



COMMENTS OF THE SOUTHEAST ASIA RESOURCE ACTION CENTER IN RESPONSE TO THE REQUEST FOR INFORMATION ON PILOTS FOR BENEFICIARIES DUALY ELIGIBLE FOR MEDI-CAL AND MEDICARE

California is home to the largest Southeast Asian American population in the United States. As of 2004, there was a total population of 705,381 Southeast Asian Americans reporting one or more ethnic/racial designations from the following groups: Cambodian, Hmong, Laotian and Vietnamese.¹ The Southeast Asian American population arrived largely as refugees following the end of the wars in Southeast Asia in 1975. Southeast Asian American refugee elders in particular face barriers in access to services including being limited English proficient. In addition, there are also high rates of disability among Southeast Asian American elders.² Southeast Asian American elders also face higher rates of poverty than the national average – 19.8% compared to the national average of 9.5%³ - thus making them a key population for Medicare and Medicaid dual eligibility services.

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 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. For Southeast Asian American elders, the right to self direct care is especially important because this helps ensure that they receive care in a linguistically and culturally appropriate manner.
- **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.

¹ Max Niedzwiecki and TC Duong. 2004. Southeast Asian American Statistical Profile, Washington DC: Southeast Asia Resource Action Center (SEARAC)

² Kaying Yang and Max Niedzwiecki. Southeast Asian American Elders in California: Demographics and Service Priorities Revealed by the 2000 Census and a Survey of Mutual Assistance Associations and Faith Based Organizations. Washington DC: Southeast Asia Resource Action Center (SEARAC), 15.

³ Southeast Asia Resource Action Center (SEARAC). 2011. Southeast Asian Americans At a Glance: Statistics on Southeast Asians adapted from the American Community Survey. Washington DC: SEARAC.

- **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, transition rights, meaningful notice and information about plan benefits and changes, stakeholder input. Most important for strengthening consumer protections for Southeast Asian American consumers is access to culturally and linguistically appropriate care, and disability access.

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

We recognize the importance of preserving the consumer choice and believe 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. However, we do recommend that DHCS pursue an “opt out” model of enrollment for the program. For the Southeast Asian American beneficiaries in particular, “opt in” models of enrollment require more outreach, education, and community knowledge of the programs at hand—infrastructure that existing providers and services are not able to provide. In addition, as refugees that fled governments of persecution, many Southeast Asian American elders are reluctant to deal with the government and this could affect self-enrollment rates among the community. Utilizing an “opt out” model will ensure greater coverage within the program, and elders will still have the choice to “opt out” and adjust their plans accordingly.

If DHCS does decide to pursue 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 dis-enroll 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 that are also culturally and linguistically appropriate are needed so individuals understand their options.

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 from 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 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.

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 consumers have the option of hiring whomever they want, including a spouse, parent or other relative, or a friend. This is especially important for Southeast Asian American elders who are limited English proficient, and provide access to culturally competent care since the consumer is able to hire someone they trust and can communicate with. 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.

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

We note 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.

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.

4. (We did not respond to Question 4)

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, because over 90% of Southeast Asian American elders live at home⁴, the program should deliver

⁴ Paul Igasaki and Max Niedzwiecki. 2004. Aging Among Southeast Asian Americans in California, Assessing Strengths and Challenges, Strategizing for the Future. Washington, DC: Southeast Asia Resource Action Center, (SEARAC) 15.

'enhanced' benefits designed to allow individuals to continue 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.

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.

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

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 and others.
- The availability of language services.

It is critical that 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 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 eligibles 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 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 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. We also encourage the use of interpreters to provide linguistic access to those who are limited English proficient wherever possible.
- Outreach prior to enrollment: if either an opt-in or a mandatory enrollment is used, then it is particularly important to provide high quality education and outreach. Prior to implementation, education and outreach from governmental or community-based organizations is more valuable than that from a plan that has a pecuniary interest in a dual's enrollment. A neutral party such as a community based organization will be in the best position to give unbiased information. In addition, ethnic and immigrant and refugee serving community based organizations can assist in providing outreach information in a culturally and linguistically appropriate manner. 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 the Southeast Asian American communities, it is important to reach out through trusted community based organizations and individuals who speak the language and utilize culturally appropriate models of care. It also is important that family caregivers, many of whom are working, are accommodated through evening sessions.

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 delivery 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 in 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 operated outside California, what is 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)? number of enrollees?
- Has any plan operated by the contractor been subject to a suspension of enrollment by CMS and, if so, 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, 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 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? What is the contractor's experience in serving refugee populations? If the contractor already operated in the county, how many of its providers speak non-English languages? Which languages? What is the contractor's experience in providing culturally competent care?
- 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?

- How does the contractor intend to integrate IHSS? How specifically does it intend to work with the local public authority?
- 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? Are there designs for language lines for Southeast Asian languages, most notably Vietnamese, Hmong, Cambodian and Laotian? 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, Chapter 16-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?

Accessibility: The disability rate for the general population is 42.2 percent, and for Asian Americans overall it is 43%. For Southeast Asian Americans, the disability rate ranges from a high of 72.6% for Hmong women to a low of 53.6% for Vietnamese men.⁵ Thus, 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

⁵ Paul Igasaki and Max Niedzwiecki. 2004. Aging Among Southeast Asian Americans in California, Assessing Strengths and Challenges, Strategizing for the Future. Washington, DC: Southeast Asia Resource Action Center, (SEARAC) 15.

- 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.

Other disability 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:

One of the Southeast Asian American community's great need is for appropriate interpretation and translation services that would enable elders to better access health care. Census data demonstrates that Southeast Asian Americans in California range from 75 percent (for Vietnamese elders) to 83.3 percent (for Hmong elders) speaking English "not well" or "not at all."⁶ 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. Specifically, DHCS should encourage compliance with existing Cultural and Linguistically Appropriate Services standards. 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 contractors to develop additional specific language access requirements for contractors 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

⁶ Paul Igasaki and Max Niedzwiecki. 2004. Aging Among Southeast Asian Americans in California, Assessing Strengths and Challenges, Strategizing for the Future. Washington, DC: Southeast Asia Resource Action Center, (SEARAC) 16.

CSR lines and to medical help lines get needed interpreter services; identification of specific documents and correspondence subject to translation requirements, etc.

Community Partnerships

Contractors ought to have a demonstrated history of working with communities of interest and the community based organizations that have the most experience in serving them. Partnerships with community based organizations is key to providing culturally and linguistically appropriate services to limited English proficient dual eligibles.

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, mental illness, those who are very frail, those who have disabilities, and those 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. For communities in medically underserved areas, DHCS should use this pilot project to develop best practices of targeted outreach and strategies for accessibility.

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.dmhca.ca.gov/dmhc_consumer/br/br_timelyacc.aspx

9. If not a potential contractor, what are you able to contribute to the success of any pilot in your local area?

SEARAC has worked extensively with community based organizations and many medically underserved communities. In contributing to the success of any pilot, we can help introduce and develop the relationship between the contractor, DCHS, and the community based organizations who have the most experience in serving large dual eligible communities.

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 HCBS, decrease unnecessary hospitalizations, reduce costs, ease administrative burdens for providers and more - and each of these 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 that 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.

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 Vietnamese speaking enrollees could be conducted at a community based organization that serves Vietnamese 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.

Data in any evaluation process ought to include collection of racial and disaggregated ethnic data for the Asian and Pacific Islander Community. Aggregated data of this extremely diverse community masks disparities that exist for smaller ethnic groups—and in particular for Southeast Asian Americans (Vietnamese, Cambodian, Hmong, Laotian, etc.) and Pacific Islanders.

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. Furthermore, survey results should look at the ease of accessing Medicare and Medicaid—if the enrollment process was seamless and embodied the spirit of a “no-wrong door policy.”

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.

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 the Medicare rates.
- 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 dis-incentivizes 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.

13. Other Concerns.

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 (and should be part of) a proposal is submitted to CMS. 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.

Stakeholder Process

We are anxious to hear more from DHCS about its plans to incorporate input from stakeholders as this process continues. Stakeholder involvement will be key throughout. Input and discussion should occur in a robust way (including opportunities for dual eligibles themselves to contribute) during the design, contract, readiness and implementation phases.

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 the 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.

Thank you for the opportunity to submit comments.