care Delivery Systems
Paul Miller, Chief, Long Term Care Division
Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

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

The National Senior Citizens Law Center (NSCLC) submits these comments in response to Department of Health Care Services "Request for Information on Pilots for Beneficiaries Dually Eligible for Medi-Cal and Medicare." We appreciate the opportunity to respond to this RFI and look forward to making additional contributions as this effort proceeds.

NSCLC is a non-profit organization whose principal mission is to protect the rights of low-income older adults. Through advocacy, litigation, and the education and counseling of local advocates, we seek to ensure the health and economic security of those with limited income and resources, and access to the courts for all. We have expertise in Medicaid and Medicare benefits and the interaction between the two. While we are a national organization, we were founded in California, have two offices here and conduct a significant amount of our work within the state.

We are supportive of the goals that DHCS has outlined for this project. In particular, we support the intention to use the integrated models to "improve utilization, beneficiary satisfaction and health outcomes by ensuring the right services are delivered to the right people at the right time" and in the right setting. We do, however, have several concerns that need to be addressed to ensure that the models developed and implemented will in fact meet the stated goals of the project. These comments are a first attempt to summarize those concerns and lay out important principles for proceeding.

We look forward to hearing DCHS' plans for continuing and expanding conversations with stakeholders regarding this effort and we are committed to ongoing participation in the process.

Sincerely,

Kevin Prindiville Georgia Burke Anna Rich

National Senior Citizens Law Center
Washington D.C. | Los Angeles | Oakland
web: www.nsclc.org **email:** nsclc@nsclc.org
1330 Broadway, Suite 525, Oakland, CA 94612-2522 | Office: 510-663-1055 Fax: 510-663-1051

**COMMENTS OF THE NATIONAL SENIOR CITIZENS LAW CENTER
IN RESPONSE TO THE REQUEST FOR INFORMATION ON PILOTS FOR BENEFICIARIES
DUALLY ELIGIBLE FOR MEDI-CAL AND MEDICARE**

Principles to Guide Design and Implementation of Integration Pilots

Before answering the specific questions in the RFI, we would like to provide the following general principles for consideration as decisions are made about integration model design and implementation.

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

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

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

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

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

National Senior Citizens Law Center
Washington D.C. | Los Angeles | Oakland
web: www.nsclc.org **email:** nsclc@nsclc.org
1330 Broadway, Suite 525, Oakland, CA 94612-2522 | Office: 510-663-1055 Fax: 510-663-1051

Phased approach. The level of integration proposed does not exist in any current model. DHCS and the pilot entities should continue to develop and implement plans thoughtfully and deliberately. Where possible, integration should be done in phases, starting with simple steps that build off of the current structures in place, then progressing towards more significant changes as necessary and appropriate.

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

1. What is the best enrollment model for this program?

It is essential that dual eligibles interacting with integrated programs retain their ability to choose what care to receive, how to receive that care, where to receive that care and from whom to receive that care. That choice must begin with the decision of whether or not to enroll in an integrated model at all. We support a truly voluntary enrollment model that would allow beneficiaries to "opt in" instead of "opt out." The "opt in" principle should apply to both the Medi-Cal and Medicare sides of the model.

A voluntary, opt-in enrollment:

- Honors the autonomy and independence of the individual.
- Affirms an important principle of the Medicare program – the right to choice of provider – and would retain for dual eligibles the same right to choose that other, non-low-income Medicare beneficiaries have.
- Allows dual eligibles with complex medical conditions to retain access to providers that may not be participants in the integrated model.
- Serves as an important quality check on pilot providers. Having to offer programs and services that attract enrollees and that enrollees can leave anytime ensures that pilots offer quality, patient-centered programs.
- Ensures that enrollees are willing participants in the care coordination activities undertaken by the pilot.
- Does not require waivers of federal laws or regulations.

Voluntary enrollment models have been successful in other states and even here in California (e.g. PACE).

While we appreciate that the intention of an "opt-out" enrollment model is to connect dual eligibles to high quality programs that will integrate and coordinate their care, at this time the ability of the pilots to deliver that benefit is speculative. If, over time, the pilots prove to be effective at integrating and coordinating care, it may be appropriate to return to the question of enrollment. Until then, the best way to ensure that the pilots grow into effective programs is to require them to earn enrollments through an "opt in" system. Other concerns that an "opt out" policy could address, such as adverse selection and marketing costs, can be addressed through

other appropriate mechanisms (appropriate rate setting, strict marketing rules, use of independent enrollment brokers, etc.).

If DHCS does decide to purse an "opt out" enrollment, consumer protections will be necessary to ensure continuity of care. Transition rights and access to out-of-network providers (discussed more below) will be key. Also, DHCS will have to develop policies for determining how enrollment would be handled in counties offering more than one pilot and for dual eligibles who are already enrolled in a Medi-Cal or Medicare managed care plan that is different from the pilot program.

Whether utilizing an "opt out" or "opt in" model, enrollment rights and periods should mirror the Medicare program where dual eligibles have the right to enroll in and disenroll from plans at any time during the year. There should be no lock-in periods on either the Medi-Cal or Medicare side for this population. Systems must also be put into place to deal with enrollment errors.

Notice of enrollment rights and options should be provided by independent entities. In addition, robust counseling and support systems are needed so individuals understand their options. Enrollment materials must be provided in formats that are accessible for all dual eligibles. For those who are limited English proficient, materials must be translated. For those with visual and other disabilities, accessible formats include e-format, large print, Braille and cassette. Without such access, those with impairments or limited English proficiency will not have the protections and the ability to fully participate in these programs.

2. Which long-term supports and services (Medi-Cal and non-Medi-Cal funded) are essential to include in an integrated model?

It is, of course, essential that duals in an integrated model have access to the full range of LTSS that would be available to them in the absence of an integrated model. This includes both Medi-Cal and Medicare funded home health services (including skilled nursing, physical, occupational and speech therapy); In-Home Supportive Services; MSSP; ADHC; and so forth. However, it is not necessary that all of these LTSS elements be completely integrated into the care model from the outset. In fact, there are a number of reasons why it may make sense to phase in over time certain LTSS elements when implementing the integrated care model. Some of the reasons for this may be:

- There may be existing organizations that already do a very good job of providing integrated care for duals eligible, such as Multipurpose Senior Services Programs and Adult Day Health Centers (to the extent funding is still available). New models should build on and utilize these programs. Pilot enrollees should not be deprived of access to existing programs that are working. Contracted entities should have a plan for utilizing, not replacing existing programs.

- Because programs like IHSS come with their own, independent regulatory and administrative scheme to ensure both beneficiary and provider rights, assessments, appeals and so forth, we are skeptical about a contracted entity's ability to come up to

speed such that they will be able to guarantee that beneficiary protections will not be reduced or impaired. Instead, we recommend phased, gradual integration , especially for contracted entities with medical but not independent living expertise.

If LTSS is integrated, it is important that unique features of California's LTSS programs be retained. Many of the current LTSS elements available to duals, again most notably IHSS, provide value for the beneficiary because they meet needs essential to autonomy and independent living. For example:

- One of the central, prized elements of the IHSS program is the individual consumer's ability to hire, fire and direct the activities of his or her provider. Participants in an integrated care program must be allowed to continue to self-direct their care.

- IHSS providers are not skilled medical providers, although some may provide limited paramedical services under the direction of a skilled professional. Instead, IHSS providers may often be helping with activities of daily living like grocery shopping, meal preparation, cleaning, assistance with ambulation, etc. where additional medical involvement or supervision is not necessary and would in fact undermine independence. These non-medical aspects of IHSS must be maintained.

- IHSS consumers have the option of hiring whomever they want, including a spouse, parent or other relative, or a friend. Sometimes IHSS providers are strangers hired from a registry, perhaps to fill in for a short period while a regular provider is absent. Given the wide variety of circumstances and range of relationships between beneficiary and provider and in order to preserve privacy and autonomy, IHSS consumers should be allowed to keep their care provider as separate from (or as integrated in) the rest of their care team as they prefer. They should be allowed to direct delivery of independent living services without medical supervision or control. They should be allowed to determine the extent to which their IHSS provider is privy to or excluded from private medical relationships.

In sum, the integration of LTSS must be done carefully, building on what works and preserving unique elements of current programs. We recommend a phased approach to the integration.

3. How should behavioral health services be included in the integrated model?

We are not specialists in behavioral health, so our responses to this question are limited and we defer to stakeholders with more specific background in this area. We note however that improving the availability and coordination of mental health services is critical for beneficiaries in need of such services. We hear repeatedly from advocates that mental health services are the weakest link in the care system for duals in California.

Nevertheless, it is critically important that dual eligibles who have succeeded in establishing a stable relationship with a mental health provider to be able to continue care with that provider. In addition, because a therapeutic relationship is so important to effective treatment in mental

health, dual eligibles with mental health needs should have the widest choice of clinicians, with the integrated model working to accommodate out-of-network providers when preferred by the beneficiary.

We also note the importance of integrating behavioral health and substance abuse services for the many individuals who need access to both.

5. Which services do you consider to be essential to a model of integrated care for duals?

Enrollees in the integrated model must have access to all Medicare and all Medi-Cal covered services. In addition, the program should deliver "enhanced" benefits, especially those designed to keep individuals living at home and in the community. Provision of all services should be made based on clearly defined standards and an assessment of the particular needs and condition of the individual.

Medi-Cal and Medicare covered services should be provided based on standards no more restrictive than for individuals not in the integration pilot. Where both Medi-Cal and Medicare cover the same service, the enrollee should receive the full degree of service provided by each program. Where the programs employ different criteria for providing the same service (e.g., home health), the integration pilot should rely on the less restrictive criteria to provide the service. Coverage standards must be based on an individual determination of whether the service is medically necessary for that individual. "Rules of thumb" like Medicare's "improvement standard" must be avoided.

One of the promising elements of integration is the potential for savings to be redirected to provide services and supports not currently covered by either program. These "enhanced" benefits should also be clearly defined and standards for providing the service should be outlined in contracts with the pilot program and in informational materials provided to enrollees.

Enrollees in the integrated model must also be protected from cost-sharing for any service that would exceed the cost-sharing they would pay for the same service in the Medi-Cal and/or Medicare fee for service system.

<u>Consumer Protections</u>

While perhaps not traditionally defined as services, the integrated care model must also contain important consumer protections, including:

Choice. It is essential that dual eligibles interacting with integrated programs retain their ability to choose how they receive care, where they receive care and from whom they receive care. Preserving the freedom to choose affirms an important principle of Medicare, respects the autonomy and integrity of dual eligibles, assures that those who do participate will comply with care recommendations and serves as an important check on the quality of the program.

There are several levels where choice is important.

- Right to choose whether to join an integration program.
- Right to choose which integration program to join.
- Right to choose providers within an integrated system (and adequate number of providers to choose from) and, in appropriate circumstances, to choose a provider outside the network.
- Right to choose whether to participate in care coordination services offered by the integration program and the right to select the providers that are part of such a team.
- Right to choose to self direct services, with support necessary to do so effectively.
- Right to choose, ultimately, which services to receive.

Transition Rights. Policies must be in place to ease transitions into and out of the integration pilot. Transition rights are an important part of any program, but become particularly important if there is any kind of mandatory or "opt in" enrollment requirement. There are levels of transition that programs must account for:

- Service transition. The program must have a method for assuring continued access to current services, including prescription drugs, when an individual enters the program.

- Provider transition. The program must also be able to provide access to existing out-of-network providers during a transition period. During the transition period, the program should be required to reach out to an enrollee's provider to encourage the provider to join the network. If outreach efforts are unsuccessful, a process should exist for the enrollee to secure approval to continue seeing that provider.

Appeal and grievance rights. Enrollees in integration pilots must have the ability to appeal decisions made by the pilot program and to file complaints about problems encountered in dealing with the program. Again, there are several layers of appeal rights including:

- Right to appeal eligibility for enrollment in the program.
- Right to appeal an assignment to a provider or care team.
- Right to appeal a decision regarding provision of a particular service.
- Right to appeal elements or non-elements of a care plan.
- Right to request a second opinion or evaluation of eligibility for a service.
- Right to file a grievance/complaint about the pilot program and/or its providers.

The appeal system should be streamlined and include the best protections provided by the Medicare and Medicaid appeals processes. Elements should include: due process protections, clear notices in a language the enrollee can understand, aid paid pending appeal, an expedited review process, a path to an independent review entity and, if necessary, federal court.

Meaningful Notice. Beneficiaries in the pilots must get information about the program, their rights and their care. Enrollees have a right to and must be provided notices and other documents that provide information about:

- Enrollment rights and options.

- Plan benefits and rules.
- Care plan elements, including care options that were available but not included in the plan of care.
- Transition protections.
- Appeal rights and options.
- Potential conflicts that may arise from relationships between providers, suppliers, the pilot program and others.
- The availability of language services.

Notice must be provided in a format and language that the enrollee understands.

Culturally appropriate services. See answer to question 8 below.

Accessible services. See answer to question 8 below.

Independent Ombudsman. Program enrollees should have access to an independent ombudsman or other entity that is tasked with assisting enrollees in the appeals and/or grievance process and advocating on behalf of enrollees generally within the program. The ombudsman would also assist enrollees in maintaining eligibility for the program (for example, maintaining Medicaid eligibility) and with advising potential members on enrollment options.

Sufficient provider rates and adequate networks. See answers to questions 8 and 12 below.

Stakeholder input. Each integration entity should have a process for soliciting and incorporating stakeholder input. See answer to question 6 below.

6. What education and outreach (for providers, beneficiaries, and stakeholders) would you consider necessary prior to implementation?

Education and outreach prior to implementation will be crucial to the success of any integrated care project.

Outreach to dual eligible beneficiaries:

Two types of outreach to dual eligbiles are necessary.

- Outreach to dual eligibles while designing the project. A stakeholder process should include input directly from dual eligible beneficiaries themselves prior to finalization of pilot development. In order to get meaningful input from dual eligibles, the state/contracted entities need to offer enough preliminary information about enrollment options, provider networks, covered services, and other important elements so that beneficiaries can offer constructive suggestions *before* those elements are finalized. Stakeholder meetings should be well-publicized at least a month in advance, and should be available via teleconference. Reaching dual eligibles, especially those most marginalized, also requires different formats than outreach to other stakeholders.

As we also recommend in our response to Question 11 regarding beneficiary participation in program evaluation, using focus groups, interviews, and small meetings at sites where beneficiaries feel comfortable, such as community based organizations (CBOs) or nutrition sites, all are likely to be more effective approaches than large meetings or call-in opportunities, which privilege more sophisticated and professional participants who are not necessarily representative.

- Outreach prior to enrollment: Although NSCLC believes that the best enrollment model for this program is a voluntary," opt in" model (see Question 1 above), if either an "opt out" or a mandatory enrollment process is used, then it is particularly important to provide high quality education and outreach to enrollees. Prior to implementation, education and outreach from governmental or community-based organizations is more valuable than that from a pilot program that has a pecuniary interest in a dual's enrollment. A neutral party will be in the best position to give unbiased information. In order to be thorough and high quality, education and outreach costs money. DHCS should consider all available means to secure additional funding for education and outreach during the transition period.

Education and outreach must take place in languages and at times and in places accessible to all dual eligibles and their caregivers in California, in particular those who are limited English proficient. For many language minority communities, it is important to reach out through trusted CBOs and individuals who speak the language and share cultural traditions. It also is important that family caregivers, many of whom are working, are accommodated through evening sessions.

<u>Outreach to providers:</u>

Outreach to providers must be more than lining them up as network participants and explaining proposed financial arrangements. An effective integrated model will require a massive culture change for many providers, significantly changing the way that they interact with patients and other providers. Pilot programs will need to explain to providers how their model works and lay out very specific expectations about how the provider will participate, required records management systems, etc. More importantly, models will fail unless there is genuine provider buy-in and enthusiasm for making the model serve the beneficiary. Even in counties where some service integration has already taken place, the changes and challenges will be significant. A great deal of provider education, explanation, coordination and team building will need to take place before the first dual eligible is enrolled in a pilot.

7. What questions would you want a potential contractor to address in response to a Request for Proposals.

We would want a potential contractor to address questions about its history, its ties to the community to be served, and its specific plans for integration. We have set out below some areas of inquiry.

History with Medi-Cal and Medicaid:

How long has the contractor had experience, if any, as a Medi-Cal contractor?

What specific experience has the contractor had, if any, in delivering services to seniors and persons with disabilities? What experience has the contractor had in the delivery of long-term services and supports, including specifically IHSS or IHSS-like services and institutional care services? In the delivery of mental health services, etc. ?

What specific experiences has the contractor had with person-centered care? Self-directed care? What is the specific experience of the contractor with care coordination? What methods of care coordination has the contractor used? What assessment tools has the contractor used?

If the contractor is an organization that also operates outside California, what are the extent and scope of its Medicaid contracts with other states? Has it been subject to any adverse actions by state authorities? What experience has it had in the delivery of LTSS, including IHSS and IHSS-like services, in delivery of mental health services, etc.?

History with Medicare:

Does the contractor currently operate Medicare Prescription Drug Plans or Medicare Advantage plans; what type of MA plans (e.g., Dual Eligible SNPs, Institutional SNPs, etc)? How many enrollees? How many dually eligible enrollees?

Has any plan operated by the contractor been subject to a suspension of enrollment by CMS and, if so, what was the nature of the violation causing the suspension? Have any plans operated by the plan sponsor been subject to Corrective Action Plans by CMS and, if so, what was the nature of the problem?

What are the star ratings for the MA plans operated by the contractor?

If the contractor operates integrated or partially integrated D-SNPS in other states, the contractor should provide its contracts with those states and the Models of Care that it has used.

History with the Service Area:

What are the contractor's experiences with and ties to the county? How many seniors and persons with disabilities served? How many dual eligibles? What types of plans are offered? What is the extent of their currently operating provider networks, including mental health networks, LTSS networks, etc. ?

What work has the contractor done with the public authority in the pilot county? With local mental health providers? With local home health providers? With other providers of LTSS services? With local nursing facilities?

History with Special Populations:

What is the contractor's experience in serving LEP populations? If the contractor already operates in the county, how many of its providers speak non-English languages? Which languages?

What is the contractor's experience in serving people with disabilities? How many of its providers have offices accessible to persons with disabilities?

What is the contractor's experience serving seniors? How many of its providers are geriatricians? What experience to they have providing end of life care?

What is the contractor's experience serving individuals that have both Medicare and Medi-Cal?

Plans for integration:

What is the contractor's proposed model for integration?

What are the contractor's plans for records sharing among providers? What systems, electronic or otherwise, are planned? Will the contractor be paying for upgrades required to connect providers? Are systems already in place? If not, where are the gaps and what is the timeline for filling them? What procedures will be used to ensure that beneficiary choices to limit record sharing will be honored?

Are providers in the network ready and willing to participate in the care coordination model the plan intends to use? Will providers be compensated for time spent meeting with a care team, etc.?

How does the contractor intend to integrate IHSS? How specifically does it intend to work with the local public authority and existing provider networks?

How does the contractor intend to integrate mental health services?

What are the contractor's specific plans to integrate ADHCs, FQHCs, MSSPs, assisted living waiver services?

What specific timelines does the contractor propose for integration of IHSS, mental health and LTSS?

What specific mechanisms will the contractor use to coordinate care? What assessment tool will the contractor use to evaluate medical and social needs?

Will the contractor integrate transportation? How? What non-medical supports will the contractor include in its integration model?

Other questions:

What will be the appeals process for members? What procedures does the contractor have for complaint tracking?

What will be the design of customer service? Call center staffing and hours? Spanish language lines? How will other language inquiries be handled?

What procedures does the contractor have in place to address the needs of LEP beneficiaries when they visit providers? Beneficiaries with disabilities?

We also urge DHCS to review the Model of Care questions in the CMS Medicare Managed Care Manual, Chapter16-B Special Needs Plans, at Appendix 1 http://www.cms.gov/manuals/downloads/mc86c16b.pdf (pp. 54-86).

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

Physical Accessibility:

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

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

Programmatic Accessibility:

DHCS should ensure a provider network that is programmatically accessible. Programmatic access means that the *policies, practices and procedures* that are part of the "typical" delivery of healthcare are modified so as not to hinder the ability of patients with disabilities to receive the same quality of care as other persons. Usual office procedures often fail to take account of barriers such as office emergency evacuation procedures that do not account for the needs of people with disabilities, appointment policies that do not account for dependence on

paratransit rides that can have issues with delays or reliability, and referral procedures that fail to consider the accessibility of the specialist office. Policies and procedures that comprise programmatic access involve: methods of communicating with patients for the provision of individual medical information and general health information (see examples below); appointment scheduling procedures and time slots; patient treatment by the medical staff; awareness of and methods for selecting, purchasing, and scheduling the use of accessible equipment; staff training and knowledge (e.g., for operation of accessible equipment, assistance with transfer and dressing, conduct of the exam); standards for referral for tests or other treatment; system-wide coordination and flexibility to enable access; and disability cultural competence.

Examples of Disability Communication Access:

DHCS should require that contractors have in place systems for effective communication for individuals who are deaf or hard of hearing. These may include: qualified interpreters, note-takers, computer aided transcription services, written materials, telephone handset amplifiers, assistive listening systems, telephones compatible with hearing aids, closed caption decoders, open and closed captioning, TTY, videotext displays, and exchange of written notes.

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

Systems for effective communication with persons with speech impairments should be required, which may include TTY, computer terminals, speech synthesizers, and communication boards.

Language access:

Because dual eligibles are disproportionately limited English proficient, it is particularly important that language access standards be well established. Title VI standards apply to all recipients of federal funds, including these contractors. CLAS standards also should be incorporated into DHCS requirements. Contractors should be required to meet all current Medi-Cal standards with respect to language access and they should be required to set out a language access plan as required of managed care plans, see http://www.hmohelp.ca.gov/library/reports/med_survey/tag/latag.pdf and in all cases to conform with the stronger of DMHC or Medi-Cal standards.

In addition, DHCS should work with stakeholders and pilot programs to develop additional specific language access requirements for pilots and their providers that could include: specific training or certification requirements for interpreters used by contractors; availability of "I speak" cards in provider offices; training for providers in language access procedures and in cultural competency; procedures to ensure that LEP callers to CSR lines and to medical help lines get needed interpreter services; identification of specific documents and correspondence subject to translation requirements, etc.

Network adequacy:

It is essential that care be delivered in a method that takes into account the high number of dual eligibles who have multiple chronic conditions, including dementia, who are very frail, who have disabilities, and who are limited English proficient.

DHCS should set appropriate ratios of primary care providers with training in gerontology to the population to be enrolled and require an adequate specialist network including a sufficient number of specialists in diseases and conditions affecting the dual eligible population. When setting standards for network adequacy, it is important that the standards take into account the number of network providers who actually are accepting new patients, wait times for appointments, etc.

Standards for geographic accessibility need to be set. When applying these standards, DHCS should take into account the fact that many members of this population do not drive and rely on public transportation so, at least in urban and suburban areas where public transportation is available, accessibility criteria should be based on times required when using public transportation and not rely solely on drive times.

DHCS should set standards that require models to incorporate longer appointment times than are typically allocated for the general population. For many reasons—complex conditions, limited English proficiency, disability, mental health condition—many members of this population require longer appointments if their needs are to be understood and appropriately addressed.

Contractors should be required to provide 24/7 access to non-emergency help lines staffed by medical professionals and to non-emergency room medical care. Standards for wait times for appointments and customer service should, at a minimum, be as rigorous as those set for California managed care organizations under the jurisdiction of the California Department of Managed Health Care. See Timely Access Regulation, Rule 1300.67.2.2 (implementing Health and Safety Code section 1367.03). See http://www.dmhc.ca.gov/dmhc_consumer/br/br_timelyacc.aspx

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

Prior to implementation, pilot entities would need to undergo readiness reviews to ensure that they are ready to perform their contracted duties. Network adequacy, disability access, assessment tools and care coordination models, care transition policies are just a few of the elements that would need to be affirmed as in place and functioning properly before implementation.

11. How should the success of these pilots be evaluated, and over what timeframe?

There are many goals associated with this effort – improve care coordination and health outcomes, increase access to HCBS, decrease unnecessary hospitalizations, reduce costs, ease administrative burdens for providers and more - each of which should be evaluated. The focus,

however, of any effort to evaluate the success of the pilots should be on the beneficiary experience. How did the lives and health of the dual eligibles who are part of the pilots change? Did they see an improvement in the options they were presented and the services and supports they ultimately received? Making this evaluation will be difficult and will require a mix of both quantitative and qualitative data.

One of the primary measures should be the extent to which pilots were able to "rebalance" the provision of long term services and supports. Successful pilots will provide beneficiaries with high quality services in the most appropriate (i.e. least restrictive) setting. Defining and measuring whether services were provided in the appropriate setting is a difficult task. A starting point would be to measure changes in home and community based services provision and long term nursing home admissions. A successful pilot will increase the hours of In Home Supportive Services, Adult Day Health Care and other home and community based services provided while decreasing long term nursing home stays.

One of the exciting things about the proposed pilot is the opportunity to use combined Medicare and Medi-Cal funds in creative ways to cover services that are not currently covered by either program, but that could improve the health of the beneficiary and support the beneficiary's desire to stay at home or in the community. Examples that have been provided include building a ramp in the beneficiary's home, giving a flea bath to a pet whose fleas have been biting the beneficiary or paying rent on an apartment while the beneficiary is temporarily hospitalized or in a nursing home. The evaluation should find a way to measure the provision of these types of enhanced benefits and track their impact on beneficiaries' ability to remain in the community.

The evaluation must look beyond just medical and cost-avoidance outcomes. In addition to collecting and analyzing various utilization and outcome data, the evaluation should survey pilot enrollees to gauge their satisfaction with the program. Special steps should be taken to ensure that survey instruments reach hard to reach populations including limited English proficient enrollees, enrollees in nursing homes and enrollees with mental health conditions. Caregivers of enrollees with cognitive impairments must also be included. Satisfaction surveys should be conducted in multiple forums (focus groups and interviews, not just in writing) and should occur in environments in which enrollees feel safe and can share freely. For example, focus groups of Korean speaking enrollees could be conducted at a community based organization that serves Korean seniors. Peer administered surveys are also recommended, particularly with LEP individuals and individuals with disabilities who may be more likely to share freely with a peer than a professional surveyor.

Consumer satisfaction surveys would provide an opportunity to look beyond medical and cost-avoidance outcomes, which alone may not paint a complete picture of the impact the pilots have on the lives of enrollees. For example, consumer satisfaction surveys should evaluate the impact the program has on community involvement, engagement in work, volunteer and educational activities and social engagement. These are all keys to keeping people at home and in the community, but without specific evaluation measures, they could be overlooked by the pilots.

While cost-savings should not be the primary driver of the evaluation, it is important that any costs savings achieved by the pilots be identified and their source understood. Did the savings come from providing less care? Providing more care in the appropriate setting? Reducing provider rates in a way that could threaten future access? Improving quality and decreasing errors? The evaluation should also track if and how savings were reinvested in community based programs.

It will take time to evaluate the performance of these models. While certain elements can be evaluated early (how did early enrollment go), the most important measures (increased access to HCBS, decreased hospitalizations and long term nursing facility placements, cost savings) will take several years to evaluate properly. We understand that a typical evaluation timeframe for demonstrations involving this population is 5 years. We recommend using that timeframe for the program evaluation. Until the evaluation is complete and the results are known, there should be no expansion of the pilot projects.

Evaluation tools should be standard across pilot sites so that the performance of different models and sites can be compared. At the same time, the evaluation method must take into account differences between the pilot counties that may have contributed to their success or failure. For example, if a COHS with very strong ties to local providers that has already done a lot of integration of services receives a contract, it would be important to understand what value the pilot added to work already being done and what supports, experience and relationship were already in place that enabled the added value.

Finally, pilots should be contractually required to provide any and all data necessary to perform the evaluation.

12. What potential financial arrangements for sharing risk and rate-setting are appropriate for this population and the goals of the project? What principles should guide DHCS on requiring specific approaches to rate-setting and risk?

While integrating responsibility and payment for all Medi-Cal and Medicare services can, in theory, improve care coordination and increase the health of dual eligibles, in practice use of risk-sharing and capitated payment models can result in delays and denials of medically necessary care or "cherry-picking" of program participants (adverse selection). If entities are at too great a risk of losing money or have too much incentive to earn shared savings, the result can be decisions which are not patient-centered and which are unlikely to improve care.

We encourage the development of alternative models or models which introduce risk and opportunities for shared savings over time. If a risk-based, capitated model is pursued, several important protections must be in place:

- Rates should be adjusted for health status of the population to ensure that rates are adequate to support appropriate care and discourage adverse selection.
- Pilots that are managed care entities must ensure that the rates they pay providers are high enough to ensure adequate and sustainable networks. See the answer to Question 8 above for more information on network adequacy.

- Since the proposal is for Medi-Cal and Medicare rates to be blended and the services of both programs to be provided seamlessly, the rates paid to providers should be as least as high as Medicare rates since they are generally higher than Medi-Cal rates. Where the Medi-Cal rate would be higher for a service, they should serve as a base.
- Rates paid by integrated care entities to home care providers must also be high enough to ensure a sufficient home care workforce which can include family members. These rates should be no lower than those currently provided under the IHSS program.
- There should not be anything in the rate structure that disincentivizes the use of home and community based services. For example, pilots should not receive a higher rate for enrollees simply because they have been admitted to nursing homes. There must be some risk for the pilot associated with that admission.
- The rate structure should encourage participation of non-profit and safety net providers by increasing access to capital to start integrated programs and by utilizing risk-sharing strategies that do not provide larger, for profit entities with financial advantages.
- The consumer protections discussed more fully in response to Questions 1 and 5 – especially related to enrollment, appeals, notices and oversight - are essential.

However the rate-setting and risk structures are set, we have many questions about how the blended Medicare and Medi-Cal financing would work in operation. For example, would funds be blended at the state level or pilot level? How will the amount of Medicare funds contributed be determined? How much risk will the state or the pilot be expected to take on from Medicare? Who will be liable if Medicare costs exceed Medicare payments? How will savings be shared with the Medicare program? How will savings be shared with the Medi-Cal program? What protections will be put in place to ensure that Medicare funds are not replacing Medi-Cal funds?

It is unclear, from the timeline provided, when in the process the answers to these questions will be provided. It is also unclear who is best able to answer many of these questions, as many of them involve matters of policy that will presumably be set by the Centers for Medicare and Medicaid Services (CMS). We believe it is important to discuss these questions and their answers with stakeholders before submitting a design proposal to CMS. It would not be responsible to submit a proposal for blending funds without having concrete ideas for how the blending would operate.

13. Other Concerns.

We have various other concerns and questions that do not fit into one of the questions raised in the RFI.

Medicare and Medicaid Integration

There are several ways in which the two programs differ. Payment structures and amounts, coverage standards, appeals processes are just a few of the broad buckets where the two programs are not perfectly aligned. In order to truly integrate these programs, DHCS will need to work with MMCO to resolve these differences in the integrated model. As with the financial integration, it is not clear from the timeline or proposal to MCCO/CMMI when this work will be

done and by whom. We believe it should be done before a proposal is submitted to CMS and should be part of that proposal. It at least needs to be completed before the Request for Proposal is submitted as bidders will need to be aware of requirements related to integrated appeals processes, coverage determinations and more. We strongly encourage DHCS to work with CMS to take the lead in determining rules for integrating Medicare and Medi-Cal rules and systems and not pass this responsibility to the pilots via general contract language requiring integration.

Timeline and Process

While DHCS has so far proceeded deliberately in designing the duals integration pilots, we are concerned that the draft timeline sets too aggressive a pace for proceeding. We are particularly concerned about the plan to have a proposal submitted to CMS by September 1, 2011. Many questions remain to be answered and more stakeholder discussion and input will be necessary before a proposal will be ready for submission. Three months will not be enough time to complete the necessary work in a thorough, careful way. California is one of only a handful of the fifteen states which received design contracts to commit to submitting a design proposal in 2011. We suggest that DHCS request an extension on this deadline. We also suggest building in more time for CMS to review, modify and approve a proposal before issuing an RFP.

It would also be helpful to provide stakeholders with more information about the timeline, including when conversations with CMS will take place, what role CMS will play in developing the proposal, what opportunities stakeholders will have to share their views on the proposal with CMS and what elements DHCS expects to include in a proposal.

Oversight & Monitoring

The RFI does not include a discussion of how the pilots would be overseen and monitored. We favor a three way contract between DHCS, Medicare and the integration entity in which Medicare and DHCS each retain responsibility for overseeing the plan and holding the plan accountable. Both Medicare and DHCS should retain the ability to issue corrective action plans, impose enrollment and marketing sanctions, levy civil monetary penalties and, if necessary, terminate a pilot program. Federal and state investigative bodies should also have authority to monitor and report on the integrated pilots.

We think it particularly important that CMS, with its expertise in Medicare services and in Medicare managed care, continue to be active in setting standards and monitoring program compliance. There is a large body of existing Medicare regulation and guidance, including, for example, the entire Medicare Managed Care Manual, which developed and evolved in response to specific needs and/or abuses. While we recognize that a new model would require some waivers and changes in procedures, it is important not to undertake a wholesale waiver of provisions that have been hammered out over many years. And it is equally important that systems currently in place for CMS monitoring and enforcement of compliance not be abandoned.

In addition to figuring out the roles for DHCS and Medicare, DHCS will need to determine what role different divisions within DHCS and perhaps at the Department of Managed Health Care or the Department of Insurance play in monitoring the pilots.

Additional oversight protections include the existence of an independent ombudsman and a comprehensive stakeholder advisory committee as discussed above.

Although we expect and anticipate that the contractual requirements for pilots would exceed requirements of current regulations and statutes, it would be a useful if DHCS could take the first step of identifying, for the benefit of both potential contractors and other stakeholders, the existing statutory and regulatory provisions to which a contractor would be subject.

Thank you for the opportunity to submit comments.