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1	Page 1	Notifications and Continuity of Care	Based on the difficulties surrounding the enrollment of the SPD population, clear notification of transition plans and continuity of care protocols should be a major goal of the Demonstration. With regard to IHSS integration, it is important that provisions are established to allow recipients to maintain their existing care providers, including family members.
2	Page 3 of 68	Coordinated Care	If case management is the desired structure, a *mandate* for *all* case manager should be trained in all things annual re-certifications a beneficiary is expected to re-certify annually meeting the “Demonstration Goals” #2 “Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services and supports in lieu of institutional/care.”/Page 8. Examples of necessary annual re-certification making the beneficiaries whole: Federal waivers (IHO or SNF), HUD Housing, Food Stamps, renewal/transportation, utility (PG&E) for low-income programs, water discounts, garbage discounts for low income beneficiaries. This can be done by establishing a contract with a NON-medical contractor such as Disability Rights California who know the laws and ideal for Intern staffing. Rights are preserved while supervision is available. Data is collected and the effectiveness of the pilot is preserved. This will afford a more “social model” component to the pilot “Person-centered” program. Public subsidized housing can be preserved when a person returns to the community. Lost subsidized housing during a facility admission is a serious threat. The likelihood of getting subsidized housing back is virtually nonexistent. The person’s personal property is preserved without warehousing same.
3	Page 3,	Paragraph 2	One month is not sufficient time to develop a quality proposal for this project. DHCS should extend its turnaround time for RFS applications submission to two months.
4	Pages 3 and 5	Purpose and Background	As stated in prior correspondence, CAHF is concerned that the RFS continues to focus on the goal to “rebalance the current health care system away from avoidable institutionalized services and toward enhanced provision of home- and community-based services” without recognizing that California is a national leader in this area. The 2012-13 Budget provides for an estimated savings of $678.8 million in 2012-13

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			for enrollment of duals into managed care. Please arrange for a meeting with CAHF and DHCS staff to discuss the assumptions for the budget savings and the proposed methodology for capitated rates.
5	Page 3	Beneficiary	Beneficiary Protections should be established from the onset in the event that pilot projects are not continued past the demonstration period. (Overview/Purpose Page 3)
6	Page 4		If health care newly established is challenged and loses the challenge(s) or the perimeters are changed due to a U.S. Supreme Court decision(s), what will happen to the pilot programs? What provisions are in place to ensure that beneficiaries are protected from all changes to health care be it revoking or court rulings? If the selected counties are required to eliminate the Public Authorities during the pilot and court rulings or congressional revoking any part of the health care act that may dramatically collide with the lives of beneficiaries in the selected participating counties. What liabilities does this place on pilots and its stakeholders if programs/services are altered or ended? Staffing current programs and their operations would be at risk.
7	Page 4	Authority	This section should clearly state that that the pilots must comply with existing state law or regulations. We believe this is essential to differentiate between the four pilots authorized under current law and the budget proposals related to dual integration and managed care that were released by Governor Brown on January 5, 2012. This section only refers to CMS's interest in testing "capitated payment models" and should be expanded to reflect the second model authorized by CMS to test fee-for-service approaches to integration. The final site selection criteria should allow integrating entities to submit applications that test both capitated and fee-for-service models.

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8	Page 4	Background	The draft says there are 1.1 million dual people enrolled in both Medicare and Medical in California and the A-pages of the budget proposal says there are 1.2 million dual beneficiaries. Please clarify which number is correct.
9	Page 4	Integrated Financing	CAHF recognizes that the financing model is still a work in progress and details are yet to be clearly defined. However, CAHF has a general concern and wants to emphasize the critical importance that capitation rates set under the new capitation model are sufficient to sustain the Applicant's network and required range of services without compromising quality. This includes the level of capitation identified to the delivery of post-acute and long-term care services. DHCS must recognize that Medicare Part A RUGs rates and Medi-Cal AB 1629 rates should be considered as the rate floor when establishing capitation for post-acute and long-term care services provided by free-standing skilled nursing facilities.
10	Page 5	Additional Comments on the Background section	The last paragraph should be deleted. While the administration may want to expand the number of counties to integrate services for dual beneficiaries, current law only authorizes pilots in four counties. The administration's proposal to expand the number of counties should be discussed through the legislative and state budget process, and should not be intertwined into the RFS that is limited to the provisions enacted in SB 208.
11	Page 6	Demonstration Goals	3. Increasing availability and access to home- and community-based alternatives. What does this mean? How is this accomplished? Caps on MSSP, moratorium on ADHC, no Linkages, no Alzheimer's Day Care Resource Centers. Will applicants have to demonstrate a plan for creating these services or increasing capacity? Same page and section further down 5. Optimize the use of Medicare, Medi-Cal and other State/County resources. Why not include formal and informal community supports? The stories of successful community living involve a coordinated patchwork of services which include medical

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			and social from formal and informal networks of care.
12	Page 6	Demonstration Goals	We agree with the goals listed for the demonstration, particularly those related to expanding access to home and community based services and preserving and enhancing self-direction. An additional goal should be added to minimize disruption of care for beneficiaries who are enrolled in the dual integration projects and to improve the quality of care provided to dual eligible. For all the goals, the Department needs to explain in this document or others how progress towards each goal will be measured.
13	Page 6		Health and a high quality of life in their homes and communities for 'as long as possible'. AGAIN, Page 6, "For beneficiaries, this means no single entity is responsible for ensuring they receive necessary care and services—both medical and social to remain in their homes and communities for as long as possible." Or, "There is a critical need for new organized systems of care that provide beneficiaries with more tailored and supportive benefits in the setting of their choice."
14	Page 6 of 68		Multiple use of "…as long as possible." Why not serve those who want to stay at home until their death using an at-home care choice whether on-going or palliative/dying. Far cheaper than putting a person in a facility? Use the at-home medical monitoring program; leave the control of the person's life in the hands of the person and/or the beneficiaries family (or Power of Attorney). They are more likely to receive one-on-one care which is never available to a person under facility care. A visiting nurse can be assigned for a weekly visit to monitor. Transfer to a facility only if medical intervention is necessary. If a person has a "Health Care Directive" it

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			should be honored. This issue is of great importance when a beneficiary is unable to speak or act on their own behalf. EVERY beneficiary should have a “Directive”. Burial plans should be a mandated within the person’s case and considered to be of primary importance. Is there more than one Power of Attorney (PoA)? This should be reviewed by the case manager annually for update. Contact telephone numbers change, addresses change willingness to act as a PoA may change. If case management is the state’s desired pilot structure, a *mandate* for *all* case manager should be trained in all things regarding annual re-certifications a beneficiary is expected to re-certify annually: Federal waivers (IHO or SNF), HUD Housing, Food Stamps, renewal/transportation, utility (PG&E) for low-income programs, water discounts, garbage discounts for low income beneficiaries to name a few. There are more. The case manager *must* be thoroughly knowledgeable on all re-certifications…ALL! On issues of “Share of Cost”. SOC must be eliminated! Using the SSI income level to qualify for no-cost Medi-Cal is inhumane. It is one possible incentive you can offer a beneficiary to remain in the managed care rather than seeking an “opt-out”. Penalizing a person for working the majority of their life is striping away the greater opportunity of survival. Receiving a husband’s or wife’s Social Security retirement AGAIN penalizes the beneficiary’s legal right to that money. Paying a substantial “Share of Cost” (SoC”) should be exempted to ensure less dependency on community-based services.
15	Page 6	Demonstration Goals	We agree with the goals listed for the Demonstration, particular those related to expanding access to home and community based services and preserving and enhancing self-direction. An additional goal should be added related to improving the quality of care provided to dual eligible. For all the goals, the Department needs to explain in this document or others how progress towards each goal will be measured.
16	Page 6	Demonstration Goals	We believe that one of the goals of a demonstration should be to test various models to provide maximum learning to the State and stakeholders concerning what models work best for this population in this state. For example, we would have liked to have

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			seen some sites use passive enrollment and others use a voluntary enrollment model since we have so much disagreement over this issue within the stakeholder community. By structuring this solicitation so as to place the design of the models to be tested in the hands of health plans to the degree proposed is not likely to produce this type of variation. Also, we do not believe that the State should be limiting the demonstration to existing Medi-Cal Managed Care plans, as is proposed. We would suggest that at least one site be in a non-managed care area, as that will require a very different model that needs to be developed to provide coordinated care in significant areas of the state. At this point, we would urge this section to be modified to expressly indicate one of the goals is to test different approaches to the design and implementation of key aspects of these demonstrations, including different enrollment models.
17	Page 6	Demonstration Goal	The goals of the project alone are not clear. For example, Demonstration Goal #3, page six states, "Increasing availability and access to home- and community-based alternatives." This document does not illustrate how this will happen, be measured nor standards to be used to guide this process.
18	Page 6	Goals	We understand that the state and federal governments want (1) to provide better coordination of care, (2) to increase availability and utilization of home and community-based services, (3) to improve the timeliness of care, (4) to increase satisfaction with care, (5) to promote high-quality care, (6) to promote client-centered care and services, and (7) to optimize the use of public dollars. Both governments share the goal of improving health outcomes and achieving increased wellness and functioning for this high-cost, high-user population. Given that this is framed as a "demonstration," we believe that the state should lay out the specific issues it wants to test in a way that will lead to appropriate measures

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			of success. We would like to see the state promote different approaches and models of enrollment, assessment, coordination, contracting or arranging for services, financial integration, etc. We do not object to the overall approach of moving this population and many of the services they need into a managed care framework, but within that common framework it would be valuable to see if different arrangements work differently for different populations and providers. The RFS seems to leave all these determinations to the plans themselves rather than suggesting different systems. Evaluation at the end of the demonstration will be nearly impossible with this approach. Further, if quality is an important goal, we need to be clear at the outset how we will determine quality and changes in quality. Will we promulgate standards and inspect to see if those standards are being achieved? Will we establish penalties or inducements to encourage plans to attain standards? Finally, we have said from the outset that we need to recognize that some 40% of the duals population lives in counties where no managed care exists. There are several dozen counties with no established structures of managed care. Many do not even have adequate health care provider networks within the county. Attempts in past decades to create Medicare managed care plans in these areas resulted in collapse of the plans and created financial hardships for providers. The demonstration should explore different models of managing care through accountable care organizations and multi-county memoranda of agreement to allow regional solutions (as is done with some Area Agencies on Aging). To place these counties in early demonstration efforts ignores that we may need several years of infrastructure building before we can expect to have successful systems in place to coordinate and integrate care. And some of these areas are unique and will require unique solutions rather than a one-size-fits-all structure.

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19	Page 6	Goals	We have been unable to reach a contracting solution with DHCS related to requirements in the Medicare Improvements for Patients and Providers Act (MIPPA) for dual eligible SNPs established under federal law. We have pursued a mutually satisfactory solution with DHCS and has negotiated in good faith. However, DHCS has not offered a solution that would avoid the negative outcome of moving more than 50,000 patients out of our SNP and its specialized care model. Ending our enrollment for more than 50,000 enrollees with complex health conditions after years of integrated care would be very disruptive. In an integrated system, disenrollment means severing the patient-provider relationships that have existed for many years. Disenrollment would reduce health status, increase barriers to care and increase costs to both Medicare and Medi-Cal. Such care disruptions are clearly contrary to important demonstration goals, including improved coordination of care and continuity of care.
20	Page. 7	Demonstration Population	The draft seeks comment on whether certain groups of individuals should be excluded from the Demonstration. It is unclear whether the exclusion would be done to protect these individuals from the potential harm of participating or to protect plans from costs associated with these conditions. Individuals who have been in institutions for 90 days prior to enrollment should be included in the demonstration. If Applicants will be asking for the authority and responsibility to provide long term supports and services, they should be expected to provide these services for all individuals that need them and should be incentivized to work to transition institutionalized individuals into the community as appropriate. We would oppose any policy that would disenroll individuals from plans after they have been enrolled in a plan for 90 days or any other length of time. The potential positive effects of an integrated system – plans working to keep individuals in the community – can only be achieved if plans bear the full risk of institutionalization. Individuals with HIV/AIDS, ESRD and ALS should have the option to enroll in an integrated model, but should not be passively or mandatorily enrolled or locked-in if they voluntarily enroll. As the question seems to indicate, individuals with these conditions – and

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			others – are likely to have complex health needs that California's Medi-Cal managed care plans and most Dual Eligible Special Needs Plans (D-SNPS) may not be prepared to care for adequately. The potential for disruption in medication and treatment regimens and provider relationships is too great to expose these individuals to a passive or mandatory enrollment process. To the extent that the models offer an improved beneficiary experience and individuals in these groups believe they could benefit by participating, they should be allowed to do so instead of being excluded on the basis of their condition. We note the inconsistency in the Department's willingness to consider that managed care may not be appropriate for these groups while insisting that it provide benefits to all others, even though many of those have conditions equally or more complex. The Department has indicated that the Demonstration population is not expected to include full benefit dual eligibles with a Share of Cost. We believe that individuals with a Share of Cost should be eligible to enroll as many of them have significant long term care needs that could be well serviced by an effective, integrated model. We also recommend providing exceptions or modifications to current Share of Cost rules to allow people who need to enter an institution, but intend to return to the community, to maintain their community housing. Finally, we note that many dual eligibles struggle to attain and maintain Medi-Cal eligibility and Medicare enrollment. The current eligibility system which requires Medi-Cal recipients to renew their eligibility each year and provide full verification of all their assets at the time of renewal presents a major challenge to those individuals who are home-bound, severely disabled and must often rely on others for assistance with their daily living activities. As a result, there are often gaps in eligibility for Medi-Cal for this population. Gaps in Medi-Cal eligibility can also impact eligibility for Medicare as termination from Medi-Cal results in termination of buy-in for the Medicare Low Income Subsidy Programs such as QMB, SLMG and QI-1. Applicants should be required to provide a plan for assisting their enrollees to maintain their status as "full eligible duals" in order to insure continuity of care.

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21	Page 7	Demonstration Population	The document specifically requests comment on whether the demonstration should exclude beneficiaries who have been institutionalized for more than 90 days. We believe the incentives for cost-effective, coordinated care and supports will only be achieved by placing the integrating entity at full financial risk for all the health care and long-term services and supports the person may receive. The integrating entity needs to be fully at risk for the most expensive settings – hospitals and nursing facilities – in order to have the incentive to be aggressive and creative in providing the supports that enable people to live in the home or community, the settings most people prefer. This incentive should not be muted by placing limits on the liability of the integrating entity for these expenses. Placing a 90 day limit on the liability of the integrating entity changes the equation when considering the cost-effectiveness of providing the supports necessary for a person to live in the community. Instead of comparing the costs in the two settings for comparable periods, the comparison would be between the costs of institutionalization for 90 days vs. the costs of ongoing support in the community with no end date. It will create a severe bias towards institutionalization. It will also eliminate any incentive to transition persons now in nursing facilities into the community. This would be a serious mistake. It has been orally explained subsequent to the issuance of this document that what is actually being considered is that persons who have been institutionalized for longer than 90 days (not counting time a person has been in a nursing facility covered by Medicare) will be excluded only for the first year, and that liability for the cost of institutionalization will otherwise be fully borne by the plan or other integrating entity. If that is the case, this is less of an issue, and we would suggest that, given the importance of this issue, the final RFS be very clear about the limitations of the exclusion.
22	Page 7	Demonstration Population	The RFS asks for comment on inclusion of several specific populations. We have no particular expertise on serving persons with HIV/AIDS, ESRD, or ALS. We know that they often have extensive and costly needs for care and support and that they have traditionally been served in systems uniquely designed for these populations.

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			Depending on the numbers of persons involved in each group, we could see the state carving them out of the managed care system, or creating special systems within managed care. The issue of excluding persons institutionalized for longer than 90 days is one where we do have a strong opinion. We would oppose any blanket exclusion of these persons in the duals demonstration. Plans must become fully at risk financially for the care of the populations they serve…that is the underlying principle of managed care. Integrating as many of these people as possible back into their communities should be a top priority of the demonstration and a significant source of cost savings for the plans. That being said, we understand the enormous challenge facing plans and providers tasked with creating appropriate community-based care and support for many of the longer-term institutional residents, especially appropriate housing and skilled care givers. We believe they should be included in the initial capitation rates to the plans and that the plans be required to propose specific procedures they will use to determine client choice and the goals they hope to attain for deinstitutionalization of these residents. This may well take longer than a few months after the initial enrollment. We assume that this issue applies only to the first year of transition as each plan joins the demonstration over the several years of the pilot. Another issue that is not clearly explained in the draft RFS is whether the demonstration will include spend-down or share-of-cost Medi-Cal populations or only full-benefit recipients. The final RFS should address this issue.
23	Page 7	Demonstration Population	Demonstration Population: The Department of Developmental Services will continue to provide services to the developmentally disabled population and those services will be carved out of the Demonstration.

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			The Department of Developmental Services provides a wide array of services that may be considered "long-term supports and services". The Departments (DHCS and DDS) should provide a list of the services that will be carved out to ensure that managed care plans are not duplicating or reducing services in this area.
24	Page 7	Demonstration Population	Demonstration Population: The Department is seeking comment on whether the Demonstration should exclude beneficiaries with conditions such as HIV/AIDS, End-Stage Renal Disease (ESRD), Amyotrophic Lateral Sclerosis (ALS) or who have been institutionalized for longer than 90 days. Our company believes that individuals institutionalized for longer than 90 days should be initially carved out of the Demonstration for the first year. However, we would support the provision of additional supports to these individuals through regular primary care in the care facility (SNFists) and other mechanisms to remove the perverse incentive for cost-shifting and reduce the likelihood of hospitalization and poor health outcomes. We believe it can provide quality care to its members, regardless of their diagnosis or co-occuring disorders. Beneficiaries with HIV/AIDS, ESRD or ALS present some unique challenges due to their use of out-of network providers. There are two key issues - adequate reimbursement and an expedited medical exemption process for beneficiaries with providers who refuse to work with the managed care plan.
25	Page 7	Enrollment	We were extremely disappointed to see in the draft plans offered the option of pursuing a lock-in enrollment model. This idea was never discussed in any stakeholder meeting we participated in. The idea of passive enrollment was discussed, but the Department repeatedly assured stakeholders that under such a model individuals would have the right to opt out at anytime. We oppose a lock-in enrollment as well as a passive enrollment model. We agree with the Department's goal of getting dual eligibles into good systems of care but stress that the Demonstrations are untried. Before we know more about the plans that will be

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			offered and how well they perform, we cannot say for certain that they will represent an improvement over currently available systems. Offering plans the option to lock-in enrollees for up to six months represents a drastic change to dual eligibles' current enrollment rights in Medicare (where duals can change Part C or Part D plans at any time effective the following month) and Medi-Cal (where in all but COHS counties duals can enroll or disenroll from managed care at any time effective the following month). These rights exist out of recognition that dual eligibles are a particularly vulnerable population with changing health needs that may require a disenrollment from a managed care plan that is not able to meet those needs. The current proposal does not contain new benefits or protections sufficient to justify the loss of these enrollment rights. Adopting a passive or lock-in enrollment policy would leave dual eligibles with fewer rights and options then they have today. We propose instead an "opt-in" enrollment system that honors the autonomy, independence and choice of the individual by preserving 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. 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. The right to "opt out" alone is not adequate to protect dual eligibles from harm. A dual eligible who is automatically enrolled into an integrated

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			model may not realize that the model is not a good fit (for example, that current providers are not part of the network) until after the enrollment has taken effect. By that time the individual may have experienced a disruption in care that opting out in the following month comes too late to remedy. Locking the dual eligible into the enrollment would only exacerbate this problem. The draft RFI does not detail how dual eligibles already enrolled in D-SNPs and Part D plans would be treated. 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. Concerns that "opt out" and lock-in policies could address, such as adverse selection and marketing costs, can be addressed in other ways (for example, through appropriate rate setting, strict marketing rules and the use of independent enrollment brokers). Until we know these models meet the goals of the Demonstration an "opt in" enrollment system provides the best way to ensure that the new models grow into effective, person-centered programs. We also oppose the timeline described for informing dual eligibles about their enrollment options. Providing information in the Fall about an enrollment that may not take effect until later in the year will only confuse this population. Decisions about the enrollment timing and process should be made by the Department and CMS with input from stakeholders, not the plans. Finally, we encourage the use of enrollment brokers to process enrollments. There have been serious problems with misleading marketing of Medicare plans to dual eligibles. Use of an independent enrollment broker is preferred. In addition to a broker, the Department and CMS must invest in both training and support for organizations that can provide personalized assistance to individuals contemplating enrollment choices, particularly individuals in hard to reach groups. Very few organizations currently have the experience with Medi-Cal, Medicare, LTSS and behavioral health that will be necessary to properly advise beneficiaries.

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26	Page 7	Enrollment	The system of passive enrollment with opt-out has had mixed success under the transition of SPDs which is now underway. Procedures and guarantees of opt-out were not fulfilled as promised. There is anecdotal evidence that some Medi-Cal SPDs have suffered considerable harm as a result of reckless arbitrary assignment and indifferent consideration of requests for exception. Information and education materials have been shown to be inappropriate so that more than 50% were arbitrarily assigned to plans without their consent. These were our greatest nightmares and create the greatest reservations we have about the demonstration. Misinformed or uninformed patients are the fault of the state and the plans, not the patients. There should have been penalties and fines in place to deal with such systemic failure. Passive enrollment in theory is not the problem. Passive enrollment in practice is the problem. Plans should be required to demonstrate the materials they will use, the steps they will take, the appeals processes they will employ and the results they achieve when duals are passively enrolled. The state should be prepared to step in immediately to suspend the plan's participation at the first sign of problems. As has been stated many times before, this is a fragile population with complex medical conditions and many psycho-social and behavioral health needs. The plans and the state need to appreciate that they are threatening the system of care and service that are a focal point of patients' lives. Postcards and computer assignment don't cut it. We would ask the state to explain more fully their proposal for a six-month enrollment lock-in. We continue to argue for a more nuanced enrollment process for this older and/or disabled population. We believe the demonstration should encourage the early enrollment of the least complex clients, based on the number of visits, diagnoses, or

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			providers. This would give plans the ability to work out the procedures for enrollment in lower-risk populations before taking on the complex, higher-risk populations (as was suggested with patients institutionalized more than 90 days). The state and plans have the capacity to do this. We would defer to the PACE programs on how they and their clients are handled in the demonstration. However, we believe that enrollees should be informed of the PACE option where it exists and informed again as their conditions change. We also hope the state will continue to promote the expansion of PACE populations and sites simultaneously with the development of this demonstration.
27	Pages 7 and 8	Enrollment	As previously indicated, the question of whether a site will use passive enrollment should not be entirely within the applicant's prerogative. This is an issue that needs to be tested. To ensure that there are some sites with this feature and somewhere beneficiaries opt in rather than are automatically enrolled, only some of the sites should be permitted to use passive enrollment. Also, we strongly believe that there should be no 'lock-in" of six months or any other period, as is apparently being contemplated in the RFS. The best early indicator of problems is the frequency of disenrollment in a plan. This should be tracked closely so that early problems can be identified and addressed quickly. Preventing people from disenrolling eliminates this important tool to make early course corrections. Also, one of the lessons being learned from the 1115 Waiver experience is that it is a mistake to transition people because it happens to be their birthday month, a strategy the RFS invites applicants to propose. This prioritizes moving large numbers of people into a new system quickly over moving people as the necessary work has been done to ensure a smooth transition. There clearly needs to be more analysis concerning how to best create systems and processes so that there is a much warmer hand-off into the new system and much fewer surprises on the part of plans, providers, and consumers. The transition of individuals should be scheduled as the in-person assessments can be arranged with all the persons necessary to assess their medical, behavioral,

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			social and long-term service and support needs so a comprehensive plan can be developed and implemented. Transitions should not be scheduled simply because a date on the calendar has arrived.
28	Page 7	Enrollment	Opposes Passive and Lock-In Enrollment which will require participants to opt out of plans in which they are auto-enrolled. We are in favor of active enrollment whereby consumers have the right to choose a plan and are able to opt out at any time. (Enrollment Pages 7 & 26)
29	Page 7	Enrollment	The RFS states that sites can choose one of two enrollment processes: a passive enrollment process with an "opt-out" provision or pursuing an enrollment lock-in for up to six months (which would require the state to seek special permission from the federal government). We support a passive enrollment process with an opt-out provision for the beneficiary. The final RFS should clarify whether enrollees are allowed to opt-out of the capitated model altogether or just change plans. We believe that all dual eligibles would benefit from an integrated comprehensive care plan and suggests that beneficiaries not be allowed to return to an unmanaged fee for- service network. While the initial enrollment of a beneficiary requires intensive assessment and care coordination work that makes a 6-month lock-in period reasonable, we do not believe that the State should allow individual plans within a county to have different enrollment processes. This is not only difficult to administer, it is harder to explain to beneficiaries why they may have different processes depending on where they live. If a six-month lock-in is approved by the state and federal government for a specific county, then all plans must be subject to that process. As an alternative, we suggest that all plans use the same health assessment and that these be transferable if the beneficiary changes plans or disenrolls. This will ensure continuity of care and reduce the need for duplicative diagnostic testing.

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30	Page 7	Demonstration Model Summary	This Demonstration will involve models through which one entity is coordinating care for the total needs of a person, including medical, behavioral, social, and long-term care services. This design could take a number of different forms. It does not necessarily imply, for example, that Demonstration sites manage behavioral health or home- and community-based services; however, there is an expectation that all services will be coordinated and that the care experience will be seamless for the beneficiary. Additionally, sites are expected to demonstrate the ability to improve quality and contain costs. The assumption that one entity can coordinate services in which they have no expertise is not valid, nor will it produce the desired results. Perhaps having an assessment tool for all patients entering the system which triggers referrals to services might be a better way to approach this concept. This would take an MDT comprised of many players to complete – and would look different in each county. Having one care manager/advocate responsible for oversight of their care coordinating those services should also be mandatory. Quality improvement will have to be two-prong: internal and with contracted entities. Cost containment will naturally occur if the assessment tool accurately flags appropriate community services for referral.
31	Page 7	Demonstration Model Summary	The Department has an expectation that while the Demonstration sites may not manage behavioral health or home-and community-based services, all services will be coordinated and that the care experience will be seamless for the beneficiary. As a health plan, we coordinate care for its enrollees today. For purposes of the dual integration pilots, the final RFS needs to be clear on the roles and responsibilities (including fiscal responsibility) for which the plans will be held accountable. While plans will coordinate access to behavioral health and alternative home- and community-based services, it needs to be clearly stated if these are the financial responsibility of the plan or they are services that will be paid and authorized by other entities. It would also be helpful to clarify the incentives that plans or the Department may use to increase coordinating activities.

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32	Page 7	Key Attributes (beneath Demonstration Population)	DHCS is seeking comments on this entire document and in particular on whether the Demonstration should exclude beneficiaries: Who have been institutionalized for longer than 90 days. If plans are not responsible for folks institutionalized for longer than 90 days, you defeat the point made earlier in the RFS regarding perverse incentives. The incentive will be to institutionalize the costliest patients.
33	Page 7	Demonstration Population	The document uses contradictory terms about the target population. This section states, "All full benefit dual eligibles in the selected Demonstration areas will be eligible for enrollment." On page eight, under "Geographic Coverage" the document states, "To be considered for the Demonstration, potential sites must be capable of covering the entire county's population of dual eligibles. SB 208 does not mandate the pilot projects to cover 100% of the eligible population of dual beneficiaries. In fact, Welfare and Institutions Code 14132.275 (c) specifically authorizes DHCS to implement the pilot projects in phases. We think the RFS should delete the requirement for project sites to cover all of a county's dual eligible so applicants can create and DHCS can test different models with high quality standards. Under the paragraph that says "Note:…" this language is not sufficiently clear about the carve-out of individuals receiving care under the Home and Community Based Services Waiver for the Developmentally Disabled (HCBS-DD). Carve-outs & Exclusions – we strongly recommend that DHCS delete the language to exclude beneficiaries with specific chronic conditions as well as the exclusion of dual beneficiaries who have been institutionalized for more than 90 days. These crave-outs are discriminatory, create disincentives about developing efforts to move people out of institutional care, violate the Americans with Disabilities Act and *Olmstead* decision, and would allow integrating entities to cherry-pick out the most expensive cases to protect their financial bottom-line. Clarification is needed about whether beneficiaries who have a share-of-cost are included in the pilot projects.
34	Page 7 of 68		"…what are the specific CMS standards and conditions (not included in this draft?)

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35	Page 7 of 68		" …activities of daily living exampled as "walking and bathing" this needs to be expanded to include all tasks activities of daily living using a minimum of IHSS tasks. Waiver recipients have complete use of providers who are allowed freedom to do what needs to be done—NOT the extreme limitations of the IHSS program tasks. There *must* be an expansion to encompass programs coordination currently restricted services like the Meals on Wheels program to be allowed without restriction to IHSS service hours. Right now, you cannot be enrolled in the Meals on Wheels program home delivered meals without severe cut in IHSS hours. Restaurant Allowance cuts more IHSS service hours. This should not be allowed. Every community-based programs should be allowed to those who if not in a pilot is offered. Share of Cost are outrageously high. Some people miss the income allowable based on SSI income levels. The SSI program is a Welfare-based program—not based on employment quarters worked. People who have worked with/without a disability and became disabled are heavily penalized for working when CA state law uses the SSI income standards to establish a SoC. Example: I moved from SSDI to Social Security Retirement. My income was $995 until the 3% raise. As a result of the 3% raise in SSA & no longer eligible for "Pickle" or "No Cost Medi-Cal". I am appealing this Notice of Action based on out-of-pocket medical expenses which are "medically necessary". The legislative Share of Cost regulation has been in effect for over 20 years without any oversight or review for the devastation it causes. Now is a chance to review the Share-of-Cost for Duals.
36	Pages 7 and 23	Demonstration Population and Section 2.1 LTSS Capacity	The RFS proposes that demonstration sites will be responsible for the provision of all medical and long-term support and serviced for enrolled developmentally disabled (DD) beneficiaries. When DHCS implemented the mandatory enrollment of seniors and disabled persons, DHCS specifically excluded DD clients who resided in long-term care facilities from mandatory enrollment. We suggest that the same policy be implemented for the demonstration sites. DD clients receive case management

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			services from Regional Centers, which are responsible for living arrangements that meet the medical and social needs of the clients. Requiring these disabled beneficiaries to be assigned to a managed care plan would be duplicative of the services provided by the Regional Centers and not in the best interest of this group of beneficiaries. Page 23 inappropriately asks for Applicants to provide a transition plan to move individuals out of intermediate care facilities for the developmentally disabled (ICFs/DD). There are approximately 1,200 ICFs/DD in California. They are small residential homes that are integrated into neighborhoods and generally care for six patients. Many DD clients have resided in their home for 10 to 20 years. To propose removing these clients from their homes is unconscionable. DHCS must reconsider this provision and should exclude DD clients from this RFS.
37	Page 7	Demonstration Population	CAHF supports the exclusion of individuals who have been institutionalized for longer than 90 days. If a demonstration site cannot arrange for home- and community-based services within the first 90 days of institutionalization, it is doubtful that they will be successful given more time. The RFS must recognize that long-stay chronic care may be medically necessary when the consumer may prefer to receive services in a facility setting and/or may not be safely cared for in the community. In addition, disenrollment from the demonstration site will provide operational efficiencies for the nursing facility by removing the complication of dealing with a third bureaucracy (the demonstration site) when the services for the balance of patients in the facility are authorized and paid by Medi-Cal fee-for-service and/or Medicare. The RFS should be modified to clarify that individuals excluded for mandatory enrollment have the option to voluntarily enroll in the managed care plan. DHCS has not explained the rationale for excluding patients with HIV/AIDS, end-stage renal disease and amyotropic lateral sclerosis from mandatory enrollment. If the demonstration does not exclude beneficiaries who have been institutionalized for longer than 90 days, the list should be expanded to include other medically fragile populations such as Alzheimer's disease, severe dementia, Huntington's disease, other progressive degenerative neurological conditions, beneficiaries enrolled in

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			hospice, hepatic system failures, and persons requiring ventilator services. The RFS should be modified to clarify that exclusion of these individuals from mandatory enrollment does not prevent them from voluntarily enrolling in the managed care plan.
38	Page 7	Demonstration Population	Due to the planned California Children's Services (CCS) pilot in Los Angeles County, L.A. Care recommends that dual eligible children be excluded from enrollment in the Duals Demonstration Project. If the CCS intervention co-occurs with the Dual Eligibles Demonstration, it will be difficult, if not impossible for evaluators to distinguish the impact of CCS versus the impact of the Dual Eligibles Demonstration on children. L.A. Care agrees that services provided through the Department of Developmental Services for the developmentally disabled population should remain as currently available and carved out of the demonstration. Consistent with existing rules on current End-Stage Renal Disease (ESRD) patients transferring into a Medicare Advantage Plan, L.A. Care believes some dual eligible beneficiaries with highly specialized needs should be excluded from the pilot. Consistent with the exemption of dual beneficiaries with Amyotrophic Lateral Sclerosis (ALS), L.A. Care believes that those with other highly complex neurological conditions such as Huntington's, Parkinson's, multiple sclerosis (MS), and cerebral palsy (CP) should be excluded under certain circumstances (e.g. advanced disease state). For Duals living with HIV/AIDS who are enrolled in organized delivery systems and utilizing AIDS Waiver services, the default option should be to stay with their current systems, rather than being passively enrolled in a new system. Specialty HIV Plans and the PACE program should both remain options for eligible Duals. Because of the opportunities to improve care coordination and delivery to Duals who have been institutionalized for more than 90 days, L.A. Care does not believe this segment should be excluded from this pilot. However, given the highly specialized provider network necessary to accomplish this, we propose including this group during the second half of the transition year to allow plans to fully develop appropriate care management models and provider networks.

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39	Page 7	Population	Exclusion of those institutionalized for more than 90 days should be removed. Often institutionalization for more than 90 days is due to a lack of available housing and service options and these individuals should be able to access the full continuum of integrated care.
40	Page 7	Enrollment	All full benefit dual eligibles in the selected Demonstration areas will be eligible for enrollment. Full benefit dual eligibles have Medicare Parts A, B, and D coverage, and Medi-Cal coverage for Medicare premiums, coinsurance, copayments, and deductibles, as well as additional services that are covered by Medi-Cal that Medicare does not cover. (QMB+ individuals, SLMB+ individuals, and other full benefit dual eligibles.) Note: Demonstration sites shall be responsible for the provision of all medical services and long-term supports and services for enrolled developmentally disabled beneficiaries. However, services provided through the Department of Developmental Services for the developmentally disabled population will remain as currently available and carved out of the Demonstration. The Demonstration will not affect eligibility for regional center benefits among dual eligibles. DHCS is seeking comments on this entire document and in particular on whether the Demonstration should exclude beneficiaries: • With any of the following conditions: HIV/AIDS, End-Stage Renal Disease (ESRD) and Amyotrophic Lateral Sclerosis (ALS); or • Who have been institutionalized for longer than 90 days. Certain sub-populations have highly specialized needs that warrant them remaining in the FFS program and with access to the specialized care delivery systems that have been established to meet their specialized needs. We recommend that these sub-populations, such as people with HIV/AIDS, End-Stage Renal Disease (ESRD) and Amyotrophic Lateral Sclerosis (ALS), be excluded from the Demonstration. Our recommendation is that the Demonstration population excludes beneficiaries under age 21. Please include any additional detailed information about the conditions and other subcategories of the Duals population.

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41	Page 7	Enrollment	The RFS allows demonstration sites to choose a passive enrollment process for both Medicare and Medi-Cal, with opt-out provisions. There should be a process to allow a beneficiary to prevent enrollment in a demonstration site to avoid disruption in services and to assure continuity of care provided by a Medicare provider that is not part of the Applicant's network. CAHF does not support a "lock-in" for up to six months because it removes the freedom of Medicare beneficiaries to choose their health care provider. A lock-in would disrupt their health care by forcing them to see new providers when many of the elderly and disabled have been seen by the same physicians, including specialists, for years.
42	Page 7	Enrollment	Demonstration sites can choose a passive enrollment process in which eligible beneficiaries would be automatically enrolled into Demonstration sites for coverage of both Medicare and Medicaid benefits. Under passive enrollment, beneficiaries will be able to opt out of the Demonstration and choose from their care delivery options as available in that county. Applicants also should explain whether they would pursue an enrollment lock-in up to six months — an approach that would require the state to seek special permission from the Federal government. A lock-in period is most beneficial to the State in providing a minimum period in which to try to achieve care management and cost-savings. We commit to supporting DHCS in the conceptual model that they prefer. We would like to work with DHCS to accomplish their goals by seeking additional mechanisms to help beneficiaries find value in Managed Care.
43	Page 7	Enrollment	DHCS intends for the enrollment process to coincide with the existing Medicare Parts C and D enrollment timeline to minimize beneficiary disruption and confusion. As such, beneficiary notification would occur in conjunction with the Part C and Part D open enrollment period from October 15 to December 7, 2012. Beneficiary notification of new coverage options would occur in October and enrollment would be

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			effective January 1, 2013. While this is true for education and outreach, it is the intention of DHCS to enroll beneficiaries into the Demonstration over 2013 through a phased-in approach. More specifically, it is anticipate that Demonstration sites that choose a passive enrollment process would phase-in enrollment during 2013. The Demonstration may apply a Please clarify this section on how DHCS sees the open enrollment process working. We would recommend that in the 2012 OEP, the beneficiaries receive information and be educated so they understand their options and can make informed decisions. Specifically, they need to understand the following at that time: What options are available to them in OEP for the portion of 2013 that they would remain in the current model What options and benefits will be available to them under the Duals Demonstration when they matriculate We suggest enrollment be phased-in based on the birth months of the beneficiaries, similar to the SPD transition. Will the file feed standards follow those of Medicare or Medi-Cal? approach similar to the transition of seniors and persons with disabilities (SPDs) into Medi-Cal managed care, in which enrollment was based on month of birth, or another strategy may be used.
44	Pages 7 & 8	Enrollment	We request clarification on dual beneficiaries enrolled in SCAN's Connections at Home program: will these beneficiaries be treated similarly to the proposed PACE program participants, where eligible beneficiaries can continue to select SCAN's Connections at Home program? Those enrolled in PACE and SCAN's Connections at Home should be excluded from the passive enrollment process and planned PACE program expansions should not be impacted by the pilots.
45	Pages 7 & 8	Enrollment	The RFS lays out the authorization for pilot sites to "choose a passive enrollment process." We are opposed to any enrollment process that would result in disruption of care for our SNP members in pilot counties. We request that DHCS provide us with a short-term (e.g. two-year) contract that would meet the MIPPA requirements and allow our SNP members to be carved out of any enrollment not selected by our members into the demonstration pilots. We believe this solution will provide the best care delivery for our enrollees who have been participating in the very type of

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			coordinated and integrated care program that the demonstration seeks to replicate. This would prevent major coverage disruptions that will otherwise occur during 2012, 2013 and 2014. This approach will enable KP enrollees to maintain high-quality, continuous care in our specialized, fully-integrated system. If a full carve-out of our SNP members is not established to avoid upheaval and disruption for patients enrolled in our integrated, delivery system, DHCS should, at a minimum, institute a transitional period to give the state time to consult with stakeholders and determine how best to handle care transitions for this population. The additional time and planning will allow for a temporary reprieve for this narrow subset of the duals enrolled in SNPs while the demonstration project is established.
46	Pages 7 & 8	Enrollment	On page 8 of the draft RFS, the narrative indicates "that Demonstration sites that choose a passive enrollment process would phase-in enrollment during 2013." On page 7 of the RFS, "DHCS intends for the enrollment process to coincide with the existing Medicare Parts C and D enrollment timeline to minimize beneficiary disruption and confusion." This approach, as outlined, seems to create a series of possible care disruptions over calendar year 2013 and 2014, especially as related to individuals in SNP plans who may be disenrolled in 2012. For example, it is possible that a member would have to change his/her plan/provider up to four times: 1. once due to the closure of a SNP; 2. again when passively enrolled into a different plan designated as a pilot site; 3. a third time if he/she chooses to opt-out of that pilot plan in which enrollment was mandatory; and

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			4. again if the beneficiary chooses to enroll in another managed care plan after opting out of the demonstration. This type of care disruption, which could affect tens of thousands of enrollees, raises major concerns and threatens outcomes that defeat several key demonstration goals. In addition, these potential scenarios include moving more than 50,000 Kaiser Permanente enrollees from Medicare 5-star, coordinated, high-quality health plans, to health plans with below-average or average quality (2.5 stars and 3 stars).
47	Pages 7 & 8	Enrollment	The RFS asks site applicants to “explain whether they would pursue an enrollment lock-in” on page 7. Although we are aware of the general meaning of this term in the Medicare landscape, the RFS does not provide context for the term and how it may be applied and evaluated in the dual site selection process. We request further specificity and clarification from DHCS on the approach to this enrollment feature in the Demonstration context. For example, would "lock-in" mean that a member could not opt out for a certain amount of time or just that once a member has decided not to opt out and is enrolled, he or she could not disenroll for a certain amount of time?

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48	Pages 7 & 8	Enrollment	Enrollment: The enrollment process will coincide with the existing Medicare Parts C and D enrollment timelines (October 15-December 7, 2012). Beneficiary coverage would be effective as of January 1, 2013. The Demonstration sites may apply a phased-in approach based on birth month or other strategy. We believe that aligning with Medicare Advantage open enrollment may be confusing to the beneficiary. Example: A beneficiary receives notification in November 2012, but is phased into a pilot in June 2013. We believe that beneficiaries will be confused since the timeframe between notification and actual enrollment may be quite long. Therefore, the final RFS must clarify when beneficiaries will be enrolled into a plan. The statement regarding education and notification periods makes sense, but enrollment becoming "effective on January 1, 2013" suggests that all eligible participants would be enrolled on a single day. We support a phased in approach based on birth month and believes that a strong consumer education and outreach program must take place 90 days (on a rolling basis) in advance to reduce confusion and ensure informed beneficiary choice. WE have been providing health coverage to seniors and persons with disabilities since the Department began mandatorily enrolling this Medi-Cal population in June 2011 and supports a phased in process that allows for plans and providers to adequately assess and coordinate the population more slowly to ensure appropriate care coordination occurs. Given the Department's intention to begin enrollment in 12 months (starting January 2013), we encourage the Department to start sharing utilization data with plans starting January/February 2012 in order to allow for enough time to make network and infrastructure changes.

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49	Page 7		With any of the following conditions: HIVIAIDS Comment: Based on experience with providing services to dual-eligible HIV/AIDS patients including medical care, mental health and substance use disorder treatment, housing, case management, in-home supportive services, access to a comprehensive medication formulary and other services TTC believes that patients will benefit if the demonstration includes persons with HIV/AIDS because of the benefits of improved care coordination and the simplification of processes that will result from a single health plan being responsible for their healthcare .
50	Page 8	Key Attributes: Benefits	Key Attributes page eight Benefits talks about demonstration sites being responsible for providing access to State Plan and long-term care supports and services. This section leaves many more questions than answers and we respectfully request greater operational detail regarding expectations for these services. For example, does the RFS essentially propose to eliminate MSSP and the provider network, a network of highly committed and skilled providers and subcontractors built over a long 30-year history, and for managed care to attempt to create a new “like” service? Where do California’s Money Follows the Person Initiatives fall in this new model of care? Who establishes and monitors the standards for care? What happens to the existing HCBS 1915(c) waivers in California and what is the plan for any transitioning into the 1115 waiver?
51		Key Attributes: Technology	We recommend the following edits to the technology provisions in the Key Attributes: Coordinated care will increasingly depend on the effective use of eCare technology, such as tele-health-enabled critical and specialist care, home tele-health

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			technologies (i.e. daily health vitals monitoring, medication optimization, care consultations), remote monitoring of activities of daily living, and safety technologies. Demonstration sites are encouraged to include such technologies in their models.
52		Project Narrative: Section 7.2: Technology	We recommend the following edits to the technology provisions in the Key Attributes in the Project Narrative: The Applicant must: • Describe how your organization is currently utilizing technology in providing quality care, including efforts of providers in your network to achieve the federal "meaningful use" health information technology (HIT) standards. • Describe how your organization intends to utilize care technology in the duals Demonstration (such as telehealth, remote health vitals and activity monitoring, care management technologies, etc). • Describe how technologies to be utilized meet information exchange and device protocol interoperability standards (if applicable)
53	Page 8	Substance Use Services	Substance Use Services should not be a supplementary benefit as it is covered by Medicare. The frequent co-occurrence of substance use with physical and psychiatric disabilities requires substance use services be available.
54	Page 8	Benefits	The RFS provides that the demonstration site shall be responsible for providing enrollees access to the full range of services currently covered by Medicare Parts C and D and Medi-Cal State Plan benefits. This statement should be modified to include Medicare Part A and Medicare Part B benefits. As written, it appears that the RFS does not require demonstration sites to provide Medicare Part A skilled nursing services. Currently, Medicare Part A pays for post-acute care, after a three-day qualifying hospital stay, in a skilled nursing facility that will allow the patient to heal and return to home. The RFS should clearly identify that short-term post-acute care, which includes medically complex services (IV therapy, etc.) and rehabilitation therapy services are to be covered by the demonstration site. Short-term patients

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			require rehabilitative services following surgery, such as a hip or knee replacement, or comprehensive care to recover from cardiac, pulmonary and neurological conditions before returning home. Skilled nursing facilities have become the dominate provider of these types of post-acute services in the Medicare program. The RFS must recognize that skilled nursing facilities play a critical role in the delivery of short term post-acute care and are more efficient at a lesser cost. These facilities reduce the cost to care for patients who would otherwise continue their care in the general acute care setting. Skilled nursing facility care enables consumers to have better outcomes so that they can return to independent living in their home. Without aggressive rehabilitative services or comprehensive care that is necessary to improve a consumer's health status, costs for acute care stays and expensive re-hospitalizations may increase significantly. The Applicant and DHCS must recognize the potential for savings that can be realized by no longer requiring a three-day acute care stay prior to authorization of Medicare Part A skilled nursing services. The applicant has the flexibility under the dual pilot to admit patients directly to the skilled nursing facility for treatment that does not warrant the expense of an acute care stay. For example, a beneficiary may require care for a pressure ulcer or a urinary tract infection that was acquired at home. Instead of authorizing acute hospital care, the Applicant can authorize treatment in a skilled nursing facility at a much lower cost. This is a critical component of the health care continuum and should not be overlooked, since the Medi-Cal program alone fails to provide significant therapy services.
55	Page 8	Benefits	Some Long Term Care and Support Services (LTSS) have waiting lists in Los Angeles County. The RFS should reconcile this scarcity and unmet need with the pilot's expected upfront savings. Some LTSS will need to be delivered outside the managed care plan benefit structure unless rates developed take this into consideration.

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56	Page 8	Benefits	If the Demonstration models are intended to provide a completely integrated seamless system to enrollees, then they must provide enrollees access to the full range of Medi-Cal and Medicare services. It is unclear from the draft whether waiver services are included in the benefits package to be offered by Demonstration models. The draft is also unclear regarding the intent for behavioral health integration and/or coordination. The draft should make explicit that coverage rules and medical necessity standards under Medi-Cal and Medicare will not be restricted, ensuring that individuals will have access to any benefits they would have had access to outside of the Demonstration.
57	Page 8	Benefits	Clarification should be added that Demonstration sites must provide seamless access to benefits but may do so utilizing a range of models that include coordination with existing agencies providing such services to integration under the Duals demonstration.
58	Page 8	Benefits	Also included will be provision of long-term care supports and services (LTSS), which include State Plan benefits of In-Home Supportive Services (IHSS), Community-Based Adult Services Center services (CBAS Center, formerly called Adult Day Health Care Services), long-term custodial care in Nursing Facilities, and the Multi-Purposes Senior Services Program. Sites must demonstrate adequate capacity to provide seamless access and coordination of services, based on the needs of the enrollees, across the full continuum of services from medical care to LTSS. Again, developing a uniform assessment tool would be vital to triggering referrals to the LTSS mentioned. And where is the money to pay for these services coming from? It sounded like the capitated rate would show a cost savings, but the array of services is drastically increasing. In order to demonstrate adequate capacity for seamless access and coordination, successful applicants should be able to identify all LTSS capacity and key staff as well as have a method for referral and communication.

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59	Page 8	Benefits	This section indicates that the demonstration sites must demonstrate adequate capacity to provide seamless access and coordination of services based on the needs of the enrollees across the full continuum of services from medical care to LTSS. We believe it is critical that this be based not only on the needs, but the preferences, of enrollees. This is particularly critical in long term services and supports, where the types of services and supports will determine where and how the person will live. We strongly urge that the only applicants considered should be those proposing a person centered assessment and care planning process that elicits the desires of consumers, bases the care plan on the results of such a process, and evaluates the experience of the consumer on an ongoing basis. The Personal Experience Outcomes - Integrated Interview and Evaluation System (see http://chsra.wisc.edu/peonies) used in Wisconsin is the type of system we believe should form the foundation for LTSS assessment, care planning and evaluation to assure consumer preferences drive decisions concerning what services and supports will be provided.
60	Page 8	Benefits	We have a number of questions on benefits that we hope will be answered in a final RFS. First, how will the plans work with MSSP sites in the conduct of assessment and coordination? Second, will MSSP services be expanded to all counties and all populations in the demonstration; will the current limits on participation in the MSSP waiver be lifted? Third, what is meant by the term “long-term custodial care” in reference to inclusion of the skilled nursing facility benefit? Fourth, what about participants in other waivers like the NIF waiver? Fifth, how will the new model treat Alzheimer’s and dementia patients who are carved out of behavioral health services? Finally, we believe it is essential that the final RFS state, with regard to benefits, that care and services will be available to each enrollee based on a multi-tiered assessment of that enrollee and a unique plan of care developed for the enrollee with input from them and their family/care giver.

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61	Page 8	Benefits	Demonstration sites will be required to provide access to the full range of services currently covered by Medicare Parts C and D, as well as all State Plan benefits and services covered by Medi-Cal, including IHSS, CBAS, long-term custodial care in Nursing Facilities and MSSP. Sites are also required to provide access to the full range of mental health and substance abuse services currently covered by Medi-Cal and Medicare. We seek clarification on the Department's expectation around "providing access" to the full range of services. On page 7, the Department states that it wants sites to "coordinate" care, but then indicates that sites will not "manage" behavioral health or home and community-based services. On page 8, the RFS states that sites will be required to provide seamless access to the full range of mental health and substance abuse services. Please describe in greater detail what the plans will be financially and programmatically responsible for providing - as well as the benefits for which plans will be expected to coordinate with entities that authorize and receive payment separately.
62	Page 8	Integrated Financing	We are extremely concerned by the lack of information about how Demonstration plans will be financed. It is critical that the rates be sufficient to fund the benefits and administration without risking the quality of care and services provided under the Demonstration. We urge that the state be more transparent about the assumptions in the model generating the rates and the rationale for those assumptions than they are in this draft. It is important that stakeholders know the expectations concerning the cost and utilization of the various services in order to both understand what is expected under the Demonstrations and to assess the results against those expectations. The indication in the RFS that rates will provide less than is currently being expended on this population prior to any analysis of the experience under these new, untried, yet-to-be-designed models is of concern. Providing quality care to this very vulnerable population should be ensured before taking money out of the system. Because lower rates will make it difficult to even maintain existing services,

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			we do not understand how supplemental services, which have been promoted as among the central benefits to the Demonstration, can be added in any meaningful way if rates are lowered. In its call on January 5, when asked by a plan representative whether plans would be bound by their responses to the RFS in light of the fact that rates have not yet been established, the response was that neither plans nor the Department would be bound until final contracts were negotiated and signed. The lack of guidance on rates, other than that they will be lower than current spending, makes it extremely difficult for plans to realistically propose what services they could offer and even more difficult for stakeholders and the Department to compare proposals since there is no guarantee that responses to the RFS will in any way correspond with the final package of services that any Applicant can or is willing to offer. This section indicates that no Part C or D premiums will be charged to enrollees, but does not address co-pays. Dual eligibles enrolled in these models should not be charged co-pays for any Medi-Cal or Medicare Part A or B services (except for duals with a share of cost) and co-pay liabilities for prescription drugs should be no higher than those set by the Part D Low-Income Subsidy level for full-benefit duals. Plans should be encouraged to reduce the Part D co-pay liability of duals. Further, the Part D exemption from Part D co-payment liability for duals receiving HCBS or institutional care should apply. The draft does not directly discuss provider rates and reimbursements. In order to have an adequate network of providers for consumers, it is critical that the reimbursement from the integrating entity be adequate to provide quality care and services and to ensure an adequate provider network. Access to providers is a current problem for dual eligibles because Medi-Cal does not generally reimburse providers for Medicare cost-sharing amounts. The RFS should include language limiting Applicants' ability to achieve savings by reducing provider reimbursement levels and should require that plans reimburse providers up to full Medicare rates to improve access. Finally, we suggest that the Department consider adding standards, incentives and/or penalties to ensure that the goal of increasing access to home and community based services is achieved. If

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			the Department expects integration to achieve savings through increased coordination and resulting reduced hospitalizations and nursing home admissions, the financial structure should explicitly reward these savings and prohibit measures that award reduced access. For example, financial arrangements could include rewards for transitioning individuals out of institutions and minimum standards for amount or percentage of funds spent on home and community based services that would reference current levels. At a minimum, the rate should include funding to support relocation of members from institutional settings into the most integrated community setting.
63	Page 8	Integrated Financing	We are extremely concerned by the lack of information about how Demonstration plans will be financed. It is critical to not disrupt the current 1991 Realignment structure to prevent unwanted Proposition 98 challenges that, if successful, could cause the unintended consequence to shift funds away from current health, mental health and social service programs. In its call on January 5, when asked by a plan representative whether plans would be bound by their responses to the RFS in light of the fact that rates have not yet been established, the response was that neither plans nor DHCS would be bound until final contracts were negotiated and signed. The lack of guidance on funding for the demonstration projects as well as the rates to be paid to integrating entities makes it extremely difficult for plans to realistically propose what services they could offer and even more difficult for stakeholders and DHCS to compare proposals since there is no guarantee that responses to the RFS will in any way correspond with the final package of services that any applicant can or is willing to offer. This section only refers to CMS's interest in testing "capitated payment models" and should be expanded to reflect the second model authorized by CMS to test fee-for-service approaches to integration. The final site selection criteria should allow integrating entities to submit applications that test both capitated and fee-for-service models. We are concerned about the statement that, "The rate will provide upfront savings to both Medicare and Medicaid." It should be recognized that savings are unlikely to be quickly achieved and that high quality systems are

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			essential to avoid preventable hospitalizations and nursing home placement. Better primary and preventive care can, likewise, produce long-term savings. The heavy emphasis on upfront savings implies that service reductions are likely to be imposed by the integrating entities on beneficiary services. Therefore, this sentence should be deleted.
64	Page 8	Integrated Financing	Rates for participating sites will be developed based on the baseline spending in both programs and anticipated savings that will result from integration and care management. The rate will provide will provide upfront savings to both Medicare and Medicaid. Are DHCS and CMS open to considering a risk-sharing agreement in the early years of the Demonstration? Specifically, a risk-sharing agreement would align the incentives for all constituents while acknowledging that this is uncharted territory and anticipated cost savings from which rates will be established could be built on ambitious assumptions. Will plans continue to be able to apply risk adjustment factors, in accordance with Medicare guidelines based on the age, gender, and health status of their population? Our recommendation is that this continues as it encourages encounter data submission. Will the current Medicare HCC age/risk factors apply? For Medi-Cal, which risk adjustment factors, including the risk of institutionalization, will be applied?
65	Page 8	Integrated Financing	In the demonstration sites to be administered by health plans on a capitated basis, it is critical that the rates be sufficient to fund the benefits and administration without risking the quality of care and services provided under the demonstration. We urge that the State be very transparent about the assumptions in the model generating the rates and the rationale for those assumptions. It is important that we know the expectations concerning the cost and utilization of the various services in order to both understand what is expected under the demonstrations and to assess the results against those expectations. The indication in the RFS that rates will provide less than is currently being expended on this population prior to any analysis of the

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			experience under these new, untried, yet to-be-designed models is of great concern. Providing quality care to this very vulnerable population should be ensured before taking money out of the system.
66	Page 8	Integrated Financing	At present, there is no transparency whatsoever in the method for setting the capitated rates for managed care. One feature of this demonstration should be the opening up of that process with greater transparency and stakeholder engagement. We believe that rates must be adequate to fund the care and services without threatening the quality or availability of those services. We know that all plans are not equally equipped financially for this undertaking and they should not be placed at risk with inadequate funding. We are especially concerned to discover that, while it is a leading goal of the demonstration, we have had no discussion of funding for care coordination. Currently, it is considered an administrative overhead cost in managed care rate setting, rather than a central focus of the systems' expected output. We believe this must be changed. It is far more troublesome that the first expression of the impact of transferring duals into managed care is the anticipated partial-year General Fund savings of nearly $680 million (annualized to over $1 billion), before we have any direct experience with the impacts on cost. No money is targeted for reinvestment in more or better services. Rather, the budget recommends massive cuts to home care funding and a diminished eligibility for needed services. From a distance it appears that the transition into managed care is, in fact, managed costs. We need to be prepared to discover that better coordination of care, more timely care, and better quality care may be more expensive care. We also hope the final RFS makes it clear whether there will be no co-payments under Medicare Parts C and D, in addition to no premiums. We would also like to know whether plans will procure drug coverage at the same cost as Medi-Cal drug

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			costs, which is not the case with most Medicare drug plans.
67	Page 8	Integrated Financing	Demonstration sites will receive a capitation rate that reflect the full continuum of Medicare and Medicaid benefits. Rates will be developed on the baseline spending in both programs and the anticipated savings that result from integration and care management. The rate will provide upfront savings to both Medicare and Medicaid. We are concerned that CMS is proposing to waive the Medicaid actuarial soundness requirements for purposes of this pilot demonstration. The state and federal government have an interest in sharing savings through better care management and reduction in unnecessary utilization. We suggest that this savings target be no greater than 3-5% in the first year to ensure adequate funding for a population that may be more costly upfront due to new providers, unmanaged conditions and other factors beyond a plan's control. However, the plans that accept the full risk for providing benefits to the dual eligible population will require the appropriate data to ensure the rate is fairly and adequately developed. The final RFS should discuss the timing of implementation of capitalization requirements for plans, given the quality incentive withholds and suggested waiver of actuarial soundness. We look forward to receiving data from the state that shows the full cost and utilization by the population. It will also be necessary to provide rates in advance (at least by June 2012) to allow for review and potential negotiation - as well as to negotiate and secure provider contracts.
68	Page 8	Enrollment	We oppose passive enrollment and prefer voluntary enrollment as previously conveyed in comments submitted to DHCS. 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,

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			Minnesota's Senior Health Options and Wisconsin's Family Care Partnerships all use an "opt in" enrollment model. Likewise, we are strongly opposed to the suggested six-month lock-in. The recent experience with passive enrollment in the state's transition plan for ADHC is revealing. In August, a letter and application packet went out to about 26,000 people in the adult day health care system, a program slated for elimination as a Medi-Cal benefit on December 1, 2011. Beneficiaries were asked to choose between three options: They could sign up for one of the managed care options; they could send in a form to opt out of those plans; or they could do nothing, and would be automatically enrolled. Of those 26,068 patients, 654 chose a managed care plan, and another 10,297 people did nothing and were automatically enrolled in a managed care plan. The majority -- 15,117 people -- chose to remain in their fee-for-service plans. At a minimum, the DHCS should test both passive and voluntary enrollment. If mandatory enrollment is required, DHCS should establish exceptions if the beneficiary has a chronic medical condition that is being treated by a specialist physician who is not a part of the managed care network or good cause for not wanting to enroll.
69	Page 8 – 3rd paragraph	PACE	Additional language is needed to inform beneficiaries about options to receive services through PACE. We think information about PACE should be included in all enrollment materials and outreach efforts so that beneficiaries are fully aware of it and are able to directly enroll in it, and that beneficiaries who are enrolled in plans who become eligible for PACE should have the option to dis-enroll and enroll in PACE at that point.
70	Page 8	Geographic Coverage	Demonstration, potential sites must be capable of covering the entire county's population of dual eligibles. How is this demonstrated?
71	Page 8	Geographic Coverage	This is going to be a very complex, difficult population to transition into a new system in which behavioral health and long-term services and supports is integrated with acute and chronic medical care. This is new to plans, counties and stakeholders, and the risks to this vulnerable population are significant. We would suggest another

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			dimension should be added to the indication in this section that sites must be capable of covering the entire population of dual eligibles in a county. It is equally important that this be done on a manageable scale, knowing that mistakes will be made and adjustments will be necessary as everyone learns. There are some counties (San Mateo and Orange are most often cited) that have been working towards the goals of this demonstration for many years and are probably much more ready than others. Given the timeline for this demonstration, however, any large sites that are just starting to think through the integration issues and develop the necessary relationships are not likely to be successful and should not be considered.
72	Page 8	Geographic Coverage	We believe the current legislative authority for the demonstration to proceed in four counties is inadequate and should be amended as quickly as possible to prevent disruption in the proposed demonstration timeline. Clearly, California's counties differ with regard to their readiness to cover our 1.2 million dual-eligibles. A few managed care plans have track records of reaching out to duals and coordinating their health services with local long-term services and supports. Having them in the pilot would allow the state to work on developing blended reimbursement rates and fine tuning appropriate contractual arrangements with long-term providers. They are obvious candidates to be pilot counties, but it would be a mistake to make these two of the four counties. At the other end of the continuum are several dozen counties with no established structures of managed care. Many do not even have adequate health care provider networks within the county. As stated above, to place these counties in early demonstration efforts ignores what may be several years of infrastructure building before we can expect to have successful systems in place to manage care. Again, some of these areas are unique and will require unique solutions rather than a one-size-fits-all structure.

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			In between these two groups are several dozen counties with varying degrees of effective managed care. They reflect several different local constructs. Not all are financially strong. Most have little experience working with community-based LTSS. Anecdotally, we have learned that they have handled the current transition of Medi-Cal seniors and persons with disabilities with very different degrees of competence. We believe these counties should be brought into the pilot based on how well they have conducted this SPD transition, on their history of serving duals with special needs, on their level of demonstrated provider accessibility, on their capacity to take on oversight of LTSS, and other factors. In summary, we believe the demonstration should be in far more than four counties. Counties (or regions) should be phased in according to the various communities' capacity and readiness to create successful blending of primary, acute, behavioral and long-term care. We will be advocating for an expansion of the number of counties and a longer timeline of phasing counties into the demonstration.
73	Page 8	Geographic Coverage	Potential sites must be capable of covering the entire county's population of dual eligibles. There are currently open zip codes in Medi-Cal Managed Care Counties where enrollment into a plan is voluntary and plans are not required to maintain licensure in those open zip codes. We currently provides care to Medi-Cal beneficiaries in San Diego, Riverside, Los Angeles, Sacramento and San Bernardino counties. There are counties in which particular areas may be able to support a managed care network while other portions of the counties cannot (i.e., Placer, Imperial). The Department should choose the counties in which managed care plans can secure and maintain a network that meets contract and regulatory requirements. For counties where a significant portion (over 90%) of the dual eligible population can be covered by a

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			managed care plan (i.e., Riverside County), the beneficiaries that reside in the rural areas should be offered a managed fee-for-service option or treated consistently as other Medi-Cal populations are enrolled in the current program.
74	Page 8 of 68		"…rebalancing care…when possible." When possible does not spell out what this means; it is too broad as it does not spell out what stakeholders will no longer have access to in a managed care plan. If this means that an existing service through fee-for-services IS an allowable and in general will no longer be available, flexibility should be built in so an "EXCEPTION" can be used without rigid restriction to access…rather on a "case by case basis". This needs to be simplified for easy use by quality assurance as details may be difficult for acceptable service costs. Some quality assurance staff take limitations to an extreme. Simplifying the "case-by-case" exceptions/allowable must be based on a person's needs NOT COST FACTOR! There are many people with multiple disabilities AND some Duals who are new to their disability such as sudden blindness and other forms of disability. Everything must be done when an accident has caused a new or possible additional permanent disability. Doing everything medical for a newly disabled person will cost less in the long run if the severity of the injury is treated with the latest medical intervention—outcomes are significantly improved. Cutting allowable medical treatments with capitated rates is a costly outcome. It is essential that a newly injured person or new illness has a feature, if requested, for a 2nd opinion outside the managed care/health plan…again, if requested. Fifty percent of that cost should be considered a benefit for the beneficiary. That opinion must be taken seriously and incorporated in the care plan for the newly injured or sudden illness onset occurrence for the first year. In addition, the appropriate medical equipment should be provided that will prevent costly medical needs by using off the shelf equipment. Custom durable medical equipment/treatments and modifying home for accessibility will save money and good outcomes in the future. A mandate that at least one established rehabilitation centers OUTSIDE of the pilot managed care system based on known status and best practices whether or not the pilot health care entity has a respected rehabilitation

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			service. This should be a center that does NOTHING but rehabilitation. Such entities as University of CA, Stanford, Los Amigos…or contract with that facility to ensure beneficiaries they have choice of treatments.
75	Page 9 & 23 and 24	IHSS Section 2.2	Will demonstration sites be allowed to provide IHSS-type services not currently available through IHSS in year one? I am thinking of serves like banking assistance, watering plants, caring for pets, travel accompaniment to social activities, etc.
76	Page 9	IHSS	We are extremely concerned the draft RFS requires Demonstration sites to contract with County social service agencies for only one year rather than for the full three years of the demonstration and fails to require a separate contract with the local Public Authority (see additional comments below). Demonstration sites do not have any experience in administering the IHSS program. This draft RFS would allow Demonstration sites to suggest an expanded role without identifying the criteria that would ensure Demonstration sites are capable of such an expanded role, nor does it describe the criteria to allow for such an expanded role that ensures adequate protections to IHSS consumers. One year is an extremely short and inadequate amount of time to ensure that Demonstration sites are capable of meeting the unique and diverse needs of IHSS consumers. Nor is it an adequate amount of time to allow Demonstration sites, working in partnership with counties and Public Authorities, to realize care and service improvements for IHSS consumers. Also starting in 2014, an additional two million individuals will become eligible for the Medi-Cal program which will result in greater demands on the health care service delivery system at the very time the department proposes to allow Demonstration sites to assume greater responsibility in the administration of the IHSS program. The RFS allows Demonstration sites to expand its role but lacks details in what way the sites may expand. Would the role of the County IHSS or the local Public Authority change and in what way? Or would IHSS services potentially change, and if so, in what way? It is unclear how the County IHSS or Public Authority roles would change, and how this would fit with existing IHSS statutes and regulations which require counties to perform assessments and other IHSS functions. The RFS is

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			completely deficient in this section and doesn't even reference Public Authorities. We recommend the Demonstration sites must contract with the County social services agency for a minimum of three years (or during the course of the demonstration). During the three years, the sites may contract and purchase different models of IHSS case management and service delivery so long as it conforms to existing IHSS statute and regulations, including tiered case management based on the individual needs of IHSS consumers served under the Duals demonstration. (note: refer to our comments on page 9-Care Coordination and pages 23/24-IHSS for additional suggestions). Likewise, we recommend that the demonstration sites be required to establish a separate contract with the local Public Authority. Welfare and Institutions Code 14132.275 (g) specifically requires demonstrations projects to provide IHSS through "direct hiring of personnel, contract, or establishment of a public authority or nonprofit consortium, in accordance with, and subject to, the requirements of Section 12302 or 12301.6, as applicable." WIC 12301.6 is the code section that establishes the authorities, functions and mandates of local Public Authorities. In compliance with state law, the RFS should clearly require integrating entities to contract with the local Public Authority for the duration of the demonstration project. The RFS should be revised to require demonstration sites to comply with existing consumer rights and protections, including their ability to select, hire, fire, schedule and supervise their IHSS provider (including the right to have family members serve as their provider) through the duration of the demonstration projects and not leave it to the health plans to describe what they want to do in years 2 and 3. We are assuming that current law will govern financing of the pilot projects, which means that counties would financially participate in IHSS services. The simple fact that county dollars will be used in the capitated rate underscores the necessity to have contracts in place between counties and integrating entities for the entire period of the demonstration project, not just in Year 1. We support the concept of shared information between the sites and counties; however, we note that given current IHSS state laws and regulations that additional

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			support may be needed from the State to facilitate information exchange.
77	Page 9	IHSS	We appreciate the proposal to leave IHSS essentially untouched in the first year of the Demonstration, but believe more direction is needed regarding years two and three. It is essential that the Demonstrations not become a vehicle for cutting IHSS hours or limiting consumer choice. Protections must be in place to ensure that enrollees maintain access to services at, at least, current levels and that key components of the program like consumer direction are maintained. It is disappointing that the draft does not discuss "(1) consumer protections for acute, long term care, and home and community based services within managed care; (2) development of a uniform assessment tool for home and community based services; and (3) consumer choice and protection when selecting their IHSS provider." These are all key issues identified in the Governor's budget which must be part of any model integrating IHSS and other LTSS.
78	Page 9	IHSS	It was very disappointing the see this section. We have for months been pointing to IHSS integration as a key issue that needed considerable attention in designing this demonstration. As currently written, this section signals that the intent is not to integrate IHSS but to eliminate it and ask health plans – who have no experience in this area – to design a replacement. Knowing the timeline for this demonstration, we would at this point suggest that this section be rewritten to indicate that the existing IHSS program will be used to provide home care services under the current structure for the duration of this demonstration, and sites will need to enter a contract with the county for the administration of these services under existing rules.
79	Page 9	IHSS	IHSS Flexibility and greater coordination of IHSS services and continued access to IHSS providers should be realized.

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80	Page 9	IHSS	We have significant concerns about the brevity and vagueness of this section. We believe the structuring of the home care benefit under managed care makes sense, but it must be handled very carefully to respect the existing delivery system. It should be developed with input from both the recipients and caregivers. It should reflect the long-standing policy of consumer-driven care. We would hope that, as part of the demonstration, the state would undertake extensive stakeholder engagement to help direct this aspect of the transition.
81	Page 9	IHSS	In Year 1 of the Demonstration, IHSS will be authorized under the same process and sites will contract with the county social service agency. In subsequent years, sites can suggest expanding its role. We support the inclusion of IHSS in the Demonstration pilots and believes that the program is critical for keeping many dual eligible beneficiaries in their homes rather than more costly care settings. Additional clarification around the county contract requirements is necessary, especially as it relates to the financing and authorization of services. If managed care plans are financially responsible for providing the benefit, it will be necessary to understand the costs associated with the county administration and wages/benefits for each collectively-bargained unit.
82	Page 9	Care Coordination	It is disappointing that the RFS contains so little detail about what will be expected from the integrating entities for care coordination. The entire theory that is being tested by the dual demonstration projects is that strong care coordination and case management will lead to better care at a lower cost. We support person-centered care coordination and think the RFS should require demonstration sites to include the consumer in the development of their care plan with the care coordination team. The RFS should also require consumers to decide whether their IHSS provider would participate in the care coordination team. CSAC-CWDA-CAPA provided the following suggestions in our December 14, 2011 letter to DHCS Director Douglas and CDSS Director Lightbourne: Under the Duals Demonstration, Health Plans should have three options in contracting with counties. These three options represent

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			increasing levels of coordination with county programs, and allows Integrating Entities to leverage existing local infrastructures where they exist in many counties (for example: counties where program and services such as Area Agency on Aging, MSSP and IHSS are jointly administered by the County): Option 1: At a minimum, Health Plans will contract with IHSS county programs for referrals, intake, assessments and authorization of IHSS services. Contracted IHSS staff would provide additional case management services for IHSS clients who receive care coordination through the Integrating Entity. IHSS social workers will also participate in care coordination efforts of IHSS consumers participating in the Duals Demonstration. Option 2: Health Plans could contract to have county staff act as care coordinators, who would be able to simultaneously authorize IHSS services and conduct a comprehensive intake/assessment of the consumer's needs and link to necessary services funded through the Health Plan and to other community-based care options. County care coordinators, working with the Health Plan, could target and better serve consumers based on acuity and multiple needs. One option for care coordinators is to utilize specialty-trained social worker staff or, as many counties have done, Public Health Nursing staff as care coordinators. One benefit in using Public Health Nursing staff is the higher draw down of federal Medicaid matching dollars for case management, and their training in the health field. County care coordinators can link consumers to services offered by Health Plans as well as leverage community resources including county behavioral health programs, transportation and community-programs (i.e. meals on wheels). Many IHSS consumers are high functioning and require minimal care coordination, while other consumers will benefit from having their medical and social services coordinated. Thus, the pilots should explore tiered approaches to care coordination through contracts with the County.

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			Option 3: Health Plans could contract with the county to establish ADRC or ADRC-type services. The benefit of this model is that it provides a "medical and social" home for care coordination whereby multiple services can be coordinated. An example of an innovative and effective approach that the State could support and fund via the Integrating entity contracts are local county Aging and Disability Resource Centers (ADRC's). ADRC's, or ADRC-type approaches, can provide the "home" for care coordination teams that include IHSS, MSSP, Triple A's and other community supports, and can serve as a bridge between Integrating Entities and county-based and community-based social service programs.
83	Page 9	Care Coordination	Person-centered care coordination will be the key to a successfully providing integrated care that fulfills that stated goals of this project. It is disappointing to see the draft provide so little detail and information about what will be expected from plans in regards to care coordination. The draft even fails to use the phrase, 'person-centered' in this section. In the absence of clear instructions to plans on what they must offer, it is likely they will continue to rely on existing care coordination strategies and practices offering no new benefit or protection to dual eligibles enrolling in plans. See more comments below on the care coordination section of the project narrative requirements.
84	Page 9	Care Coordination	We would suggest that language be added to this section clearly indicating the need for a tool such as the Personal Experience Outcomes - Integrated Interview and Evaluation System (see http://chsra.wisc.edu/peonies) to assure consumer preferences drive decisions concerning what services and supports will be provided.
85	Page 9	Care Coordination	Mental Health Services should be required to be integrated in year one, rather than the final year of the demonstration. (Care Coordination Page 9)
86	Page 9	Care Coordination	We note that the draft RFS suggests there will be varying degrees of care coordination. We think there should be further discussion on this notion. We believe care coordination should exist across all types of care and service and be equally available to all enrollees. As mentioned earlier, we also recognize that coordination is

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			at the heart of improving utilization, saving money, and allowing client-centered care. As a mandated benefit it should be recognized as a separate cost item, not buried in a figure for administrative overhead. It should be considered service, not administration, when calculating medical loss ratios.
87	Page 9	Explicit Coordination	should be required of behavioral health and home and community based services for all beneficiaries. (Summary Page 9)
88	Page 9	Demonstration Population	All Duals. We support inclusion of all full benefit duals in the demonstration counties. Exclusions. We do not support exclusion of any duals from this pilot program. As a COHS plan, all of these beneficiaries (including individuals with HIV/AIDS, ESRD, ALS and those who are institutionalized for longer than 90 days) are already our Medi-Cal members, and excluding them from the pilot would be extremely disruptive for the care of these members. We also have several established clinical programs, such as our long term care clinical program, which works to prevent avoidable hospital admissions for those members residing in long term care facilities. Gains from such programs would be lost with a long-term care population exclusion. 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. Finally, because we recognize that a) local situations and structures may favor one approach over another and b) the purpose of a demonstration is to test multiple models to see what works best, we support allowing pilot counties the option to include all full benefit duals from the beginning or make the case for excluding certain populations during the initial year. This would align with the permissive language contained in the draft RFS related to passive

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			enrollment for individual pilot sites. Issues Not Addressed. The RFS does not address how pilot sites will deal with lapses in Medi-Cal eligibility or barriers to full dual status, such as Medi-Cal Share of Cost, loss of or lack of Medicare Savings Program (e.g., QMB, SLMB, etc.) eligibility, and failure to convert to Medicare entitlement. It is our experience as a D-SNP, these issues create significant barriers to a beneficiary's initial enrollment, continued eligibility and continuity of care. We would like DHCS and CMS to consider critical elements that impact continuous dual eligible status as part of the demonstration. Please see the last section of our comments titled "Other Issues to Consider" for more information about these issues and how they relate to the demonstration.
89	Page 9	Demonstration Population	We would prefer the inclusion of members with the following conditions: HIV/AIDS, End-Stage Renal Disease (ESRD) and *Amyotrophic Lateral Sclerosis* (*ALS*); or Who have been institutionalized for longer than 90 days.
90	Page 9	Demonstration Population	"DHCS is seeking comments on this entire document and in particular on whether the Demonstration should exclude beneficiaries…who have been institutionalized for longer than 90 days." We agree that the goal of the Demonstration is to address current fiscal disincentives and service fragmentation that dually eligible Californians face by having an integrating entity provide and be at risk for all of an individual's care needs under a blended capitation rate including primary, acute, behavioral, and long-term care regardless of setting. Therefore we recommend that the Demonstration be available as an enrollment option for all dual eligibles in the selected counties, regardless of setting of care at enrollment, including those living in institutional settings. To exclude beneficiaries who have been institutionalized for longer than 90 days changes the fundamental nature of the Demonstration and would decrease the ability for beneficiaries to receive improved care coordination across all settings of care. It would also substantially limit the opportunity for dual eligible beneficiaries in institutions to have access to care coordination efforts to help them transition back into the community. If DHCS ultimately decides to exclude these beneficiaries initially, we recommend that all dual eligibles within the specified

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			geographic region of the Demonstration sites be eligible for enrollment by the end of the first year.
91	Page 9	Demonstration Population	The draft document states that DHCS is seeking comments on whether the demonstration should exclude beneficiaries who have been institutionalized for longer than 90 days. We understand the department's intent is to exclude beneficiaries who already have been institutionalized for longer than 90 days, rather than exempting beneficiaries who, once enrolled in the pilot, become institutionalized for more than 90 days. However, if the department decides to provide the latter, we urge you to allow beneficiaries who are enrolled in plans, who are eligible for PACE, to disenroll from the plans and enroll in PACE before they are placed in a nursing facility, in order to give them an opportunity to remain in the community.
92	Page 9	Demonstration Population	Exemption of People Who Have Been Institutionalized for Longer than 90 Days (Demonstration Model Summary: Key Attributes, Demonstration Population, p. 9). In this section the State poses the question, *"DHCS is seeking comments on this entire document and in particular on whether the Demonstration should exclude beneficiaries…Who have been institutionalized for longer than 90 days."* That the State should pose this question gives us great concern. To the best of our knowledge, such an exemption was not discussed in stakeholder meetings nor documented as a decision point in distributed materials during the development phase. It is a complete surprise that the State is contemplating this idea. It is contrary to feedback that we (and many other stakeholders) have provided. Furthermore, we do not understand the policy rationale for such an exemption; it is out of step with best practices for long-term services and supports to ignore the desires of people who wish to move from institutional settings to the community. We believe that it is contrary to the requirements of the Olmstead decision. Such an exemption would also be costly to the State. A few examples: the state of Texas has transferred over 25,000 people from nursing facilities to home and community-based services

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			(HCBS), resulting in a $2.6 billion savings between 1999-2007 (Texas Legislative Budget Board, 2009). Pennsylvania is a smaller state with a similar experience – for the past three and a half years, the state has transferred 1,600 people each year from nursing facilities to HCBS, contributing to an estimated drop of 2,000,000 in the number of Medicaid days and saving the state an estimated $200 million in nursing facility expenditures (State staffs, Pennsylvania Department of Aging, Office of Long-Term Living, personal communication, 9-22-11). The state of Tennessee has historically been one which provided very few HCBS, however, in launching its 2008 Long-term Care Community Choices Act, the state made intentional policies to incentivize HCBS in multiple ways within its managed care program. As a result of these policies, the state is now seeing an average of 1% rebalancing away from nursing facility utilization *each month* (State staffs, Tennessee Long-term Care Strategic Planning and Program Implementation, Bureau of TennCare, personal communication, 11-22-11). California should be just as intentional in reducing nursing facility utilization in the dual eligible demonstration. CFILC is strongly opposed to exempting persons who have been institutionalized for 90 days, or any period of time, from the dual eligible demonstration. We recommend that transition services, including services to assist in securing housing and transportation, and an allowance for flexible relocation expenses, be developed as core services within all plans. These mechanisms are utilized in a number of state managed LTSS systems and California should develop them as well.
93	Page 9	Demonstration Population	Beneficiaries who have been institutionalized for longer than 90 days and those with HIV/ AIDS, End-Stage Renal Disease (ESRD), and Amyotrophic Lateral Sclerosis (ALS) should not be excluded from the Demonstration. Managed care incentives should result in the right care at the right time in the right setting for all beneficiaries. This means not only a focus on prevention and wellness, but also the management of serious, chronic conditions. Integrating all long-term supports services (LTSS), including fully

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			integrating nursing homes, into the Demonstration will provide incentives to use the more cost effective and consumer preferred use of services. Not all plan s will be able to immediately take on the full risk of integrating LTSS and nursing home care. DHCS should develop a portfolio of risk options that plans may assume with specific criteria, starting with pass through payments and ranging up to and including full risk. A phased-in approach would let plans elect an appropriate level of risk the first year and add more risk over a period of up to three years, with the goal of all Managed Care plans assuming full risk at the end of the three year demonstration period. DHCS must approve the plan option selected, based on objective criteria, plus elect ions for additional risk at each phase. This will protect consumers as well as program longevity. Too much risk too soon carries the possibility of under-treatment, consumer access issues and potential solvency problems.
94	Page 9	Demonstratio n Population	In order to achieve cost-effective coordinated care and support services that are truly rebalanced toward home and community based services, Demonstration Sites must assume financial risk for all long term care services and settings. (Full financial risk may be phased-in over several years.) The entity must be responsible for the most expensive care settings, such as hospitals and nursing facilities, as well as the least expensive so that there is an incentive toward supports that allow people to live at home, where they prefer. Your proposal to “carve out” individuals who have been institutionalized for longer than 90 days would dis-incentivize any possible transition into a community based setting because there would be a drastic cost difference between institutionalization for 90 days and ongoing support in the community with no end date. In addition, there are many people currently residing in institutions for longer than 90 days who would greatly benefit from transitioning back into their homes. In order to rationalize decision-making and rebalance services toward community and

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			home-based settings for the dual eligible population, every eligible recipient should be included in the Demonstration. The Demonstration is aimed at rebalancing care away from institutional settings and into the home and community; however specific “carve outs” create a severe bias towards institutionalization.
95	Page 9-10	Enrollment	Passive Enrollment. We support the flexibility for demonstration sites to choose a passive enrollment process with beneficiary ability to opt-out. Lock-In Option. We are not familiar with the enrollment lock-in option and there are no details in the draft RFS. Questions include: a) does the lock-in option mean enrolled beneficiaries cannot disenroll or opt-out until after 6 months (currently, duals can disenroll from a SNP every month) and b) do pilot sites have the option of choosing both passive enrollment and lock-in up to six months, or choosing only one of the two? In order for us to communicate our intent to pursue or not pursue such an option, we ask that more information be provided to make an informed decision. Phased-In Approach. We support the flexibility of pilot sites to adopt an alternative phased-in strategy that is different from the one used for SPDs, especially for COHS plans. As noted earlier, local situations and structures may favor one approach over another and the purpose of a demonstration is to test multiple models. For example, if selected as a pilot site, we may recommend the following enrollment strategy: In year 1, a) passive enrollment of all our existing D-SNP members – it must be done all at once, not piece-meal, to prevent severe disruptions for our current SNP members, and b) passive enrollment of duals with Medicare FFS; In year 2, passive enrollment of duals who are currently enrolled in other Medicare Advantage plans (including other D-SNPs) in order to give us enough time to work out potential sub-contract arrangements with these other plans (e.g., Kaiser offers a D-SNP in San Mateo County). However, we have questions about passive enrollment and potential subcontracting with other D-SNPs, and need more clarification and discussion about how this is expected to work.

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96	Page 9	Enrollment	We support the goal to preserve and enhance the ability for consumers to self-direct their care and receive high quality care (p.8). Hence we disagree with allowing sites to choose a passive enrollment process or pursue an enrollment lock-in up to 6 months since both those options contradict the goal of enhancing self-directed care. During the meeting on December 12, 2011 in San Francisco, someone expressed the concern that if voluntary enrollment was allowed, no one would enroll. We believe that a well-designed plan that advances the demonstration goals, if presented appropriately to the dually eligible population, would attract many to enroll. An example of a successful model that uses voluntary enrollment is the Program for All-Inclusive Care for the Elderly (PACE). We need to apply the lessons from the 1115 Waiver mandate to enroll seniors and people with disabilities (SPD) into Medi-Cal managed care, which uses a passive enrollment process. Since the mandate became effective, we have seen numerous problems ranging from lack of continuity of care to confusion about where SPDs can and cannot get care. Any savings from marketing a plan would be wiped out by solving these problems as well as dealing with beneficiaries' frustrations and anger, which are not measurable. We oppose a lock-in enrollment of any period because it contradicts the goal of self-directed care and because it takes away rights and options that dually eligible beneficiaries currently have. Dually eligible beneficiaries currently are allowed to change Medicare Advantage and Part D plans once a month throughout the year, unlike beneficiaries who have Medicare only. This exception is based on the recognition that dually eligible beneficiaries have higher needs and changing health care needs. The Dual Eligibles Demonstration Project should preserve or enhance beneficiaries' rights and options, not take them away.
97	Page 9	Enrollment	We prefer a six month lock-in for Dual Eligible members as this will enable members to benefit from strategies that are deployed by the health plan, to improve member health.

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98	Page 9	Enrollment	We strongly support allowing all beneficiaries to make an informed choice of what type of plan or program to enroll in, including remaining in fee-for-service Medi-Cal if that is their choice. We believe the RFS should make it clear that passive enrollment can only be applied if beneficiaries have been presented up front with balanced information on all of their choices, including PACE if it is available, and have not made an election of how to receive services. We also support the creation of a single point of entry and independent screening and assessment process, to identify dual eligibles who have significant care needs and refer them to plans and programs that are best able to meet their needs. Through this process, dual eligibles who appear to meet the PACE eligibility requirements would receive additional information about PACE and be given an option to enroll in PACE at the point of initial enrollment.
99	Pages 9-10	Demonstration Population and Enrollment	This RFS refers to MAPD D-SNPs but there are actually 3 types of SNPs and we believe all 3 models need to be considered in the final plan to care for the Dual Eligilbes. The other kinds of MAPD SNPs are Chronic Special Needs Plans (C-SNP) which are for beneficiaries diagnosed with certain chronic and disabling disease conditions; and Institutional Special Needs Plans (I-SNP) for institutionalized beneficiaries. Both C-SNPs and I-SNPs have extensive experience in caring efficiently and cost effectively with specialized severally ill populations. These programs currently have in place provider networks which are experienced and skilled at providing care to their populations. Current federal legislation does not require C-SNPs and I-SNPs to have direct contracts with the state and these SNPs will continue to be an option for beneficiaries after the dual integration program is implemented. Therefore these specialized programs which are already meeting many of the State's dual requirements will be able to continue and grow based upon their unique programs to provide care to their specialized populations. We however believe these programs should be integrated into the pilot allowing these specialized programs to be more available to beneficiaries and help achieve the state goals for the pilot. We propose the following possible modifications to the pilot to include

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			these programs. Option 1: Allow for the C-SNPs and I-SNPs to directly contract with the State DHCS to provide the required Medi-CAL coverage in addition to the contracted D-SNPs. When the passive enrollment occurs include a default to these plans for their specialized populations. Option 2: Require the pilot County Local Initiatives, commercial plans, or County Organized Health System to contract with the C-SNP's or I-SNP's. The state should develop contracting guidelines to ensure fair and efficient contracting with the C-SNP and I-SNPs. Option 3: If the State does not incorporate C-SNPs and I-SNPs into the pilot, then during the passive enrollment process C-SNP and I-SNP options should be clearly included on the Choice Form as a beneficiary's alternative option, in addition to the Fee for Service system.
100	Page 9	Enrollment	"Lock-in" Enrollment for Six Months (Demonstration Model Summary: Key Attributes, Enrollment, p. 9). In this section the State indicates that beneficiaries would be automatically enrolled into the Demonstration and signals its willingness to approach the Centers for Medicare and Medicaid Services to ask for a so-called 'lock-in': *"Under passive enrollment, beneficiaries will be able to opt-out of the Demonstration and choose from their care delivery options as available in that county. Applicants also should explain whether they would pursue an enrollment lock-in up to six months – an approach that would require the state to seek special permission from the Federal government."* Throughout the process, we have expressed a preference for affirmative choice to enroll in one of the plans being offered under the demonstration. The State signaled clearly that it would be proposing passive enrollment; however, the counter to our concern was the promise that individuals would have the option to "opt-out." We are again surprised by this enrollment "lock-

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			in" proposal, which ignores a vast amount of stakeholder input. The most important consumer protection is the ability to leave a plan that is not effectively addressing a consumer's needs. Furthermore, we believe that the State should be signaling high expectations to the plans; demonstrating that they will be expected to deliver high-quality, innovative care and that they should expect to have to compete for both the State's and the individual consumer's business. The six-month "lock-in" provision sets a very low expectation from the outset and directly undermines the incentive to provide high-quality care. We believe that financial sustainability of the plans should be provided by other means, such as a risk corridor where the state and the plans share both risk and profit beyond a certain point, and through means of a blended rate with risk for nursing home utilization, where plans benefit financially if current nursing facility utilization is lower than the historical experience used to set the rate. We recommend that the state should in fact strengthen consumer choice by providing options counseling about the services available, and recommend that Programs of All-Inclusive Care for the Elderly (PACE) should be included in all enrollment materials and outreach efforts so that beneficiaries are fully aware of it and are able to directly enroll in PACE. Beneficiaries who are enrolled in plans who become eligible for PACE should also have the option to disenroll and enroll in PACE at that point. CFILC strongly opposes any proposals for a six-month enrollment "lock-in" and recommends options counseling to support choice, as well as the full opportunity for all eligible beneficiaries to enroll in PACE.
101	Page 9 & 10	Enrollment	With careful attention to continuity of care issues, passive enrollment with opt-out will ensure a reasonable balance between the needs of the plan and the success of the Demonstration with consumer choice and protection. The option for applicants to pursue up to a six month enrollment lock-in un necessarily curtails consumer choice and infringes on the protection opting-out gives beneficiaries in deciding where and how they receive their care.

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			Additionally, the Program of All-Inclusive Care for the Elderly (PACE) should be a benefit under the demonstration, not an alternative option . PACE should also be given the ability to contract for IHSS services from the public authority.
102	Page 9	Passive Enrollment and Opt-out Options	We believe a 6 month enrollment lock-in unnecessarily restricts consumer choice. Passive enrollment and opt-out options can offer a reasonable balance between the needs of the consumer, the benefit of the integrating entity, and the overall success of the Demonstration Project.
103	Page 9	Pharmacy Benefits	The draft indicates how Demonstration sites will be paid for pharmacy benefits, but fails to discuss the benefits they will be required to provide. Sites should be responsible for providing Part D drug coverage and should be encouraged to limit or completely eliminate co-pays. To the extent passive or lock-in enrollment options are pursued, plans must offer robust formularies to ensure that duals that are forced into plans can get the drugs they need (since enrolling in an alternative plan better suited to their needs would not be an option under a lock-in scenario). The draft should also be explicit that the sites will be responsible for covering non-Part D drugs that are covered by Medi-Cal. If most of the Demonstration sites will be operating as D-SNPs (per p. 18), we do not understand the exemption from submitting a Part D bid to CMS. If they are not submitting a bid, who will review their formularies, utilization management rules, networks and more to ensure that they are complying with Part D rules and regulations. For models that do not formally become D-SNPs, it is unclear how they will provide pharmacy benefits to dual eligibles. We are concerned about these ambiguities in the draft concerning responsibility for oversight of prescription drug requirements for sites. Currently, CMS addresses formulary issues, beneficiary protections, call center requirements and multiple other issues through extensive regulatory and sub-regulatory guidance. CMS oversight of Part D plans is continuous and has become increasingly intensive in response to issues that have arisen since the inception of the program, for example, CMS oversees plan P&T committees; plans must get CMS approval for changes in formularies; CMS

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			monitors call center wait times; CMS requires reporting of drug denials at the pharmacy during transition periods, etc. The draft does not indicate whether CMS oversight will continue at the same level and how that oversight will work in light of the fact that plans are not required to submit Part D bids. For sites that are not operating D-SNPs, but are meeting D-SNP requirements (per p. 18) it is unclear how enrollees will access Medicare prescription drug benefits.
104	Page 9	Pharmacy Benefits	Demonstration Sites will be paid according to the regular Part D payment rules, with the exception that they will not have to submit a bid. The direct subsidy will be based on a standardized national Part D average bid amount. This national average will be risk adjusted according to the same rules that apply for all other Part D plans. CMS will provide additional guidance for plans in the Draft and Final Call Letters for contract year (CY) 2013 in February and April 2012, respectively.1 The statement, "The direct subsidy will be based on a standardized national Part D average bid amount," suggests that the proposed reimbursement will be based on costs for all members. However, normalized costs for dual eligible members do not correlate well to all members. We suggest that separate risk corridors should be implemented for this Demonstration. Also, the current bid payment methodology assumes that administrative costs are correlated to the risk scores which may not be an accurate assumption. We anticipate that the dually eligible needs will be more complex and require much more human intervention on the part of the health plans. Therefore we suggest that there be an adjustment to the direct subsidy to reflect the administrative costs for the duals population versus the average administrative costs for all Part D members, particularly in the early years of the Demonstration.
105	Page 9	Pharmacy Benefits	Demonstration sites will be paid according to the regular Part D payment rules, except there will not be a bid requirement. Instead, plans will be based on a standardized National Part D average bid amount. Please clarify if the Department intends to continue the risk corridors that Part D provides to plans that experience higher-than predicted costs. While we assume that

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			the low-income and co-pay subsidies will also continue for this population, the final RFS should clarify this point.
106	Page 9	Supplementary Benefits	Many stakeholders, including NSCLC, were brought to this conversation on the promise that integrated care would create opportunities for duals to receive benefits they currently do not receive from Medicare or Medi-Cal including benefits recently lost due to state budget cuts (dental, vision, etc.) and enhanced or alternative services designed to help beneficiaries remain in their homes and communities. Applicants should be required, not just encouraged, to provide supplemental and alternative services to enrollees. The Department should set clear standards for when and how these services must be provided. Contracts for Wisconsin's integrated programs provide examples for how to do this.
107	Page 9	Supplementary Benefits	We recommend stronger language to ensure Demonstration sites offer supplementary benefits not covered under Medi-Cal and/or Medicare that are integral to helping persons remain in their home and communities. The list should also be expanded to include social services and supports noted by consumers and providers to be critical, such as access to housing modifications.
108	Page 9	Supplementary Benefits	We strongly encourage this notion as the state develops its demonstration. Providing additional benefits should play a key role in attracting people to choose managed care, as has been the case in private Medicare Advantage plans. We should use the demonstration to end the existing bias in Medi-Cal wherein people receive dental, eye and other care in an institution, but not in community care. Non-emergency transportation is another important service for this often isolated population and should be a benefit.

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109	Page 9	Supplementary Benefits	Demonstration sites are encouraged to offer additional benefits, including contracts for community based services that help beneficiaries remain in their homes and communities. We suggest that applicants be allowed to specify the types of supplementary benefits in their application so long as the cost and utilization data (as well as draft rates) are available to better understand how these benefits can be financially supported. Ideally, dental, vision and non-emergency transportation should be covered as supplemental benefits.
110	Page 9	Supplementary Benefits	Demonstration sites are encouraged to offer additional benefits, such as non-emergency transportation, vision care, dental care, substance use services. We recommend rephrasing this sentence to read: Demonstration sites are strongly encouraged to offer additional benefits, such as non-emergency transportation, vision care, dental care, and substance use services expanded beyond those available today in most Medicare Part C benefit plans. As an example, an insurance plan has found that TTC-provided case management services are effective in preventing readmission to inpatient substance use treatment and reduce the cost of care. These services are today not reimbursable under Part C.
111	Page 9	Technology	Technology should be not be relied on at the expense of in-person, one-on-one visits and observation that are core elements of a person-centered care coordination program.

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112	Page 9	Technology	The RFS should advise applicants that the conversion to CMIPS II may impact the timeline to implement demonstration project.
113	Page 9	Behavioral Health	Demonstration sites will be required to have formal partnership agreements with county specialty mental health plans to address the needs of enrollees with serious mental illness. We are committed to providing necessary care for individuals with behavioral health needs. Given the severe access challenges in the county mental health system currently, we seek additional clarification to better understand how plans will ensure access to these systems in the Demonstration sites when it is not possible today. The final RFS should allow plans to send beneficiaries to non-county mental health providers or provide guidance on how counties will be providing dedicated availability to individuals in the pilot sites, either through enhanced financial incentives or other mechanisms.
114	Page 9	Behavioral Health	Behavioral Health: Demonstration sites are required to have a plan to achieve full integration of behavioral health services by January 1, 2015 (i e. inclusion of behavioral health services into the integrated capita ted payment). We recommend rephrasing this sentence to read: Substance use and mental health services: Demonstration sites are required to have a plan to fully integrate comprehensive substance use and mental health services into the integrated capitated payment by January 1, 2015.
115	Page 9	Paragraph 4	Many specialized HIV/AIDS providers are not in large healthcare plans' networks. Protections must be in place to guarantee patients have access to specialized HIV/AIDS care.
116	Page 9	Qualification Requirements	Disability Access (Application Submission; Selection of Demonstration Sites, Qualification Requirements, 9. Americans with Disabilities Act and Alternate Format, p. 21). In this section the State creates a requirement for disability access:

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			"Applicants must certify that they shall fully comply with the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, and shall develop a plan to encourage its contracted providers to do the same. The Applicant must further certify that it will provide an operational approach to accomplish this as part of the Readiness Review." We agree with the State's emphasis on disability accessibility within the demonstration. This will be especially critical to the population of dual eligible individuals. We believe that these provisions should be further specified and strengthened: "Applicants must certify that they shall fully comply with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act (ADA) and the Rehabilitation Act of 1973 in all areas of service provision, including communicating information in alternate formats, and shall develop a plan to encourage require its contracted providers to do the same. The Applicant must further certify that it will provide an operational approach to accomplish this as part of the Readiness Review." Provide Specifics: The State requires that the plan's medical and related buildings and facilities are architecturally accessible to people with disabilities in compliance accordance with Federal and state standards. The State must also require the plans to assess their full provider network for compliance with these physical accessibility standards. Plans and providers must adopt policies and procedures for programmatic

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			accessibility to effectively communicate and to provide necessary medical information and directions in accessible formats, including the use of sign language interpreters wherever needed. Medical staff and others that interact with these beneficiaries must complete staff training programs on how to identify and assist individuals who may have programmatic accessibility needs, how to interact with disabled persons with language or communication limitations, and meet linguistic and cultural competency standards. Specify Enforcement: All plans should be required to meet explicit network standards for primary and specialty care and other critical professional, allied health, supportive services, and medical equipment that are above the existing State standards for primary care providers. Prior to being authorized to participate, each plan must demonstrate its capacity to provide non-disrupted and appropriate health care to seniors and people with disabilities. County-based plans must also demonstrate that capacity to serve and must have policies and procedures in place for appropriate care prior to any enrollments. The state should utilize all state agencies with legal jurisdiction to monitor, assess, and report on the progress of the transition and implementation of the mandatory managed care program. These include, but need not be limited to, the California Department of Managed Care, the Office of Statewide Health Planning and Enforcement, and the Safety Net Financing Division of the Department of Health Care Services.

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			CFILC recommends that several specified measures be adopted to strengthen the disability access provisions of the demonstration, and that enforcement should be added to ensure compliance. We also recommend that performance measures should also be utilized to ensure accessibility (see Recommendation 9, below).
117	Page 10	Quality Incentives	We urge the State and CMS to consider more innovative approaches in place of withholding capitation. Risk sharing models can incentivize plans and providers to invest in technology and infrastructure for improved efficiency of care delivery, better outcomes, and greater cost reductions. Performance bonuses (as opposed to withholds) provide an incentive to raise the bar beyond the required standard.
118	Page 10	Quality Incentives	Participating sites will not be eligible for Medicare star bonuses. Plans will be subject to an increasing quality withhold (1, 2, 3 percent in years 1, 2, and 3 of the Demonstration). Sites will be able to earn back the capitation revenue if they meet quality objectives. Because Year 1 is a start-up year that will have phased enrollment through the course of the year, the effective and accurate measure of quality in that first year will be tenuous. We propose that Quality Incentives be deployed in Year 2 or later. We ask that DHCS establish a Quality Incentive that is a bonus to be earned based on achieving established targets, rather than as a withhold from assumed actuarially sound rates. Creating new metrics will be burdensome to plans and providers. We suggest that the same metrics be used as those in the Star bonus program, even if not part of that program.
119	Page 10	Quality Incentives	We have been told the quality objectives to be used to earn back withheld capitation revenue have not yet been determined. We would suggest that one of the measures be the extent to which beneficiaries needing long-term services and supports have their references honored, as measured by the Personal Experience Outcomes – Integrated Interview and Evaluation System (see http://chsra.wisc.edu/peonies).

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120	Page 10	Quality Incentives	Plans will be subject to an increasing quality withhold with the ability to earn back the capitation revenue if quality objectives are met. The Department should issue the quality criteria in advance and the criteria should be clear and agreed to before the capitation revenue is withheld. Potential criteria would include reduction in avoidable or unnecessary emergency room utilization; reduction in 30-day readmissions for the same diagnosis or improved HEDIS scores. In order for plans to include this quality criteria in provider contracts, this criteria will need to be published on or before June 2012.
121	Page 10	Beneficiary Notification	It takes considerable time and resources to develop effective beneficiary notification materials, processes and rules. The Department has not begun to have any serious conversations with stakeholders about these issues and we are skeptical that they will be generated within the compressed timeframe laid out in the draft. We believe that individuals need to receive information about any upcoming enrollment options or changes 90 days in advance. The task of developing enrollee materials should not be left to plans. The Department should work with CMS to develop model materials that plans are required to use as is currently done in the Medicare program. Stakeholders should be involved in the development of these materials. As models are developed, the Part D and Medicare Advantage rules should be integrated with California laws and regulations adopting these standards from each program that provide the most protection to individuals. For example, in the area of language access, the RFS should be clear that both Title VI and translation and interpretation requirements under Dymally-Alatori apply. Finally, we question in the draft the discussion of marketing materials. One argument we have heard put forward by plans in favor of passive enrollment is that it would save everyone the expense of marketing. If a passive enrollment system is employed, we suggest limiting the marketing that plans are allowed to do and relying on independent enrollment brokers as the primary source of information for individuals forced to join

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			a plan. Alternatively, if the Department opted for a voluntary enrollment system, it may be appropriate to consider relaxing some Medicare marketing requirements, such as the prohibition on contacting current Medi-Cal managed care enrollees with information about a Medicare D-SNP offered by the same organization.
122	Page 10	Beneficiary Notification	Communication in alternate formats will be required. CMS and DHCS will approve all outreach and marketing materials in advance, subject to single set of rules to be developed. All communication should go through a consumer advocacy group first – such as DRC or HICAP.
123	Page 10	Beneficiary Notification	One of the clear learning's from the 1115 waiver experience with the SPD population is that there needs to be a much better job of informing beneficiaries of their options and helping them make choices. This population is even more fragile and vulnerable and is going to need more help. In addition to the alternative formats promised not materializing, the packets of information provided to potential enrollees were large, dense and not very helpful in assisting beneficiaries to make choices, as reflected in the very high default rates. In addition to substantially improving the materials for this population, we believe it is critical to provide this population independent choice counseling similar to that provided to seniors by the Health Insurance Counseling and Advocacy Program (HICAP).
124	Page 10	Appeals	We support the intention to create a uniform appeals process. The process should be set by CMS and the Department and should integrate the strongest protections from each program into a single process that is easy for beneficiaries to navigate. As with the beneficiary notification section, however, we are concerned that, given the lack of discussion and progress on this item to date, the Department does not have the time and resources to create and implement an integrated appeals system prior to the enrollment of individuals into plans. We worry that this is an area of promise that will not be fulfilled.
125	Page 10	Appeals	It is unclear what the impact will be on IHSS appeals processes, rights of the IHSS consumer, and what will be the role of the county and the health plan. We understand this will be clarified in a future proposal and will provide additional

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			feedback at that time.
126	Page 10	Appeals	There will be a uniform appeals process across Medicare and Medi-Cal. We assume that "appeals process" in this section of the RFS applies to the beneficiary. There will need to be a uniform appeals process for providers as well. We believe that the first level of appeal for both beneficiaries and providers should be made to the plan.
127	Page 10	Network Adequacy	The approach to network adequacy is an example of a larger problem with the approach laid out in the draft RFS as it does not represent an improvement over current programs available to dual eligibles. Instead of describing new person-centered models which would build network requirements around the needs, preferences and existing relationships of the people in the plan, the adequacy standards outlined rely on existing, oftentimes inadequate, standards which define networks by the business relationships between the plan and providers. In a person-centered model, plans should be required to offer open networks. We do not understand the reference to allowing plans to utilize an exceptions process to current Medicare standards. We oppose any exception which would decrease requirements plans currently need to meet.
128	Page 10	Network Adequacy	The most significant difference in the networks necessary to serve this population and the networks for the SPD population being enrolled in managed care plans now is the network of long-term services and supports, something that is foreign to most Medi-Cal managed care plans, as well as state regulators. While DHCS could and did turn to DMHC to assist in the analysis of the adequacy of health care networks for the SPD population, neither agency has expertise in assessing the adequacy of networks to provide LTSS services to the population to be served under this demonstration. The RFS seems to suggest that there are Medi-Cal standards for

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			LTSS network adequacy, but on questioning it has been clarified that this is still on the to-do list. It is very important to get this right for the dual eligible population, which is another reason to have demonstration sites that are of a manageable size, to maintain the existing IHSS program for the duration of this demonstration, and to use only sites where there is a strong, well-organized LTSS community. The prospect of the adoption of last-minute LTSS network standards, coupled with sites administered by plans that have no history of providing LTSS or interacting with LTSS providers in the community, is very concerning.
129	Page 10	Network Adequacy	The Department intends to follow Medicare standards for network adequacy for medical services and prescription drugs; Medi-Cal standards for long-term supports and services. The final RFS should specify to which entity plans are required to submit their provider network for adequacy determination and be held to a single standard. Participating plans should not be required to submit its network to multiple regulators.
130	Page 10	Monitoring and Evaluation	This is another area where the lack of specificity raises serious concerns. Monitoring and evaluation are key components of the framework of consumer protections that will be necessary to protect enrollees in these plans. A recent report from the State Auditor indicated that the Department has not been monitoring adequately Medi-Cal managed care plans. Significant work needs to be done to ensure that as plans become responsible for providing more benefits, the monitoring capacity at the Department is improved. In addition to needing to further define what will be monitored and evaluated and by whom within CMS and the Department (or other parts of California's government), the RFS should be explicit that monitoring and evaluation will be done in a transparent way including the public release of all reporting measures submitted by plans. In addition, contracts with plans should be clear that plans are covered by the California Public Records Act. While perhaps not appropriate for including in the RFS, we also strongly recommend that an ombudsman (more likely an organization) be identified to assist in monitoring and

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			evaluating the performance of these plans. This was a need identified as a core principle by the 1115 Dual Eligibles Technical Workgroup. The ombudsman would have the capacity, authority and responsibility to assist individuals with making enrollment decisions, appealing plan denials and services and navigating, generally, problems that arise in plans. The ombudsman would also collect data and identify systemic problems to report to the Department and CMS as they arise. The ombudsman should be specific to dual eligibles and others receiving LTSS from plans and should have expertise in the health systems duals rely on – Medi-Cal, Medicare and LTSS. The ombudsman could be funded by the legislature or by an assessment on plans. In Wisconsin, both stakeholders and the state report great satisfaction with the role Disability Rights Wisconsin plays as ombudsman to the state's integrated care model. We recommend a similar approach in California.
131	Page 10	Monitoring and Evaluation	An external evaluator will be contracted to measure quality and cost impacts to both Medicare and Medicaid in this Demonstration. Evaluation should include some non-paid party input – perhaps from retired health care and social service professionals/administrators??? Random thoughts - Successful applicants must demonstrate an understanding of the community based organizations in their service area, including services offered, utilization by duals, capacity and wait lists. I have concerns that while there is a great deal about collaboration with and utilization of community based services, it feels a little optional – or like the collaboration could be a phone call. If the person creating the plan of care is a nurse care manager who has never worked outside a health care agency, he/she will likely not know or understand what services are available in the community and the needs they meet. What guarantee is there that health plans will not give people an option of one service rather than all necessary services? I can see having language in there about services which are currently 1915 c waivers

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<tr><th>Comment #</th><th>Page # of RFS</th><th>Section</th><th>RFS Draft Language & Comment</th></tr>
<tr><td></td><td></td><td></td><td>being available singularly per patient; however other services are often needed in concert. Why does the site have to have an active SNP?

Can they have experience having a SNP in lieu of currently having a SNP?</td></tr>
<tr><td>132</td><td>Page 10</td><td>Integrated Financing</td><td>Baseline Spending and Anticipated Savings. Plans need more information on how the Medicare rate will be calculated. How will baseline spending be defined? For example, will the Medicare baseline spending be based on the plan's current spending, local Medicare FFS only, or will it incorporate the savings produced by Medicare Advantage and D-SNPs in our service area? In San Mateo County, a high proportion of duals are in a D-SNP – 60% of all full benefit duals are enrolled in our D-SNP alone. We have seen significant reductions in ED visits and hospitalizations as a result of our Care Coordination Program for D-SNP members. An internal analysis of the Care Coordination (CC) Program in 2006 had the following results:
<table>
<tr><th>Outcome Measure</th><th>Before CC</th><th>After CC</th><th>% Decrease</th></tr>
<tr><td>% of at least one non-psychiatric hospital admission</td><td>30.5 %</td><td>16.9 %</td><td>- 45 %</td></tr>
<tr><td>Average length of stay</td><td>8.2</td><td>7.3</td><td>- 11</td></tr>
<tr><td>% of at least one ER visit</td><td>42.9</td><td>29.8</td><td>- 31</td></tr>
<tr><td># of ER visits per member</td><td>1.2</td><td>0.7</td><td>- 42</td></tr>
</table>
These results are statistically significant and evaluation in subsequent years continues to produce similar results. More detailed information about this and other relevant results are available upon request. As a Medi-Cal managed care plan with an established (and successful) D-SNP, it is critical we know the payment and incentive structure as soon as possible in order to determine whether we could implement a successful pilot with the resources that are available. If the rate provided is to include upfront savings to both Medicare and Medicaid, it is critical that the baseline spending benchmark take into account savings that have already been</td></tr>
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			achieved through several years of care coordination, as described above. Efficient plans that provide high quality care should not be penalized through this process. In addition, it will be difficult to achieve savings if the pilots are not allowed to change current practices, especially in the IHSS program (see below). Why is there no mention of risk adjustment for the pilot (other than for Part D)? Risk adjustment is absolutely critical to ensure plans are appropriately reimbursed for the populations under their care (see last section "Other Issues to Consider" for more). Baseline spending for substance use services is nonexistent although there is a benefit and need for such services. LTSS and Medi-Cal Only. The RFS does not make clear whether the capitated rate for pilot sites will include all LTSS financing, or just LTSS financing for enrolled duals. More specifically, will pilot sites be responsible for all of IHSS or just IHSS for enrolled duals in the pilot? We believe strongly that pilot sites should be responsible for all LTSS financing and management, for both duals and Medi-Cal only; this is critical if pilot sites are expected to deliver integrated services and a seamless experience. As a COHS, all Medi-Cal members are enrolled with us already; it would be confusing for beneficiaries and inefficient to have two separate administrative infrastructures for IHSS. Also, a single entity should be accountable to all IHSS beneficiaries and IHSS providers within the demonstration county.
133	Page 10	Integrated Financing	Up-front savings for Both Medicare and Medicaid (Demonstration Model Summary: Key Attributes, Integrated Financing, p. 10). In this section the State provides a very brief description of the integrated financing model, including the expectation of first-year savings: *"The rate will provide will provide (sic) upfront savings to both Medicare and Medicaid."* We are concerned that the State is assuming savings with the very brief level of

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			planning and detail that has been provided. While we support a blended capitation rate with risk for utilization of services (including institutional services), no detail has been provided to stakeholders about the financing models that would demonstrate that there will be enough money in the system for high quality and enhanced services along with year one savings. The models are too new, the capacity unclear, the experience with managed long-term services and supports (MLTSS) too untried, to justify this assumption. If the State and the health plans do not make strategic investments into expanding HCBS, the potential for long-term savings is greatly reduced; therefore, we urge that funding should be left in the system at the current level during the first year, and estimated savings should be held off until year two, and then should be based on analysis and evaluation in an appropriate justification. We are also very interested in understanding the details of the financing models, especially in the incentives that will encourage high quality services, provision of HCBS, and control inappropriate utilization of institutional services. We are uneasy that these projects are proceeding on a fast-track without this information being thoroughly and transparently considered. CFILC opposes taking upfront savings to Medicare and Medicaid in year one, based on the uncertainties of the new model and the vulnerability of the population, and seeks more information about the financing model.
134	Page 10	Program of All-Inclusive Care for the Elderly (PACE)	Aging Services of California strongly supports the inclusion of PACE services as a separate and distinct program for the dual eligible population. We believe that PACE should be offered as an option to beneficiaries and included in all enrollment materials and outreach efforts. Further, we support providing managed care plans with the ability to refer eligible beneficiaries to PACE and that these beneficiaries have the ability to disenroll from plans and enroll in PACE at the point they are eligible, prior to entering a nursing home.
135	Page 10	PACE as a separate program	Finally, we support the language in the draft RFS providing that PACE will remain as a separate program, with enrollees able to choose it in the counties where PACE exists. While we support these elements of the draft RFS, we believe several

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			elements of the draft RFS need more clarification and elaboration in order to ensure that the ability of beneficiaries to choose to enroll in PACE, both initially and as their needs change, is preserved.
136	Page 10	PACE as a separate program	In order for beneficiaries to have the opportunity to enroll in PACE, we strongly believe that PACE must be presented as an enrollment option and included in all enrollment materials, enrollment assistance programs, and outreach programs related to the dual pilots, and must presented to beneficiaries at each point of contact in which enrollment choices and options are made available. As we have previously commented, these measures have not been included in the transition of seniors and persons with disabilities to managed care under the state's existing Section 1115 waiver. As a result, many beneficiaries who could benefit from PACE and who would opt to enroll in PACE, do not learn that it is an option in their geographic area. Finally, we support allowing beneficiaries who are enrolled in plans, who meet the eligibility requirements for PACE, to disenroll from the plans and enroll in PACE at the point they are eligible for PACE, while they are still living in the community and before they have entered a nursing home. We believe plans should be required to assess enrollees and to notify those who appear to be eligible for PACE programs that they have the option to do so. The RFS should provide a clear process for this to occur and should require plans to explain in their applications how they will coordinate with PACE programs on these transitions. We also believe beneficiaries who voluntarily disenroll from plans who are eligible for PACE should be informed of their ability to enroll in PACE before they disenroll, to provide an opportunity for them to consider continuation in models of integrated care. We recognize that not all duals who are eligible to enroll in PACE will choose to do so, but for a significant portion of them, PACE will be the best option for them. Experience with the transition of seniors and persons with disabilities to managed care suggests that without these provisions, many dual eligibles who are enrolled in plans will enter nursing homes and many will eventually disenroll from the plans and return to fee-for-service Medi-Cal. At that point, many will no longer be able to be cared for in the community, even

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			by PACE programs.
137	Page 10	PACE	We believe that PACE should be a benefit under the Demonstration project, not an alternative option. PACE should also be given the ability to contract for IHSS services.
138	Page 10	Benefits	"…Sites also will be responsible for providing access to all State Plan benefits and services covered by Medi-Cal. Also included will be provision of long-term care supports and services (LTSS), which include State Plan benefits of In-Home Supportive Services (IHSS), Community-Based Adult Services Center services (CBAS Center, formerly called Adult Day Health Care Services), long-term custodial care, Nursing Facilities, and the Multi-Purposes Senior Services Program…" Though State Plan benefits and services are mentioned as being included as part of the benefits demonstration sites will be responsible for providing, the document is silent on other Medi-cal waiver services including the Acute Hospital Waiver and the Assisted Living Waiver (available only in selected areas). We recommend that such services be included in the demonstration, and should be explicitly mentioned.
139	Page 10	Benefits	Specifically, we support requiring participating plans to provide or arrange for all Medicare and Medi-Cal covered services, and allowing them to provide other services needed to keep enrollees safely in the community (Page 11).
140	Page 10	Geographic Coverage	We also support starting the pilot in a limited number of counties, and specifically support the four county approach outlined in the RFS. Given the experiences from the transition of seniors and persons with disabilities to mandatory managed care, we believe there are a number of challenges inherent in the transfer of dual eligibles from fee-for-service to managed care plans and programs that will take time to work out, believe there is much that can be learned from a carefully focused pilot.
141	Page 10	Paragraph 3	AIDS Healthcare Foundation requests that the following language be added to the RFS:

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			"In Demonstration areas where AIDS Healthcare Foundation's managed care plans are available, AHF's plan will remain a separate program. HIV positive dual eligibles meeting the eligibility requirements will be able to select AHF, the Demonstration plan, or may opt-out of both."
142	Page 11	Pharmacy Benefits	SNP Bid and Supplemental Benefits. The RFS states that pilot sites "will be paid according to the regular Part D payment rules, with the exception that they will not have to submit a bid." In the past, our D-SNP bid has been below the Medicare Advantage benchmark, allowing us to use the difference, or "rebate" dollars, to cover supplemental benefits (dental, taxi rides for medical visits) and to lower Part D premiums and deductibles for beneficiaries. Will the methodology to calculate capitated rates to pilot sites include these assumptions? If not, pilot sites will not be able to continue to cover these important supplemental benefits for all pilot members. If yes, pilot sites need to know this in advance in order to structure benefits and marketing materials accordingly. Copayments. Encourage CMS and State to consider the waiver of dual eligible copayments for dual eligible beneficiaries with serious mental illness. Copayments for this population are a barrier to effective care and treatment. Coordination. Coordinating the pharmacy benefit for duals who are mentally ill is particularly challenging. The RFS should require applicants to have a plan for coordinating formularies, prescribing, and pharmacy network with county mental health for mentally ill beneficiaries.
143	Page 11	Pharmacy Benefits	We recommend more specific guidance on formularies. Sites should provide the same prescription drug benefits that dually eligible beneficiaries receive now under Medicare Part D and Medi-Cal (for drugs not

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			covered by Part D). If sites are required to comply with Medicare Part D rules and regulations, they should be provided the references and encouraged to join lists to receive updates on Medicare Part D. Similarly, sites should have references to Medi-Cal rules regarding Medi-Cal-covered drugs. We would also like more details on the financing of the prescription drug benefit. All dually eligible beneficiaries now have the low income subsidy or Extra Help. They pay a statutory copayment for Medicare Part D-covered drugs and nothing for drugs covered by Medi-Cal. They should not have to pay more in a dual demonstration plan than what they would pay with Extra Help and under Medi-Cal.
144	Page 11	Pharmacy Benefits	Should highlight the importance of coordinating formularies, prescribing and pharmacy network with county mental health for beneficiaries with mental illness. Furthermore, beneficiaries stable on medication regimen should be exempt from any new formulary restrictions.
145	Page 11	IHSS	Year 1. Pilot sites should have the flexibility to adjust certain IHSS rules in year 1 if they can demonstrate local support for proposed changes and the capacity to implement those changes. Arbitrary restrictions in year 1 should not be applied uniformly across all pilot sites without factoring local context. Why restrict pilot sites in year 1 if pilot sites are ready to implement adjustments in year 1? If there is no flexibility provided for IHSS, it will be difficult to change current practice and achieve savings.
146	Page 11	IHSS	IHSS (Demonstration Model Summary: Key Attributes, IHSS, p. 11). In this section the State provides for only a year one plan for the integration of IHSS into the demonstration: “In the first year of the Demonstration, IHSS benefits will be authorized under the same process used under current state law. The Demonstration site will contract with

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			the County social service agency. Sites must work with Counties to develop processes that allow information sharing on the care needs of the clients. In the subsequent years, the Demonstration site can suggest expanding its role." We believe that with regard to the IHSS program, the state's most important HCBS program and a key strength of the long-term services and supports system, the level of planning and detail offered in the RFS is wholly inadequate. The State should not expect to make wholesale changes to the IHSS program on the strength of one paragraph of placeholder language. We believe that the State should endeavor to negotiate and present a detailed plan for the IHSS program's integration into the dual eligible project on an ongoing basis for future years. Most importantly, we are concerned that the consumer direction of the IHSS program is seen by the State as an additional program detail that can be worked out in the future. This is unacceptable. We assert that consumers should continue under the dual eligible demonstration to have the rights to hire, fire, schedule and supervise their personal care services providers, and should continue to have the option to hire family members to perform these services. These consumer protections should be explicitly delineated in the RFS, and should be protected in perpetuity as the ongoing basis of California's strong and successful personal care services. The consumer direction of personal care services cannot be compromised, whatever the service delivery model that California adopts. We support the development of further detail and negotiated out-year plans for IHSS program administration. Furthermore, we strongly oppose any and all proposals that do not preserve the consumer direction of personal care services as a foundational concept and that explicitly protect and preserve that

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			principle into the future. Consumer direction must be an explicit pillar of the demonstration; it cannot be deferred to be negotiated in the future.
147	Page 11	IHSS	We believe that integrating IHSS into managed care can provide positive outcomes, however the transition needs to be done strategically and with great attention to and enforcement of existing standards and policies. We see the IHSS provider becoming a unique and valuable addition to the patient care team, and we believe that in order to achieve the core goals established by the Demonstration, transitioning IHSS into managed care should be implemented in year one. We noticed that the current criteria for IHSS integration is only provided for one year of the Demonstration. Our concern is that after the first year of the project, anything is possible. It is imperative that existing bargaining rights and other union protections will remain intact throughout the Demonstration.
148	Page 11	Behavioral Health	Coordination. We support the requirement for close coordination with county behavioral health systems. Integration by 2015. Behavioral health benefits are a key component in the full continuum of care available to duals but very little detail if provided in the RFS as to the parameters for full integration by 2015. Also, it is unclear how mental health match would work. DHCS and CMS should provide at least a framework in the RFS about the administration and financing of behavioral health.
149	Page 11	Behavioral Health	Behavioral Health (Demonstration Model Summary: Key Attributes, Behavioral Health, p. 11). In this section the State primarily addresses the fiscal and system organization of behavioral health integration: *"*Demonstration sites are required to have a plan to achieve full integration of behavioral health services by January 1, 2015 (i.e. inclusion of behavioral health services into the integrated capitated payment). For enrollees with serious mental illness who currently receive services through the County Specialty Mental Health

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			System, formal partnership agreements between Demonstration sites and Counties will be required. Phased approaches will be acceptable, but should include incentives that promote shared accountability for coordination and achieving set performance objectives." In principle, while we find that 2015 is a very long timeframe to wait for full integration of behavioral health, we do not object per se to a phased approach. We do believe that specific focus should be given to the needs of any dual eligible persons residing in state hospitals or skilled nursing facilities designated as Institutions for Mental Disease, and that those persons should be served by the project in year one. We are troubled however that more attention appears to have been focused on the problem of integrating the system, and no attention has been given to the integration of behavioral health for the person. Discussion with demonstration planning project staff revealed no consciousness of the major gaps in mental health services in California, the unserved needs of racial, ethnic and linguistic minorities, of older adults, especially those with dementia, of persons with physical disabilities, and the underserved needs of persons who are currently served by the mental health system. It is the State's responsibility to fully understand these gaps in services and to design a fully integrated approach to behavioral health care *from the inception of the project,* so that all participants receive the level of behavioral health services that they are entitled to, regardless of how long the fiscal or administrative phasing may last. This is another strong argument against taking Medicare and Medicaid cost-savings up front; there are huge unmet behavioral health needs for the dual eligible population, and appropriate planning, financing, services, monitoring, evaluation and oversight will be needed to fulfill the State's responsibilities.

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			We believe that the State has given inadequate attention to the integration and provision of integrated behavioral health services under the RFS, and that it needs give formulate a clear plan for meeting its responsibilities to fully address these needs from year one of the demonstration. The plan should include an analysis of the population's behavioral health needs, disparities, gaps in services, a detailed array of services to be offered and financing to adequately address identified needs.
150	Page 11	Technology	Aging Services of California strongly endorses efforts to incorporate eCare technology into the selection criteria. Technology holds great promise to improve care for dual-eligible population and create efficiencies and cost savings for the state.
151	Pages 11-12	Technology	New Technologies. It is unlikely that pilot sites will have the resources to invest in new technologies given the lack of upfront funding to support these expenses.
152	Page 11	Medical Loss Ratio	We understand that the intent of this provision is to ensure that plans are not prohibited from investing in care coordination activities that may be reported as administrative expenses in a medical loss ratio (MLR) calculation, but we worry that not setting a minimum MLR (and excluding these plans from existing MLR requirements) lessens accountability. The state auditor report referenced above indicating concerns about plan reserve and executive compensation levels. A minimum MLR is one way to ensure that the state's money is spent on providing care to low-income dual eligibles and not the enrichment of plan employees or investors. We recommend that a standard be adopted that is at least as stringent as the 85% MLR that applies to Medicare Advantage plans. Whether or not a minimum MLR is adopted, cost data must, as indicated in the draft, be reported. The RFS should explicitly indicate that the data will be shared publicly.

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153	Page 11	Medical Loss Ratio	Rather than waiving the 85/15 medical loss ratio, we recommend that DHCS establish line item in the rate under the 85% medical cost side that would cover the costs of care coordination.
154	Page 11	Medical Loss Ratio	We do not understand the statement that there will be no "minimum medical loss ratio" in the Demonstration. Does this mean there will be no standard of medical loss ratio applied? Is this consistent with federal and state law?
155	Page 11	Medical Loss Ratio	While there is no minimum medical loss ratio requirement in the Demonstration, plans will be required to report on costs to ensure transparency and facilitate evaluation. We support transparency for purposes of the evaluation, and suggests that administrative costs associated with sub-contracts be examined as part of the pilots.
156	Page 11	Learning and Diffusion and Ongoing Stakeholder Involvement	These activities will only be meaningful if the recommendations above regarding transparent release of plan data on costs and quality and the identification of an independent ombudsman are adopted. Timeline The timeline for selecting sites and drafting the state's proposal is very aggressive especially given the Department's limited resources and many important policy initiatives underway. This is an ambitious project tackling many complex issues and we are concerned that rushing through the design and site selection process will negatively impact all stakeholders as the process continues. We are also concerned that even if the timeline is met, there will be very little time to prepare for a January 2013 enrollment. Very little progress has been made on important policy issues like rates, networks, LTSS integration, appeals processes, assessment tools, consumer protections and more. Once those policy decisions are made, there will be even less time to translate those decisions into contract requirements and beneficiary notices. This process should be driven by a desire to 'get it right' not be

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			artificial deadlines and budget projections. Application and Submission Information We appreciate the note that responses will be public and suggest that they be made available on the Department's Web site within a reasonable time. The RFS should include more information about the criteria to be used to define which information is proprietary. Models of care should not be kept confidential. We also support the discussion of subcontracted entities. In particular, we support the statement that incentive arrangements not induce subcontractors to withhold, limit or reduce medically necessary services. We would like the Department to ensure that this is also true of incentive arrangements with capitated managed care plans. We also have more global concerns about the entire approach of the Request for Solutions in light of the Governor's budget proposal. One question we have in relation to the Governor's budget is whether, given the goal to mandatorily enroll dual eligibles into Medi-Cal managed care and to integrate LTSS benefits into Medi-Cal managed care in 2013, a Request for Solutions is an appropriate vehicle for moving forward. The RFS is designed to solicit input from plans indicating a willingness to participate in a pilot or development of a new system. But if all current plans will be expected to participate in the Medi-Cal enrollment and LTSS integration pieces of the Governor's proposal, a RFS does not seem appropriate. Instead of waiting for plans to indicate what they would like to do, the Department will need to set clear standards and requirements plans must meet. Further, we oppose an approach that requires all current plans to become integrated plans. The Demonstration should begin with plans that indicate a willingness to take on this difficult task and can demonstrate steps they have already taken to prepare. We favor limiting the Demonstration to four pilot counties and limiting the total number of impacted beneficiaries until new models are tested and proven to improve access and quality. We do not favor an approach that would include all dual eligibles in a large county like Los Angeles.

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157	Page 11	Ongoing Stakeholder Involvement	We are concerned with this issue, especially over private plans that provide optional managed care coverage in many counties. We have far fewer concerns in COHS counties where there is not only stakeholder engagement but public accountability. We believe each plan should develop and submit a written statement of how they propose to guarantee stakeholder engagement, and that this statement be a key part in evaluating the proposal.
158	Page 11	Demonstration Model Summary	Supplementary Benefits: Demonstration sites are encouraged to offer additional benefits, such as non-emergency transportation, vision care, dental care, substance use services, etc. Additionally, a key part of this Demonstration is bringing together social services and medical services (such as Meals on Wheels and other social supports). Demonstration sites are encouraged to contract, utilize, and pay for community-based services that can help beneficiaries remain in their homes and communities. Comment: Options Counseling (OC) is a person-centered, interactive, decision-support process whereby individuals are supported in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values. Options Counseling is a core service of California's Aging & Disability Resource Connection (ADRC) and should be considered a supplemental benefit that can assist individuals to remain in their community. Skills training, for the purpose of assisting an individual to adjust after the onset of a disability or chronic condition, may provide additional opportunities to reduce the amount of health care services needed. Examples include learning to take public transportation after a driver's license is revoked; preparing basic meals after a stroke; money management following a brain injury. These services, combined with enhanced assistive technology solutions, can assist an individual to rely less on health care services by providing the skills necessary to accomplish certain talks on their own.

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159	Page 11	Supplementary Benefits	"Demonstration sites are encouraged to offer additional benefits, such as non-emergency transportation, vision care, dental care, substance use services, etc… Demonstration sites are encouraged to contract, utilize, and pay for community-based services that can help beneficiaries remain in their homes and communities." One of the promising elements of integration is the potential to redirect savings to provide services and supports that may not be covered by either Medicaid or Medicare, but that are essential to improving, restoring or maintaining the health of individuals. In this spirit, DHCS should require integrating entities to provide access to necessary supports and services, including enhanced benefits (such as home modifications and caregiver training) that are designed to keep individuals living at home and in the community. Identification of a beneficiary's need for services should be ascertained through completion of a uniform assessment that all Demonstration sites use that incorporates measures on health, functional, behavioral, and cognitive status. Provision of all services should be made based on clearly defined standards. Enhanced benefits should also be clearly defined with standards for providing the service clearly outlined.
160	Page 12	Beneficiary Notification	Approval Process. Right now, all our Medicare Advantage outreach and marketing materials are reviewed and approved by CMS Region 9. The Medicare Advantage timeframes for plan submission to CMS, CMS approval and then plan dissemination to beneficiaries are very short, particularly for the Annual Notice of Change and Summary of Benefits. If approval of all outreach and marketing is "subject to a single set of rules to be developed," we recommend that either CMS or DHCS be the approval entity, but not both. Medicare plans and CMS are already constrained to meet Part D timelines for outreach and marketing materials; adding another review layer could delay pilot sites from sending out outreach and marketing materials in a timely manner. Streamline Materials. We strongly encourage CMS and DHCS to work together to streamline beneficiary materials. Currently, we know from member surveys and focus groups that members are overwhelmed with paper, and that the current type and volume of material (especially as required through Medicare) only

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			confuses members.
161	Page 12	Beneficiary Notification	Passive enrollment is essential to the viability of the Demonstration. However, learning from the experience of seniors and person s with disabilities (SPDs) enrolled in Medi –Cal managed care, default enrollment must be coupled with superior advance notification and continuity of care proto cols, including clear accountability for the Demonstration sites. These provision s should be written into the Demonstration model. Further, some of the projected cost savings from the program should be budgeted to strengthen these processes.
162	Page 12	Quality Incentives	Quality Withhold. Pilot sites should not be punished with a "withhold" amount from their baseline capitated rate. Instead, pilot sites should be rewarded for high performance with an amount that is above the baseline capitated rate. As a D-SNP that has earned a 2013 STARS bonus, it is critical we know the payment and incentive structure as soon as possible in order to determine whether we could implement a successful pilot with the resources that are available. Will there be any acknowledgment in the rates of the bonus that plans have already earned for 2013? Under the current proposed financial structure, it is unclear why a plan with more than three stars would want to participate in the pilot. Performance Measurement. The RFS mentions that pilot sites will not receive STARS bonuses. Questions include: a) does that also mean pilot sites will not be evaluated based on the Medicare STARS rating system as well? and b) what measurement system will be used? Plans need at least a framework for how quality will be measured and the impact on

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			payment rates before submitting an application.
163	Page 12	Quality Incentives	Quality Incentives (Demonstration Model Summary: Key Attributes, Quality Incentives, p. 12). In this section the State specifies an approach to quality incentives: "Participating sites will not be eligible for Medicare star bonuses. Plans will be subject to an increasing quality withhold (1,2,3 percent in years 1,2 and 3 of the Demonstration). Sites will be able to earn back the capitation revenue if they meet quality objectives." States with established MLTSS systems go further, establishing performance measures that support quality. For example, Tennessee has strict performance measures with associated liquidated damage penalties for missing service timeline requirements for sentinel events, such as enrollment in HCBS, assessment, services planning and commencement of services. Arizona has similar performance measures to reinforce timelines for service delivery. Texas requires their managed LTSS plans to develop a long-term services plan within 30 days for new enrollees. California would benefit from such standards. In addition, we have received widespread reports that physical and programmatic disability access requirements are not being adhered to within the State's transition of seniors and persons with disabilities to managed care through the 1115 waiver. Full compliance with all state and federal disability accessibility and civil rights laws, including but not limited to the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, should also be included in the plan performance measures, with penalties assigned for failure to comply.

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			We support the development of performance measures requiring service timelines for sentinel events to reinforce quality and performance, including full compliance with all state and federal disability access and civil rights laws.
164	Page 12	Quality Incentives	In addition to strengthening continuity of care processes, program savings should be reinvested in programs and services that help people receive care at home. Specifically, savings should be reinvested in IHSS provider training and co-training with their clients as well as in the provision of supplementary benefits such as housing transition, transportation and Meals on Wheels.
165	Page 12	Timeline	We think the proposed timeline is overly aggressive and needs to build in time for local input and compliance with the Brown Act prior to the deadline to submit applications (currently slated for mid to late February 2012). The timeline doesn't contain any consideration of the time needed at the local level to comply with provisions of the Brown Act prior to approving and submitting letters of support/agreement in partnership with integrating plans as part of the application process. It often takes 4-8 weeks for counties to post documents and agendas to comply with Brown Act requirements. Boards of Supervisors, County Administrative Officials, as well as other local stakeholders should be given an appropriate amount of time to provide input to entities that are interested in applying to become demonstration sites before applications are submitted to DHCS.
166	Page 12	Timeline	The following is a process planning timeline for California's Dual Eligibles Demonstration project authorized by SB 208 (Steinberg, 2010). (text followed by a charge). We suggest that the State provide delivery of data on the duals population as soon as possible to assist with the appropriate preparation to effectively educate and serve the population.

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167	Page 12	Network Adequacy	This section references “Medi-Cal standards for network adequacy for LTSS”. Can DHCS provide these standards or provide a reference as to where these can be found.
168	Page 12	Network Adequacy	“DHCS intends to follow Medicare standards for network adequacy for medical services and prescription drugs and Medi-Cal standards for network adequacy for LTSS.” Integrating entities should provide adequate access to providers that are able to serve the unique needs of California’s dual eligible population. In particular, measures of network adequacy need to take into account the high number of dual eligibles who have multiple chronic conditions including dementia, who are very frail, who have disabilities, and limited English proficiency. Integrated model networks must include appropriate ratios of primary care providers with training to serve the diverse dually eligible population, an adequate specialist network including a sufficient number of specialists in diseases and conditions affecting this population and a range of high quality home- and community-based provider options. When setting standards for network adequacy, it is important that standards take into account the number of network providers who actually are accepting new patients, wait times for appointments, cultural competency, physical accessibility, and geographic accessibility. Many members of this population do not drive and may instead rely on public transportation, which must be taken into account. In urban and suburban areas with public transportation, accessibility criteria should be based on the amount of time required when using public transportation and not rely solely on drive times. In addition to having expertise and being available for appointments, network providers must be prepared to provide special accommodations to dual eligibles. For example, the integrating entity should enforce policies and payment structures that incorporate longer appointment times than are typically allocated for the general population. For many reasons — complex health conditions, limited English proficiency, disability, mental health condition — members of this population may need longer appointments if their needs are to be fully understood and appropriately addressed. Finally, integrating entities should ensure that they can

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			provide 24/7 access to non-emergency care help lines staffed by medical professionals and to non-emergency room medical services. Even where integrating entities have met these standards for network adequacy, DHCS should require them to create and implement a process for granting exemptions to individuals who need to receive services from out-of-network providers when those are the only providers capable of providing the needed care.
169	Page 12	IHSS	*This is **shocking** and should NOT be allowed!* This violates "Demonstration Goals" numbers 1 and 2 , Page 8! Additionally, Page 8 numbers: 1, 2, 3, 4! We (advocates, legislators, state departments) have worked for decade to create a working method by which people with disabilities and their special needs have an agency that is completely versed in disabilities. Incorporate this agency to expand their services as disability consultants, assessment staff for incoming pilot beneficiaries…their knowledge of disabilities is an ASSET not a cost factor issue! They can act as a consultant for doctors who have little to no knowledge of disability needs or other medical staff who work with other pilot staffing and services. This would be not only life-changing but life-threatening for beneficiaries! Use the Public Authorities by integrating them in areas where there is little to no understanding about things related to disabilities. Incorporating their knowledge teamed up with the waiver programs to better serve the home care needs of persons with disabilities.
170	Page 12	Paragraph 5	DHCS needs to further explain the rationale for declining to use the Medicare star system for quality incentives.
171	Page 12	Monitoring and Evaluation	"Quality requirements will be integrated, and include a unified minimum core set of reporting measures, to evaluate quality improvement of sites during Demonstration period."

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			We recommend DHCS require, as a condition of participation, that all integrating entities involved in the Demonstration utilize a uniform assessment consistent across all sites to assess the health, functional, behavioral, and cognitive needs of individuals enrolled. Information ascertained through these measures should be used to direct and implement an individualized care plan and that individuals should be re-assessed at specified intervals. This information should also be incorporated into a uniform set of reporting measures to evaluate quality of care and quality of life. DHCS should also require integrating entities to report this information at a specified interval (i.e. annually, upon change in a beneficiaries condition, etc.).
172	Page 12	Network Adequacy and Monitoring and Evaluation	From written materials to office equipment, Medi-Cal SPD consumers have faced accessibility issues as they have transitioned from their old providers to managed care. Currently, the only leverage that plans have with providers in their network is to cancel the contract, which may be difficult due to network adequacy requirements. DHCS should be empowered to directly enforce demonstration standards at the provider level to ensure the highest consumer protections including appropriate accessibility. We believe this principle should be written into the demonstration model. Further, SB 208 states that the Demonstration must monitor how IHSS is used both before and during integration with the sites. The Demonstration should go beyond this initial data collection and evaluate how the integration of IHSS/LTSS has impacted, amongst other measures, health outcomes, consumer and IHSS provider satisfaction and health care costs. This will establish a baseline to start measuring the role IHSS plays in keeping consumers safe, satisfied with their care and healthy in their homes.
173	Page 12	Provider Accountability	Provider accessibility has been a serious issue throughout the process of transitioning SPD's into managed care. Because plans are limited in their ability to resolve these issues with providers, we believe that Demonstration should provide

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			that DHCS has the authority to directly enforce demonstration standards at the provider level.
174	Page 13	Supplementary Benefits	Ensure that by using services and programs that whatever is used within the community-based services does NOT affect the number of home care hours a beneficiary is assigned. Home delivered meals takes an outrageous hunk out of home care IHSS program hours. Using the Meals on Wheels does not eliminate other meals, nor does it not mean that your attendant does not have to transfer the food onto a plate, reheat the meal which is not often hot enough to eat or have to clean up after the meal!
175	Page 13	Paragraph 1	What entity will be developing the rates for the new capitated payment model?
176	Page 13	Ongoing Stakeholder Involvement	"Meaningful involvement of external stakeholders, including consumers, in the development and ongoing operations of the program will be required." We recommend that the final RFS provide a clear definition of "meaningful involvement" of external stakeholders, including consumers, in each of the pilot sites. Integrating entities, at a minimum, should develop a process for gathering ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.
177	Page 13	Ongoing Stakeholder Involvement	Demonstration sites should be held to public sector standards for open meetings and records.
178	Page 14		Notification" **before** a beneficiary is placed in the managed care pilot make sure that ANY accommodation is so noted and complied to fully. If a person needs alternative foremast to printed material… Example: Large print, recorded, Braille that ALL formats are used on EVERY level from Notices of Action, Hearing dates, mailing anything to the beneficiary. Blind

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			and/or vision impaired or cognitively impaired people should received a follow-up call to ensure that they were aware that something has been mailed to them. Harking back to the Public Authority, this is something that they can do because they already have the personal information about the IHSS beneficiary's disabilities, limitations etc. Page 14, Beneficiaries of a pilot MUST be able to choose their durable medical providers! This is especially true if there is a long history with the provider. History on the device repairs, they have services dates and met CMS' standards through the bidding process, how old the DME is. Respiratory equipment (tank both portable and non-portable, nebulizers and supplies, O2 concentrator supplies and services as well as other medical suppliers for disposable supplies (diapers, pads). Records on medical supplies RoHo equipment bed pads and seating systems. Eliminate "Home bound Rule" for DMEs which is extremely inflexible and can lead to devastating outcomes! Severe limitations on range of skin breakdown before help is offered and/or aggressive pressure sore treatments must be lifted for far better outcomes!
179	Page 14	Subcontracts	Sites will be allowed to subcontract with other entities to provide services under the Demonstration, provided that the contractor is responsible for assuring that all subcontractors meet the requirements of the negotiated contract. There are inefficiencies that occur in the state's current 2-plan model and its sub-contracting relationship. We believe that these pilot demonstrations allow for new business relationships and contracts to allow for more efficient and effective use of premium dollars. For example, if plans currently provide coverage to Medi-Cal beneficiaries through sub-contract, adhere to MIPAA requirements and have a D-SNP in good standing with

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			CMS, we believe that the Department should allow for a direct contract to enroll dual eligibles in a pilot county. Second, contracting plans should be allowed to sub-contract specific services and responsibilities to other entities as long as the contractor holds ultimate responsibility for the coordinated care of the enrollee and is able to terminate, change or alter a contract if quality or other issues arise.
180	Pages 14-15	**Application Submission**	Because some required documents, such as Medicare SNP Model of Care, can be 50 or more pages, L.A. Care recommends DHCS consider increasing the 50 page limit for the application and attachments.
181	Pages 14-15	Application and Submission Information - Application Submission	Each Application must include all contents required in this document and conform to the following specifications. Failure to follow these specifications will result in disqualification. • Use 8.5” x 11” letter-size pages with 1” margins • Font size must be no smaller than 12-point. • The Project Narrative must be double-spaced. • All pages of the Project Narrative must be numbered in the lower right hand corner with the name of the submitting entity in the left lower corner. Applications must not be more than 50 pages in length, which includes the executive summary and Project Narrative. Supporting attachments are limited to 50 pages in length We believe the page/spacing/font size limits laid out in the Draft RFS for the Project Narrative are too restrictive to present DHCS with sufficient information to make fully-informed site-selection decisions. Also, an Executive Summary limited to 1 page is insufficient to present anything substantial. We request that the limit for the Executive Summary be increased and that it be excluded from the overall page limit. We recommend eliminating page number and font restrictions to the supportive documents so that responders can fully comply with

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			what is being requested.
182	14-15 and 17-21	Application and Submission Information - Application Submission	N/A Applications will be evaluated by the state using a four-stage process. 1. Qualification Requirements. Applicants must certify they meet the Qualification Requirements described below. Failure to do so will result in Applications being disqualified. Since there is no reference to the submission and placement of each applicant's certification of the Qualification Requirements listed on pages 17-21, we propose they not be included in the Supporting Attachments, not have a page limit and are placed in each applicant's submission prior to the Project Narrative response. In that case, the contents of the submission would be as follows: Part 1: Qualification Requirements Part 2: Project Narrative Part 2: Project Narrative: Supporting Attachments
183	Pages 14-15	Timeline	This compressed timeline is somewhat aggressive given the large number of beneficiaries impacted and the inherent complexities associated with implementing new demonstration projects. The proposed timeline negates DHCS' opportunity to take advantage of any lessons learned from the SPD transition.
184	Page 15		, "Learning and Diffusion"…in a Two Plan Model county, the alternate plan which beneficiaries can choose should be willing to fully participate in the development, planning, oversight and attend all meetings for the Two Plan Model county to be chosen! Otherwise the alternative plan will not be a choice…rather used as an escape from county health plans.
185	Page 15		Ongoing Stakeholder Involvement, "Meaningful involvement of external stakeholders, including consumers in the development and ongoing operations of the program will be required."

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			I have thorough e-mails *proving* that one of the applicants for this pilot had anything but a "Meaningful involvement of external stakeholders, including consumers in the development and ongoing operations of the program will be required." "Stakeholders include county health plan employees with three *real* stakeholders." Heavily attended by employees who were appearing as "stakeholders". Fake video of a focus group planted with phony (scripted) focus group members who were told what the questions were going to be and pre-trained them for their responses – all of this while the Two Plan Model Commission submitted their request to become a Two Plan Model. After a full year of planning without a disability sub-committee the planning steering committee was forced to set up a sub-committee on disability. It was chaired by a person who had a private medical insurer, was not a low-income individual and did the county's consultants bidding. It was **anything** other than "meaningful"! The county's employees far outweighed in numbers the number of the true low-income "stakeholders". If such effort to control this sub-committee activities what will this county do with a pilot!? I have any number of e-mails documenting the details of sub-committee activities and recommendations.
186	Page 15	Data Availability	When will health plans get access to the claims data of existing Dual Eligibles?
187	Page 16	Criteria for Additional Consideration	We recommend amending criteria (a) as follows: Record providing Medicare benefits to dual eligibles; with longer experience offering a D-SNP or Part D plan without significant sanction or corrective action plans considered beneficial. Evidence of Medicare sanctions and corrective action plans will be viewed negatively. We recommend amending criteria (e) as follows and making it a requirement for all Applicants per our comments regarding Supplemental Benefits above. Inclusion of *enhanced and alternative* benefits beyond the minimum Medicare and Medi-Cal

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			benefits will be *required*, for example: dental, vision, substance abuse, *housing assistance, home modification and other services likely to assist an individual to remain in the community, but not currently covered by either Medicare or Medi-Cal*.
188	Page 16	Criteria for Additional Consideration	We would suggest adding: Existence of a draft Agreement or Contract with the local Aging and Disability Resource Center (ADRC), or if there is no ADRC in the locality with existing local entities performing similar functions in the community, demonstrating significant steps in the development of a formal agreement with an entity or entities with significant knowledge of and experience with long-term services and supports providers in the community. Existence of a draft Agreement or Contract with the local Area Agency on Aging, demonstrating significant steps in the development of a formal agreement to coordinate or provide Older Americans Act services that are designed to maintain older persons in the community.
189	Page 16	Qualification Requirements	Applications will be based on specific criteria, including that defined by SB 208. We suggest that applicants be required to demonstrate experience and history of providing care to low-income, medically complex populations in California. Specifically, plans should be able to demonstrate existing enrollment of dual eligible beneficiaries. For plans operating within California only, this enrollment should be at least 2,500 enrollees. For plans that operate in multiple States, this minimum should be 15,000 enrollees.
190	Page 16	Qualification Requirements /Financial Condition	We would suggest that the Department of Managed Health Care announce a process and timeframe for requesting these letters in order to provide them in accordance with the Department's timeframe for applications.
191	Pages 16-17	Selection of Demonstration Sites	We believe financial capacity is as important as structural capacity in determining a plan’s ability to sustain the demonstration.

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			We point out (as we did in the SPD Waiver process) that HEDIS measures are not adequate to reflect a plan's results because they do not include data on older adults which are the majority of the duals population. We would hope to see existence of a draft Agreement or Contract demonstrating significant steps in the development of a formal agreement with the following: 1. Local MSSP providers 2. Local ADHC/CBAS providers 3. Local Area Agencies on Aging 4. Local Aging and Disability Resource Centers 5. Local Skilled Nursing Facilities
192	Page 17	Criteria for Additional Consideration	Draft Memorandum Of Understanding Agreement with County Mental Health should be a requirement of all proposals and not an element for additional consideration. (Criteria for Additional Consideration Page 17)
193	Page 17	Criteria for Additional Consideration	Length of experience as DSNP; most recent 3 years of HEDIS results; NCQA accreditation for Medicaid plans; length of Medi-Cal contract; inclusion of supplementary benefits; existence of draft agreement or contract with county IHSS Agency; draft agreement or contract with county mental health agency; contracts with provider groups with track record of providing innovative and high value care to dual eligibles. We support all of these additional criteria as they will allow for stakeholders and the Department to evaluate the site's capacity to provide coordinated, comprehensive care to the dual eligible beneficiaries in the pilot. In addition, we would also suggest that applicants be able to demonstrate care management beyond telephony, given the medical and social issues requiring high touch outreach and education. Plans

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			should be capable of demonstrating administrative and financial capacity to serve the population and manage high-cost services and start-up costs. Given the short timeframe between the RFS and announcement of site selection, we would suggest that a letter of intent between the plans, county IHSS agency and county mental health agency replace a draft agreement for purposes of additional criteria consideration. Draft agreements and/or contracts should ideally be done through a small technical working group of plan and county counsel in order to standardize terms and conditions as well as reduce unnecessary duplication.
194	Page 17	Knox-Keene License Qualification Requirement	Under "Qualification Requirements" we recommend that the Knox Keene License requirement is amended to read: "Applicants must have a current unrestricted *or limited* Knox-Keene License showing authority to operate in the State in order to participate in this RFS…" We believe that this qualification should be expanded to include entities who have limited Knox-Keene licenses. These licenses are granted pursuant to the Knox-Keene Health Care Services act of 1975, and enable an entity to assume full risk, both professional and institutional, in the same manner as an entity with an unrestricted license. For purposes of the dual eligible demonstration pilots, a limited license achieves the same protections of financial reserves and solvency as an unrestricted license, with the potential for additional cost savings to the State. In addition to demonstrating that the license holder has no adverse actions with regard to enforcement or quality management, licensees should be required to demonstrate the following: Financial solvency/Financial reserves: revenue to debt ratio of less than 10 A minimum of ten years of full risk experience for the provision of both professional and institutional services A minimum of ten years in demonstrating adequacy and stability in provider networks Effective management of hospital utilization, and effective predictive modeling to reduce hospital readmissions for high risk patients. Overall, these demonstration pilots will test different health care arrangements to determine what model improves care

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			integration for dual eligibles. Rather than restrict the eligibility to certain organizations, the State should permit limited Knox Keene licensed organizations to apply for participation if they satisfy the financial requirements of their unrestricted license counterparts. In the advent of health care reform and the evolution of accountable care organizations, it is more important than ever to test the viability, and potential benefits of new models and risk arrangements.
195	Page 17		e. Inclusion of additional benefits beyond the minimum Medicare and Medi-Cal benefits will be beneficial, for example: dental, vision and substance use. We recommend rephrasing this sentence be read: Inclusion of additional benefits beyond the minimum Medicare and Medi-Cal benefits is strongly encouraged, for example: dental, vision and substance use.
196	Page 18	Current Medicare Advantage Dual Eligible Special Needs Plan and Current Medi-Cal Managed Care Plans	If the Department is only exploring risk-based capitated managed care plans as vehicles for integration, we believe that all Applicants should be required to be D-SNPs. Experience as a D-SNP and compliance with accompanying regulations and rules guarantees a minimum level of quality and protection that we expect the Department and CMS to improve upon. Experience as a Medicare Advantage plan alone should not be enough. We also recommend that Applicants be required to demonstrate experience operating D-SNPs in the same county as the proposed dual eligible site (just as they are required to under section 4). We encourage the Department to adopt a requirement that all Applicants operate D-SNPs, not simply certify that they will work in good faith to meet all D-SNP requirements by 2013. CMS has developed a thorough and extensive process to determine whether a plan meets all D-SNP requirements. That process should not be cut short in the interest of an earlier implementation date. If the enrollment process for dual eligibles remains voluntary, we would support an approach that

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			would only require one plan in a county to offer an integrated benefit. If the enrollment rights of dual eligibles are limited in any way, there must be a choice of integrated plans in non-COHS counties. Counties that do not have two plans that currently operate a D-SNP and a Medi-Cal managed care plan would be excluded in that scenario. We have a question on the definition of 'good standing.' A Medicare plan in good standing should have no current, open corrective action plans and should not have been subject to sanctions at anytime during the previous three years. We also ask the Department to indicate how it will handle a situation in which a plan that has been approved as a Demonstration site is placed under sanction by CMS.
197	Page 18	Medicare Advantage Dual Eligible Special Needs Plans (D-SNP)	We recommend that the first paragraph in this section is amended to read as follows: "There must be experience in ~~operating~~ *managing and coordinating the care of the D-SNP population* in each Demonstration county. Criteria for D-SNP experience will vary by type of county. All applicants must provide responses to all SNP Model of Care Elements and Standards, as modified to reflect the Dual Demonstration Application." Rather than limit qualified applicants to entities that operate a D-SNP, it should be expanded to applicants that manage the care of the D-SNP population and assume full financial and administrative risk to provide services for this population.
198	Page 18	D-SNPS	There are currently only about a dozen D-SNPs in California. We are hearing that some of the C-SNPs are rapidly moving to qualify as a D-SNP. The language in this section should clarify whether applicants must have D-SNP status when they apply or as of the target date to begin enrollment of dual beneficiaries in the integration pilots on January 1, 2013.

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199	Page 18	D-SNP Requirements and Current Medi-Cal Managed Care	Limited pool of applicants. The specific requirement to be currently operating managed care plans limits the applicant pool and should be removed. (D-SNP Requirements and Current Medi-Cal Managed Care Page 18)
200	Page 18	Current Medi-Cal Managed Care Plan	We recommend that the first paragraph in this section is amended to read as follows: "Applicants must have an *active full-service or limited Knox Keene license to operate a Medi-Cal Managed Care contract in the same county in California as the proposed dual eligible site.* Currently, certain health plans in CA are able to operate a D-SNP without having a direct contract to operate a Medi-Cal managed care contract in a given county. Given that this is not a current requirement for all health plans, there should be some flexibility in how these pilots are set up.
201	Page 18	Current Medi-Cal Managed Care Plan	As indicated previously, we believe this demonstration should not be limited to Medi-Cal managed care plans, but should be open to entities that are prepared to demonstrate how the goals of this demonstration can be implemented in a more rural area where existing managed care plans do not operate. We have seen such models in other states (e.g., Community Care North Carolina) and this seems to be an ideal opportunity to encourage the development of such a model in this State.
202	Page 18	Current Medi-Cal Managed Care Plan	As expressed earlier, we believe the Demonstration should seek proposals from counties or multi-county regional groups where no managed care now exists. We recognize these jurisdictions may not be ready to undertake enrollment in January 2013, but they may need years to get on a path to design a system of coordinated and integrated care. They should not be left out of the Demonstration.

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203		Current Medi-Cal Managed Care Plan	Plans will be required to show a letter from the Department of Managed Health Care Services demonstrating they are in good financial standing. We currently have direct contracts with the Department to provide care to Medi-Cal beneficiaries in 4 counties (Sacramento, San Diego, Riverside and San Bernardino) with a sub-contract to provide care to over 108,000 enrollees in Los Angeles county. We suggests that licensed plans that currently provide care to Medi-Cal enrollees in that particular county, through direct contract or subcontract (and compliant with MIPAA) be allowed to apply for and receive a contract to participate in the dual integration pilots. These contracts would be for dual eligible populations only (not for other Medi-Cal populations) and would be held to the same standards as proposed in the RFS.
204	Page 18	Selection of Demonstration Sites	Criteria for Additional Consideration. Additional consideration should be given to those pilot sites that have demonstrated low voluntary disenrollment rates in their D-SNPs, especially if such a site is proposing passive enrollment.
205	Page 18	Qualification Requirements Current Medicare Advantage D-SNP Plan *and* Current Medi-Cal Managed Care Plan	There must be experience operating a D-SNP in each Demonstration county. Criteria for D-SNP experience will vary by type of county. All Applicants must provide responses to all SNP Model of Care Elements and Standards, as modified to reflect the Dual Demonstration Application (See Appendix C). Two-Plan Model Counties: At least one of the Applicants must operate a D-SNP in good standing with Medicare. The other Applicant must certify that it will work in good faith to meet all the D-SNP requirements in that county the next year. And Applicants must have a current contract with DHCS to operate a Medi-Cal Managed Care contract in the same county in California as the proposed dual eligible site. Two-Plan Model Counties: For Applicants in Two-Plan Model Counties, Applications will only be considered if both plans submit an individual Application. As a result of separate QIF entities, the Medi-Cal managed care contract and a Medicare D-SNP contract are not necessarily held by the Applicant in the same corporate structure. Therefore, an Applicant's experience operating a D-SNP should be considered to be inclusive of the

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			experience of any related parent or subsidiary entity.
206	Page 18	Current Medi-Cal Managed Care Plan/Geographic Managed Care	We seek clarification on whether all plans within the GMC model would receive dual eligible enrollments, even if all plans don't apply? Secondly, we assume that the two (or more) plans that apply from a Geographic Managed Care county will have to do so similar to a 2-plan model - and submit an application separately?
207	Page 19	Countywide Coverage	We would like clarification from the Department on the suggestion that Applicants could enter into 'partnerships of agreed upon geographic divisions.' We oppose the idea that individuals in one part of a county would have a different set of plans to choose from than those in another part of the county.
208	Page 19	Countywide Coverage	While we are licensed to provide services in all Los Angeles County zip codes, we are currently exempted under our DHCS Medi-Cal managed care contract from providing services in Catalina Island. We request clarification on whether this exclusion meets the pilot criteria.
209	Page 19	Countywide Coverage	When will health plans get a list of current providers of the Dual Eligibles?
210	Page 19	Countywide Coverage	This section indicates that successful applicants will need to demonstrate the ability to "cover" the entire dual eligible population in a county. That is fine as far as it goes, but it is very unclear what this means. If it simply means that the plan and its partners are authorized by DMHC to provide medical coverage in all the zip codes in the county, it does not go nearly far enough. The coverage needs to extend to all the long term services and supports that are going to be provided in this demonstration as well. As previously indicated, there are no LTSS network standards now so it is not clear what standard they would be held to in the 3-4 weeks between the release

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			of the final RFS and the date the applications are due. At a minimum, however, applicants should be required to indicate how they are going to cover LTSS, as well as medical care, for this population throughout the county.
211	Page 19	Countywide Coverage	Applications must demonstrate ability to cover the entire population of dual eligibles, either on their own or through partnerships of agreed-upon geographic divisions with other Applicants. There are currently open zip codes in Medi-Cal Managed Care Counties where enrollment into a plan is voluntary and plans are not required to maintain licensure in those open zip codes. We currently provides care to Medi-Cal beneficiaries in San Diego, Riverside, Los Angeles, Sacramento and San Bernardino counties. There are counties in which particular areas may be able to support a managed care network while other portions of the counties cannot (i.e., Placer, Imperial). The Department should choose the counties in which managed care plans can secure and maintain a network that meets contract and regulatory requirements. For counties where a significant portion (over 90%) of the dual eligible population can be covered by a managed care plan (i.e., Riverside County), the beneficiaries that reside in the rural areas should be offered a managed fee-for-service option or treated consistently as other Medi-Cal populations are enrolled in the current program. We understand the Department's intent with this particular criteria, but believes it may involve anti-trust provisions if rates or financial terms are included. It should either be modified or removed entirely from the final RFS document.
212	Page 19	Business Integrity	We believe that this is an extremely important element of the RFS. The Department and CMS should only be allowing plans with a strong record serving dual eligibles to take on this new responsibility and to be rewarded with the new financial flexibility proposed. Plans that have a history of sanctions under Medicare or Med-Cal should be excluded from participating. In addition to the items listed, plans should be required to list all corrective action plans issued by Medicare over the last five years

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			including information about the reason for the corrective action plan and the resolution.
213	Page 19	Business Integrity	Applicants must demonstrate business integrity by certifying they have no unresolved Medi-Cal or Medicare quality assurance issues in California; list all sanctions and penalties in the last 5 years from either Medicare or the state of California; certifying they are not under sanction by CMS; certifying the plan will notify the Department within 24 hours of any Medicare sanction or penalty taken in California. The term "unresolved" should be clarified in the final RFS since enforcement issues before the Department of Managed Health Care are clearly defined and outlined by statute and regulation. Clarification is also necessary for plans that have sanctions in place or receive a sanction during the pilot. The RFS indicates that sanctions and penalties within the last 5 years do not necessarily result in disqualification. However, for sanctions that occur after the pilots are announced, how does the Department intend to handle new sanctions or penalties? Would enrollment be suspended for plans that receive CMS sanctions during the pilot? It may be necessary in the final RFS or subsequent contracts to require plans to disclose their penalties in terms that external stakeholders can readily understand (administrative, financial, clinical). There should be a particular sanction or level of penalty that plans would need to receive in order to be suspended during the pilot.
214	Page 19	ADA and Alternate Format	We are pleased to see the RFS include a requirement regarding ADA compliance. We recommend adding a similar section to indicate compliance with all state and federal civil rights laws, particular those related to language access.

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215	Page 19	ADA and Alternate Format	This section requires applicants to develop a plan to "encourage" its contracted providers to fully comply with the ADA. Encouraging is not enough. In this section the state should set forth the requirements for an accessible provider network with which applicants will need to comply to be considered in this demonstration. It may be that every contracted provider needs to comply; it may be that the network must have a certain number or ratio of contractors who comply. But as written, there is no standard other than that the applicant is to "encourage" compliance by contracted providers. There needs to be more certainty for the benefit of applicants as well as disabled beneficiaries.
216	Page 19	Qualification Requirements - High Quality	Applicants must demonstrate a capability of providing for the health and safety of dual eligible beneficiaries. Applicants must demonstrate meeting or exceeding minimum quality performance indicators, including: a. DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements. b. MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements. Please define what quality measurements are required. We suggest that the measures be drawn from existing standardized quality measures to avoid complications of requiring providers to track data unique to this population.
217	Page 19	High Quality	Plans must demonstrate minimum quality indicators including Department indicators, MA-SNP quality requirements and mandatory HEDIS measurements. We support this and would suggest that the quality incentives referenced on page 10 be directly tied to these performance measurements. Plans should be informed in advance of the metrics that will be used to evaluate performance and the criteria must be applied equally to all plans, regardless of type or size of plan.

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218	Page 19	Encounter Data	Applicants must certify they will provide complete encounter data as specified by the Department. We work with providers to obtain accurate encounter data today. Plans should be required to certify encounter data as the most complete and accurate available for purposes of this pilot demonstration. If the Department requires participating plans to identify and withhold payment from providers that fail to provide encounter data, this may make this process more effective and efficient.
219	Page 20	County Support	Counties and Public Authorities strongly support the preservation of consumer rights in the IHSS program to hire, fire, schedule and supervise the IHSS provider. Some health plans have expressed concerns about liability exposure if they are held responsible for tort claims associated with the provision of service by an IHSS provider. Under current law, the state and counties enjoy total immunity from tort claims when IHSS is administered through a local Public Authority. We believe that contract language can be established between demonstration sites and Public Authorities that will address liability concerns and preserve the right of consumers to have the person they want perform personal care assistance. There is also an expectation that IHSS providers may receive training under the dual demonstration pilots. One of the core mandates of the Public Authority is to provide access to training to IHSS consumers and providers. For these reasons, we believe that demonstration sites should be required to submit a separate letter of agreement from the local IHSS Public Authority must be submitted by the applicant.
220	Page 20	County Support	Applicants must submit letters of agreement to work in good faith from county officials with operational responsibility over IHSS, behavioral health and health. We have already initiated discussions with many of these county partners and is working in good faith to address the complex issues of including these critical benefits. However, the Department must provide financial and operational detail to

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			the pilot participants in order to facilitate such agreements and contracts. We would suggest a standard agreement or contract for the parties to use in their discussions.
221	Page 20	Stakeholder Involvement.	We appreciate the inclusion of this requirement. Of the specific items listed, we believe items two through five should all be required. Items three through five are essential to demonstrating stakeholder input into the development of the application and item two is the most effective way to encourage ongoing stakeholder input into plans as they are implemented. Advisory boards set up under item two should include advocates like local legal services programs who can help dual eligibles present concerns and push for resolution of problems.
222	Page 20	Stakeholder Involvement.	We believe that a history of meaningful stakeholder engagement should be demonstrated as a condition of the application being considered. Relationships and trust are only built over time, which are going to be important to a successful demonstration.
223	Page 20	Stakeholder Involvement.	Broad stakeholder participation across the lifespan detailing specific activities must be ensured in spite of the aggressive timeline. (Stakeholder Involvement Page 20 and Stakeholder Input 26)
224	Page 20	Qualification Requirement	Comment on Qualification Requirement #3 and 4 page 20 Qualification Requirement 3a requires a Medi-Cal managed care plan operating in a Two-Plan Model county to either operate a SNP or certify that it will work in good faith to meet all the D-SNP requirements in that county the next year. Qualification Requirement 4a requires both plans in Two-Plan Model Counties to submit an individual Application for a Duals Demonstration. The rationale for Requirement 4a included in the RFS states DHCS' interest in encouraging cooperation and collaboration between local plans. Based on the Teleconference on January 5, 2012, it is our understanding that DHCS and CMS seek to preserve consumer choice in mandating that both plans in a Two-Plan Model county participate and meet the D-

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			SNP requirements, as outlined in the RFS. As long as Applicants in Two-Plan Model Counties demonstrate cooperation and collaboration as well as preserve consumer choice, we strongly urge DHCS allow significant flexibility in how Duals Demonstration plan partnerships are developed within Two-Plan Model Counties. Applicants should be asked to describe models for ensuring consumer choice, which have garnered the support of consumer stakeholders and representatives and allow for the use of subcontracting and delegated relationships to demonstrate a good faith effort to meet the D-SNP requirements. Without this flexibility, we are concerned that highly qualified plans in Two-Plan Counties will be unfairly excluded from competing as a Duals Demonstration site because although interested in cooperation, collaboration and supporting consumer choice for duals, one plan's business interests may not justify the operation of a full D-SNP in that specific county. This scenario increases in likelihood in those counties with infrastructure and options already in place for providing choice to consumers.
225	Page 21	Nonprofit Organizations	The RFS seeks certification of the applicant's standing as a corporation, LLC, nonprofit, etc. but not as a public entity as described in our enabling legislation (Article 2.81 of the California Welfare and Institutions Code (commencing with Section 14087.96). We would like to confirm public entity participation in the RFS and pilot.
226	Page 21	Qualification Requirements -Conflict of Interest	Applicants must certify that no prohibited conflict of interest exists. DHCS reserves the right not to award a commercial health plan contract to an Applicant that will be contracted, subcontracted, affiliated, or otherwise entered into a partnership arrangement to serve as a Local Initiative in the County to which it proposes to become the commercial health plan, or has indicated intent to do so, by the Contract Award Date. Submission of an Application or bid in response to a Request for Application does not constitute such intent for the purposes of this RFS.

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			Please clarify what this language means in the context of the Duals Demonstration.
227	Page 21	Qualification Requirements : High Quality	"Applicants must demonstrate meeting or exceeding minimum quality performance indicators, including: a. DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements. b. MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements." We recommend that DHCS consider the work that the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF) are currently engaged in to develop duals-specific quality performance measures, which should be incorporated into the Demonstration.
228	Page 21	**Qualification** Requirements Business Integrity	Demonstration applicants are not limited to those who only provide services in California. Many applicants will be national organizations that provide Medicaid and Medicare services in other States. DHCS must ensure that all applicants demonstrate business integrity by: a. Certifying they have no unresolved Medicaid or Medicare quality assurance issues anywhere they do business in the United States. b. Listing all sanctions and penalties taken by Medicare or a State government entity within the last five years. c. Certifying that they are not under sanction by the Centers for Medicare and Medicaid Services. d. Certifying that it will notify DHCS within 24 hours of any Medic are or Medicaid

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			sanctions or penalties taken against them in any state where they provider medical services.
229	Page 22	County Support	County Support. We support additional consideration or weight given to applicants that have draft contracts or agreements at the time of application submission with all key local health and social services agencies.
230	Page 22	County Support	"Applicants must submit letters of agreement to work in good faith on this project from County officials, including the County agency head with operational responsibility for: • IHSS and aging services; • Behavioral Health (both Mental Health and Substance Use, if those are overseen by separate County entities); and, • Health (the County agency with the most direct responsibility for the County public medical center(s), if any)." We recommend that this list should be broadened and clarified as follows to include the range of LTSS including, but not limited to, transportation, services provided under the auspices of local Area Agencies on Aging, Independent Living Centers, and Aging and Disability Resource Centers; caregiver resources, home modifications; and affordable housing.
231	Page 22	Program Design - Section 1.1	In addition to generally describing experience serving duals in Medi-Cal and Medicare Special Needs Plans, the Applicants should be required to specifically describe their experience in delivering long term supports and services.
232	Page 22	Stakeholder Involvement	Stakeholder Input Process. We support the requirement of applicants to demonstrate a meaningful local stakeholder process in both the design and implementation of the pilot.
233	Page 22	Stakeholder Involvement	"Applicants must certify that 3 of the following 5 are true: • The Applicant has at least one dual eligible individual on the board of directors of its

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			parent entity or company. • The Applicant has created an advisory board of dually eligible consumers reporting to the board of directors (or will do so as part of the Readiness Review). • The Applicant has provided five letters of support from the community, with sources including individual dual eligible consumers, community organizations, and/or individual health care providers. • The Applicant sought and accepted community-level stakeholder input into the development of the Application, with specific examples provided of how the plan was developed or changed in response to community comment. • The Applicant has conducted a program of stakeholder involvement (with the Applicant providing a narrative of all activities designed to obtain community input.)" We recommend that integrating entities applying to be pilot sites in the Demonstration certify that a minimum of four out of five of the elements listed regarding stakeholder engagement are true. We recommend that the RFS clarifies the types of community organizations/representatives from which applicants can receive letter of support, such as advocates for seniors and persons with disabilities, consumers of services, organizations representing LTSS such as community-based organizations providing services to seniors, people with disabilities, and caregivers
234	Page 22	Executive Summary	Applicant must provide a one-page executive summary of the Demonstration project. For Applicants that are interested in participating in multiple sites (i.e., two or more counties), does the Department intend for them to submit one application that applies to all counties of interest, or an application for each county in which the applicant would like to participate?
235	Page 23	LTSS Capacity	Applicants are asked to describe their experience dealing with group homes, residential care facilities for the elderly (RCFE), intermediate care facilities (DD and BH), congregate living facilities and other type of "institutionalized" settings.

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			Applicants are asked to describe a transition plan for moving individuals out of these care settings. As previously stated, the misguided proposal that Applicants should transition DD beneficiaries out of ICFs/DD should be removed from the RFS. CAHF also objects the expectation that the Applicant will transition behavioral health (BH) beneficiaries from residential and inpatient settings. BH beneficiaries may appropriately reside in skilled nursing facilities with special treatment programs for the mentally disordered [SNF/STP or Institutions for Mental Disease (IMD)], mental health rehabilitation centers (MHRC), psychiatric health facilities (PHFs), adult residential facilities (ARFs), or residential care facilities for the elderly (RCFEs). BH clients in who reside in SNFs/STP and MHRCs have been conserved by the court and ordered to receive involuntary care in a locked/secured setting. Decisions about their care are made by their conservator and the county. Furthermore, the counties, not the Applicant, will be the primary source of funding, with county case managers coordinating and managing client services. Case managers approve lengths of stay, decide when a client is ready for discharge to a lower level of care, or can benefit from less restrictive community-based services. Since BH clients care is already coordinated with conservators and managed by county case managers, there is little benefit for them to be enrolled in pilots. However, in responding to RFS, Applicants should be aware of the unique nexus between the counties and public guardian's office for this population of dual eligibles. We continue to suggest that DHCS carve them out of the demonstration, or DHCS should be very specific on how it expects the Applicant to successfully integrate this population into pilot. CAHF was surprised by the inclusion of RCFEs as "institutionalized" care in the RFS (Page 23). According to Department of Social Services, there are over 8,000 RCFEs in California. These assisted living facilities allow the elderly to stay in a home-like environment when they cannot stay in their own homes because of their inability to perform activities of daily living and do not have extensive medical needs. DHCS should request that Applicants explain their plans to provide medical case

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			management for RCFE residents who have chronic care needs to reduce emergency room visits and hospitalizations, instead of transitioning the elderly clients to other living arrangements.
236	Page 23	Comprehensive Program Description - Section 1.2	This section is so broad and general in its requests that it is difficult to imagine responses that will be specific and meaningful. For example, a question asking "Explain how the program will affect the duals population," seems to call for general claims that the population will be better served but does not elicit specific information that would assist in evaluating responses.
237	Page 23	LTSS Capacity - Section 2.1	The second bullet contemplates that the applicant is going to determine the reimbursement of LTSS providers. We believe this is a mistake. In order to have an adequate network of providers for consumers, it is critical that the reimbursement from the integrating entity be adequate to provide quality care and services. For at least the basic services (medical, hospital, skilled nursing, adult day health centers, home care), this should not be left to negotiations between providers and the integrating entities, which would have various degrees of negotiating leverage in different geographic areas. For the most part, there are reimbursement levels for medical and long- term services and supports that the state has adopted, or could adopt by reference, to remove this potential source of instability. Particularly for demonstration pilots, the state should be exploring the potential benefits of utilization management, not the potential for cost savings through reducing provider reimbursements to the point of risking quality care and services.
238	Page 23	IHSS - Section 2.2	While this section sets parameters for the first year, it does not explicitly carry over the consumer protections in Year 1, including especially the consumer rights in the first bullet on p. 24, into subsequent years. Further, the Department has provided no LTSS framework (in its Jan. 5 call, the agency stated that the reference to an Ex. E was in error). It is critical that the Department set minimum requirements so that the core protections in IHSS (consumer choice of providers, including family members,

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			consumer right to hire fire, supervise, assign tasks, etc.) are maintained. Other protections such as the consumer's right to determine the extent to which the IHSS worker is involved in the care plan, need to be spelled out. Further the issue of how IHSS assessments and care coordination will be integrated with other LTSS needs to be addressed. Applicants need to be required to lay out how IHSS and other long term supports will be coordinated. Suggest changing the last bullet to: "Describe your transition plan for moving individuals out of inappropriate, unnecessary or unwanted institutional care settings. What processes, assurances do you have in place to ensure proper care and respect individual preferences?"
239	Page 23	Qualifications	Under section "Qualifications", Item 17, Conflict of Interest – This section is confusing. Please elaborate on this section by providing an example.
240	Page 24	IHSS - Section 2.2	The second section contemplates the transition of IHSS services to a new model developed by the participating Medi-Cal managed care plans. As indicated previous, we believe this is a mistake. IHSS should remain as is for the duration of this demonstration.
241	Page 24	Coordination and Integration of Mental Health and Substance Use	Clarify the role of County Mental Health after year one particularly related to covering all Medicare and Medi-Cal specialty services per the 1115 waiver as there is variance among counties in the provision of rehabilitation and recovery services. (Coordination and Integration of Mental Health and Substance Use Page 24)
242	Pages 23-24	IHSS	1st Bullet – Require 3-year contracts for the course of the demonstration, per our previous comments. 3rd bullet – We recommend indicating that sites must be able to articulate how IHSS workers will

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			participate in care teams based on the negotiated discussions with the county program. We recommend adding that sites may contract with counties for additional supports and services beyond the current IHSS program. Examples include but are not limited to: purchasing additional care coordination (tiered case management) and contracting with counties for care coordination to other social services besides IHSS, 7th bullet – The process for purchasing additional service hours needs to be clarified. Does this mean the Demonstration site has the ability to question the county IHSS assessment? Does this mean the Demonstration may increase IHSS hours beyond what is authorized? Additional clarification is needed. Also, when and how will CMIPS be changed to accommodate? Professional training of the IHSS worker – The RFS should require demonstration sites to contract with Public Authorities for training of IHSS providers. The RFS should require collaboration between the Public Authority, integrating entity, local IHSS Advisory Committee and exclusive union that represents IHSS providers to 1) identify training and other support needs of personal care providers and create materials, tools and work aids that will enable homecare providers to improve the quality of care and create opportunities for career ladders, and 2) identify training needs of IHSS consumers and develop training, educational materials and other methods of support to help consumers understand how to

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			access and manage personal assistance services as well as other medical and supportive services that are available from the Integrating entity and develop/improve skills required to self-direct their care. Training implies that the providers who are more skilled will be paid higher wages for their services, which is likely to increase costs to the program. Tiered levels of training and certification should be considered. Note that IHSS County Social Work staff currently receive training from the California Department of Social Services via a grant with CSU Sacramento. Will this change in the future, and if so, how?
243	Page 24	IHSS	Applicants must contract with county IHSS agencies to administer the IHSS program in Year 1. The process of hiring, firing and authorizing services and payment remains as currently administered. The financial terms of the IHSS benefit will directly impact the ability of plans to contract with county IHSS agencies. If the capitated rate for plans contains funding for the IHSS benefit, the plans must have an ability to review and otherwise alter the authorization of services. We are supportive of the IHSS benefit and is willing to negotiate in good faith with county agencies and public authorities to ensure this valuable benefit is included for dual eligible beneficiaries. However, the Department needs to provide additional clarification around the financial terms of this benefit.
244	Page 24/25	Project Narrative - Comprehensive Program - Section 1.2:	The Application must: • Describe the overall design of the proposed program, including how you will provide the integrated benefit package described above along with any additional benefits provided beyond the minimum Medicare and Medi-Cal limits you intend to provide, if any.

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			• Describe how you will manage the program within an integrated financing model, (i.e. services are not treated as “Medicare” or “Medicaid” paid services.) • Describe how the program is evidence-based. • Explain how the program will affect the duals population. • Explain how the program will impact the underserved, address health disparities, reduce the effect of multiple co-morbidities, and/or modify risk factors. • Explain whether/how the program could include a component that qualifies under the federal Health Home Plans SPA. • Identify the primary challenges to successful implementation of the program and explain how these anticipated risks will be mitigated. • Explain what you will need from state and federal agencies to assist in the success of the Demonstrations.
245	Page 25	Care Coordination	How will plans establish levels of care coordination, this should be described and expectations articulated, such as timely client access to care coordinators, caseload sizes, etc.
246	Page 25	Care Coordination – Section 4	This section asks Applicants to complete and attach the model of care coordination as outlined per current D-SNP requirements. This requirement is emblematic of the core problem with the RFS, which is that it does not propose genuine innovation to provider person-centered, integrated care, but instead relies entirely on a medical model. The SNP model of care is only about Medicare services and excludes entirely LTSS that allow individuals to live where they wish with maximum independence. This goal of this Demonstration to be make it easier for individuals to seamlessly access the full range of Medicare and Medicaid services that they need. The design of a model of care needs to be built around those goals, not around Medicare SNP obligations. (Note, for example the SNP model of care reference (p. 37) to the need for a “gatekeeper,” a concept that is contrary to the vision of facilitating, not limiting, access to appropriate care and the provision allowing phone interviews for assessments (p. 39), a practice that the SPD

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			enrollment process has shown to be inadequate for this population). Significant alterations and additions to this model will be necessary to make it person-centered. The Department must engage with stakeholders to develop a new model with sufficient protections for LTSS consumers to protect against incentives the plan will have to use care coordination programs to deny or limit necessary care. Preliminary adjustments can be made to the attachment. For example, the model should specifically require Applicants to spell out how consumer choice will be integrated into care coordination. The Department should require protections that allow individuals to determine their care, where they receive that care, and from whom. Applicants should be required to describe how they will implement those protections. Further, Applicants should be required to be much more specific about how care will be coordinated, where care coordination will be centered, who will be responsible and how care coordination will differ depending on health condition. The Department also needs to continue to engage with stakeholders on the assessment process and its relationship to care coordination. The lack of discussion of assessments in the draft was striking. We appreciate that this section asks Applicants to specifically address care coordination for individuals with cognitive impairments. There is significant expertise in the stakeholder community around Alzheimer's disease and dementia that both the state and the Applicants should draw on to better serve these individuals. We also note that there are many other subgroups within the dual eligible community that will also need specialized approaches and that stakeholders, including consumers, have much to contribute in designing appropriate approaches. We also note that there are no requirements in this section or anywhere else in the project narrative where plans are required to describe the extent to which providers in their network currently participate in care coordination and what steps they will take to train/incentivize/monitor providers who are not experienced in participating in care teams and care coordination. Applicants should be asked to specifically address both issues.

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247	Page 25	Project Narrative - Section 4: Care Coordination	The Applicant must: Describe how care coordination would provide a person-centered approach for the wide range of intellectual and cognitive abilities among dual eligibles, including those with dementia and Alzheimer's disease. Attach the model of care coordination for dual eligibles as outlined in Appendix D. The SNP model of care is outlined in Appendix C (Appendix D is the Framework for Understanding Consumer Protections). Please replace reference to Appendix D with Appendix C.
248	Page 25	IHSS - Section 2.2	Please clarify, does the health plan premium from DHCS include funding for services rendered by County IHSS?
249	Page 25-26	IHSS - Section 2.2	Flexibility with IHSS Model. As previously stated, the IHSS requirements are too prescriptive for there to be a demonstration of anything other than the status quo. For example, how will county social worker time be freed to "participate actively" in care coordination teams if they must continue to follow all current IHSS rules concerning assessment and authorization of services?
250	Pages 25-26	Project Narrative Section 2.2: IHSS	IHSS should be fully integrated as part of the benefit package offered by the Demonstration in Year 1. If the Demonstration is to achieve the highest possible cost savings that come from reducing emergency department usage, hospital admissions and re-ad missions and nursing facility admissions, fully integrating IHSS and the II-ISS provider into the care coordination model from the start is critical. IHSS providers can play an important role not only in care coordination, but also in enhancing consumer satisfaction with care and the plan. The unique position of IHSS providers with respect to their clients allows them to recognize behavior or health changes that are critical to keeping consumers healthy, communicate any changes

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			to their client's status to the patient care team, perform basic interventions under the guidance of the team and generally advocate for their client. An enhanced role for the IHSS provider on their client's coordinate d care team and professional training in Year1 will realize the full potential of this reform to improve health outcomes and reduce costs. Further, the Demonstration must ensure that bargaining, including wages and benefit, and other union protections continue throughout the life of the Demonstration.
251	Page 25	*Paragraph 4*	NCQA does not accredit Medicare SPN. Every nationally recognized accreditation agencies' accreditations should be considered equally. For example, DHCS should equally weigh accreditations from the Utilization Review Accreditation Commission (URAC), the Joint Commission and the Accreditation Association for Ambulatory Health Care (AAAHC).
252	Page 25	LTSS Capacity - Section 2.1:	We requests that "Residential Care Facilities for the Elderly (RCFEs)" be struck from the list of providers included in the "institutionalized" settings: Describe relevant experience with individuals living in group homes, ~~Residential Care Facilities for the Elderly (RCFEs),~~ Intermediate Care Facilities (ICF-DD, ICF-BH), Congregate Living Facilities (CLF) or other type of "institutionalized" settings. Residential Care Facilities for the Elderly (RCFEs) are included in the RFS' list of provider types characterized as intuitions. RCFEs ***are*** home- and community-based settings that offer care and supervision to residents who need it. These are voluntary housing choices and not medically oriented. RCFEs cover a gamut of configurations from small 6-bed "board and care" facilities to amenity rich independent living communities such as Continuing Care Retirement Communities (CCRCs). This "social model" of community-based living should be encouraged

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			under the dual eligibles integration, not treated as institutions. We strongly believe it is inappropriate to include RCFEs on the list of "institutionalized settings."
253	Page 25	LTSS Capacity - Section 2.1:	"The Applicant must…describe relevant experience with individuals living in group homes, Residential Care Facilities for the Elderly (RCFE), Intermediate Care Facilities (IFC-DD, ICF-BH), Congregate Living Facilities (CLF) or other type of 'institutionalized' settings." In addition to demonstrating relevant experience with institutionalized settings, we recommend that DHCS requires integrating entities to describe relevant experience in working with home- and community-based service providers and the broader network of LTSS providers.
254	Page 25	LTSS Capacity - Section 2.1:	"The Applicant must…Describe how you would use your Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS." As noted in Comment #5, we recommend DHCS require, as a condition of participation, that all integrating entities involved in the Demonstration to utilize a uniform assessment consistent across all sites to assess the health, functional, behavioral, and cognitive needs of individuals enrolled. Information ascertained through these measures should be used to direct and implement an individualized care plan and that individuals should be re-assessed at specified intervals. This information should also be incorporated into a uniform set of reporting measures to evaluate quality of care and quality of life. We recommend that DHCS also requires integrating entities to report this information at a specified interval (i.e. annually, upon change in a beneficiaries condition, etc.).

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255	Page 25	Consumer Protections - Section 5	The fact that the Department is not further along in developing specific consumer protections is very concerning. Consumer protections need to be woven into every aspect of the Demonstrations.
256	Page 25	Consumer Choice - Section 5.1	As discussed above, consumer choice begins with choice to participate in the Demonstration. Demonstrations are by their nature experiments. Dual eligibles should have the right to make an affirmative determination that they choose to participate in such an experiment.
257	Page 25	Consumer Choice	Consumer choice is the most important attribute that needs to be built into this demonstration, particularly when it comes to LTSS: Choice of Plans – Where services for dual eligibles are to be administered by a managed care organization, there should be, at a minimum, a choice of at least two fully qualified plans from which they may choose. This is a requirement imposed by CMS in the terms and conditions for the enrollment of Seniors and Persons with Disability in any non-COHS county under the 1115 Waiver, and should be a condition for any demonstration site under this project. Even in COHS counties, preference should be given to sites where the option of a PACE program is also available to clients. Independent choice counseling should be provided to assist individuals make the best decision for their situation. As previously indicated, there should be no 'lock-in" of six months or any other period, as is apparently being contemplated in the RFS. The most important consumer protection is the ability to leave a plan that is not serving the consumer's needs. Passive Enrollment – We prefer that individuals affirmatively choose to enroll in one of the plans being offered under the demonstration. Plans should be incentivized to make the offer attractive enough to encourage a sufficient number of individuals to 8 enroll. We also understand that there are concerns about whether inertia will effectively

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			result in most individuals choosing the status quo. As indicated above, we would suggest that this is something that the state should seek to test in this demonstration, requiring some sites to have voluntary enrollment and others passive enrollment. Where passive enrollment is permitted, the state needs to ensure that consumers have timely, adequate information to provide a real choice to opt out of the plan if they choose to do so. Choice of Long-term Care Settings – Consumers needing long-term supports and services can potentially receive them in a variety of settings. This may include nursing facilities where a person receives skilled nursing services in a facility where they reside, Adult Day Health Centers where similar services are available only during the day, or at home where many services can be provided by in-home supportive services workers. The consumer should have the choice as to what setting is most appropriate under the circumstances. I would note that while AARP and other consumer representatives have historically pushed very hard to enable consumers to receive services in their home or the community, which we know most would prefer, once an integrating entity has financial responsibility for all types of medical and long-term services and supports we begin to worry about the barriers that may be erected to access to more expensive options, including nursing facilities for which the consumer may be eligible. Consumers' situations will differ in many respects, including their abilities, caregiver supports, and preferences. The choice of the setting in which services are provided should be a decision made by the consumer. Choice of Provider – Consumers should have a reasonable choice of all types of providers. In the case of home care workers providing personal care services, consumers should have the ability to hire, fire, schedule and supervise their provider, and should be continue to have the option to hire family members to perform these services.
258	Page 25	Consumer Choice	Applicant must describe how beneficiaries will be able to choose their primary provider, specialists and participants on their care team, as needed. For beneficiaries enrolling in the pilot, we support the continuity of care provisions as

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			applied to the mandatory managed care enrollment process for seniors and persons with disabilities (i.e., up to 12 months of out-of-network care if provider agrees to accept rate). Beneficiaries should be able to choose a provider within the plan's network. For beneficiaries with a provider that does not or will not contract with the participating plan, there should be an agreed-upon process and reimbursement to transition that patient to a contracting provider.
259	Page 25	Section 3: Coordination and Integration of Mental Health and Substance Use Services (bullet 2)	County Mental Health. The RFS is unclear as to what is meant by the evolving role of county mental health after year 1. Also, there could be more in this section drawn from the Framework section – Appendix F. Mental Health Director and Psychiatrist. Please clarify whether pilot sites are required to have an in-house Mental Health Director and Psychiatrist. Pilot sites should have the flexibility to determine whether to sub-contract clinical expertise, as long as pilot sites can demonstrate a coordinated effort on the behalf of pilot beneficiaries. We currently do not have a dedicated Mental Health Director or Psychiatrist within our plan for our D-SNP; we subcontract this expertise to our county's Behavioral Health and Recovery Services. This arrangement has been successful and adding these two positions within our plan would be duplicative.
260	Page 25	Coordination of Mental Health and Substance Abuse Services	Applicants are required to demonstrate how they will provide seamless and coordinated access to the full array of mental health and substance abuse benefits covered by Medicare and Medi-Cal. We use private mental health and substance abuse providers for Medicare beneficiaries today. Under the pilot demonstration, it is assumed that plans will be allowed to provide mental health and substance abuse benefits through contracts with existing providers. Does the Department intend for plans to use county-based services as a mechanism

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			to supplement existing provider networks in this area? We would suggest that plans be allowed to provide this benefit through providers that can meet appropriate care and access standards.
261	Page 25	Enrollment Process - Section 5.5	Coordination. How will DHCS work with the Social Security Administration on eligibility issues that involve interacting across county social services and SSA? See also comments at end of this document regarding enrollment – Other Issues to Consider.
262	Page 25	LTSS Capacity (bullet 3) Section 2.1:	Health Risk Assessment (HRA). Applicants are asked to describe how the HRA may be used to identify/ target high-need members and how various assessment tools may be consolidated or streamlined. We fully support the ability of pilot sites to streamline the numerous assessments so that beneficiaries are not subjected to overlapping assessments, and staff can spend more time providing valuable care and support services. It is unclear whether pilot sites would have such flexibility given State law and judicial decisions. For example, plans have been mandated to use the CBAS assessment tool for CBAS eligible Medi-Cal members. However, the CBAS assessment tool is not comprehensive enough to make care decisions related to other LTSS services, such as the types of services now provided through MSSP or IHSS. Because demonstrations are meant to test multiple models in order to see what works best, we recommend that pilot sites have the flexibility under a demonstration authority to modify and streamline the various assessment tools if there is local support from the stakeholder community to do so.

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263	Page 25	Comprehensive Program Description (bullet 8) Section 1.2	Health Homes. Support inclusion of Health Homes SPA as a potential funding source for some demonstration project components; State may also want to consider how to fold in other funding opportunities from the ACA and/or CMMI (such as primary care at home initiative, currently just directed at the fee for service system), as a way to provide additional resources for the start up of the dual pilots.
264	Page 26	Social Support Coordination Section 2.3 (bullet 3)	**ADRC. Please clarify whether the San Mateo County Aging and Adult Services agency would qualify as the local ADRC-type model.**
265	Page 26	NCQA Accreditation Section 5.6	NCQA Accreditation Requirement. We do not currently have NCQA accreditation for our Medi-Cal or D-SNP programs. We fully support accreditation as a requirement but offer the following two recommendations: Pilot sites provide a plan to achieve accreditation by the end of the third year (not second year) and accreditation required for continuation beyond year three. Staff time and costs to achieve NCQA accreditation is quite significant – estimated to be between $2-3 million. It would be unfortunate if a pilot site obtains accreditation after year two but the demonstration is not continued in that pilot county after year three. These high costs must be factored and included in capitation rates for pilot sites. Many smaller community based Medi-Cal and D-SNP plans are not in a financial position to absorb the level of cost required to obtain accreditation while also taking on more financial risk.
266	Page 26	Access - Section 5.2	This question includes no specific reference to language access. More globally, the Department should be setting rigorous standards for accessibility and require Applicants to at least meet those standards and describe how they will

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			do so. Accessibility is a basic consumer right established by law (Title VI, Olmstead, Dymally-Allatorre, etc.) and cannot be an item to be defined by Applicants.
267	Page 26	Education and Outreach - Section 5.3	While the general questions here are useful, the Department will need to develop much more specific requirements around all aspects of communications with beneficiaries including Web sites and customer service centers.
268	Page 26	Stakeholder Input - Section 5.4	An important element of stakeholder input is transparency. Stakeholders cannot have meaningful input if they do not have access to information on all aspects of plan performance, costs, etc. We repeat our request that the Department require that Applicants agree that information submitted to the Department and CMS also be publically available. We also reiterate our comment in Section 4 that consumers and other stakeholders have much to offer in terms of specific knowledge and recommendations, particularly about the needs of diverse subgroups of duals. Besides having more general stakeholder involvement at the macro level, Applicants and the Department should set up processes to tap into this specialized knowledge on a continuing basis.
269	Page 26	Enrollment process - Section 5.5.	Applicants should not be designing the enrollment process. The State has extensive experience with enrollment brokers for enrollment in Medi-Cal managed care. For any enrollment system, especially if it has opt-out elements, it is critical that individuals have impartial information in order to make an informed decision at the beginning of the process and not experience disruption in care because they have to bounce in and out of a plan. As discussed above (p. 4), independent enrollment brokers should be used to process enrollments and investments should be made in HICAPs and CBOs to enable them to assist individuals in making enrollment choices. The creation of an independent ombudsman would also be useful for ensuring an effective enrollment process. Any opt-out system, particularly one with a lock-in, should explicitly permit opting out prior to the date of opt-out enrollment. Individuals who do not want to participate or who would not be appropriately served

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			by the Demonstration need to have that choice from the start and not be subjected to care disruption. Further, individuals already enrolled in PACE, although they should be permitted to join the Demonstration, but should not be included in any automatic opt-out enrollment. They should only be enrolled in an opt-in manner.
270	Page 26	Project Narrative - Section 5: Consumer Protections Section 5.5 Enrollment Process	The Applicant must: Explain how you envision enrollment starting in 2013 and being phased in over the course of the year. If you are seeking a passive enrollment approach with a voluntary opt-out, describe that process. If you are seeking an enrollment lock-in for as long as six months (requiring special Federal approval), then describe that process. Describe what your organization needs to know from DHCS about administrative and network issues that will need to be addressed before the pilot. Will the Plans be receiving one enrollment file for the Medi-Cal members and a second enrollment file for the Medicare members? How will the files be reconciled with the payments that will come from two different sources? Will the State consider enrolling the Medi-Cal beneficiaries as mandatory managed care members, with the ability to opt out of Medicare managed care? We recommend covering these beneficiaries, at the very least, under Medi-Cal managed care, even if they opt out of the SNP component.t programs begin enrollment.

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271	Page 26	Program Savings: "Vision for training"	To further expand on the success of the Demonstration, any cost savings achieved by the Demonstration should be reinvested back into those Medi-Cal programs and services that help people stay in their homes. We believe that investment in IHSS provider training and co-training with their clients can achieve additional savings over time. The PACE model is a shining example of how upfront investments, such as meals-on-wheels, can save money for a program in the long run.
272	Page 26	Monitoring and Evaluation	SB 208 requires the Demonstration to show IHSS usage before and after integration. In order to fully realize the true impact of this integration, Demonstration sites should go beyond this initial data collection and evaluate health outcomes and consumer and provider satisfaction in great detail.
273	Page 27	Appeals and Grievances - Section 5.7	We appreciate that Applicants will be required to comply with a uniform appeals and grievance procedure. As noted above, we have serious concerns that no specific work on design of an appeals system has begun, or at least has been shared with stakeholders. Designing a process that is both easy to navigate and incorporates all needed protections is a difficult and time-consuming task.
274	Page 27	Selection of Demonstration Sites - Project Narrative - Section 5: Consumer Protections - Section 5.7 Appeals and	Section 5.7: Appeals and Grievances Applicants must: Certify that your organization will be in compliance with the appeals and grievances processes described in the forthcoming Demonstration Proposal and Federal-State MOU. Please define processes in the Final RFS for *both* Beneficiaries and Providers. Please standardize the processes which are currently different for the Medicare and Medi-Cal programs. To facilitate acceptance by providers, we recommend that the process they are required to follow mirror one that they follow today.

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		Grievance	
275	Page 27	Operational Plan - Section 6.1	We ask for a requirement that the monthly reports of the Applicants be publically available so that there is accountability to all stakeholders. More broadly, as noted above, we have serious concerns about the timelines currently proposed by the Department in light of the many critical details that have not been worked out.
276	Page 27	Network Adequacy - Section 7	As noted above, we do not believe that Medicare standards for network adequacy are sufficient to meet the requirements of this high needs population. Provider networks in person-centered integrated models must be built around the needs of the enrollees, working to ensure access to existing providers. Plans should be required to offer open networks that allow access to all Medicare providers in the area. Applicants should also be asked how they will ensure that the network is adequate for the specific enrollees they have. What will they do to bring in existing providers for their members? With respect to Part D data, we do not understand to whom the formularies and drug event data will be submitted. Will CMS continue to review formularies? What about drugs covered by Medi-Cal and not Medicare? We also note that provider payment rates and terms have much to do with network adequacy. Although we recognize that specific rates cannot be set yet, Applicants should be required to describe the methodologies they plan to use (capitation, Medicare rates, extra payments for care coordination, etc.) to pay providers.
277	Page 27	Paragraph 1	C-SNPs and Institutional SNPs have dual eligible patients within their structures and to exclude them is to deny them participating in the Demonstration Project. Therefore C-SNPs and Institutional SNPs must be included

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278	Page 28	Enrollment Process - Section 5.5	Are there benchmarks for enrollment percentages?
279	Page 28	Transition and Discharge Planning Section 7.1	The Department and CMS should set rules plans must follow to ensure smooth transitions into plans by maintaining access to current providers and services, treatments and drug regimes. These protections should not exclude any types of providers; we have seen in the SPD enrollment transition, for example, that the exclusion of transition rights related to DME providers has caused hardship and disruption for beneficiaries. If a plan decides to terminate or reduce a service that was being provided to the individual prior to enrollment in the plan, the individual must retain the right to continue to receive those services during an appeal.
280	Page 28	Budget - Section 9	Examples of infrastructure support should also include capital investments and training to increase accessibility of network providers.
281	Page 28	Meaningful Stakeholder Input (Project Narrative Section 5.4)	Shield welcomes the opportunity to participate in meaningful stakeholder input. We hope the engagement plan will entail more than a single provider call or town hall meeting. Stakeholders want to know that their comments and feedback are taken seriously and that DHCS gives thoughtful consideration before taking action.
282	Page 28	Enrollment Process (Project Narrative Section 5.5)	The passive enrollment process outlined in the RFS will be problematic and confusing for many dual eligible seniors. There is nothing *passive* about being automatically enrolled into a new program. These individuals are used to self-directing their coverage choices as in the case of Medicare Advantage Plans. The prospect of a six-month enrollment lock-in period will be particularly restricting to this population.
283	Page 29	Network Adequacy	Asks that the applicant certify that the goals of the program will “not be weakened by sub-contract relationships of the Applicant”. As applicants may be insurance companies that are not direct service providers, they will certainly have to

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			subcontract in order to provide the necessary programs. Can DHCS please clarify the goal of this certification and more specifically outline what would constitute “weakening” of the program’s goals. Additionally, the RFS does not provide any information related to how these responses will be evaluated, by whom and what the scoring methodology will be. It would be helpful for Applicants to know what sections of this proposal carry more weight than others so they may focus their responses.
284	Page 30	Section 7.2 : Technology	In addition to the two current requirements of describing utilization of technology in providing care, the applicant must describe how the organization will use medication compliance to reduce unnecessary hospital and nursing home usage. Medication compliance includes the provision of in-home medication dispensing and reporting systems for beneficiaries at very high risk of nursing home admission due to medication noncompliance.
285	Page 36	IHSS - Section 2.2	To assure that people with dementia are identified, allotted appropriate in-home services, and cared for appropriately, it is necessary to add: "Training for care coordinators and for care providers in the unique presentation and needs of people with dementia and Alzheimer's disease." Otherwise, history shows that these patients will be under-recognized, misunderstood, and cared for poorly.
286	Page 36	Measurable Goals	2a. Describe the specific care management goals including: These goals must be stated in measurable terms that indicate how the plan will know whether the goals have been achieved. The care management goals should include at a minimum: • Improving access to essential services such as medical, mental health, and

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			social services; The bulleted goal should be revised to also reference substance use services.
287	Page 37	Coordination and Integration of Mental Health and Substance Use	In a program for duals, there is not only a need for a dedicated psychiatrist but for a psychiatrist with training in geriatric psychiatry. In California, people with Alzheimer's and most dementias are not cared for by County Mental Health systems. Their care has been "carved out." Therefore it is critical that the plans have geriatric psychiatry expertise to deal with the challenging behaviors seen in people with dementia such as hallucinations, delusions, paranoid ideation, agitation, insomnia, and so forth. These are the behaviors that frequently lead to expensive emergency room, hospitalization and nursing home use. In the sentence, "Describe how you will include consumers on local advisory committees to oversee the care coordination. Partnerships and progress toward integration", I would suggest that the wording be changed to state "consumers or their advocates." People with moderate to severe cognitive impairment will not be able to participate but their advocates (family caregivers or consumer advocacy groups like the Alzheimer's Association) can represent them.
288	Pages 38-43	Appendix C – SNP Model of Care	Model of Care. Applicants are asked to provide a “current SNP model of care, revised to reflect the Duals Demonstration.” Our D-SNP model of care already reflects the same duals population that is eligible under the demonstration. Our model of care is detailed and comprehensive – it is 300 pages. It took many hours of dedicated staff time to pass a rigorous CMS and NCQA approval process. Revising the model of care to meet an arbitrary 50 page limit would not be appropriate or practical.

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			We recommend that applicants include their current D-SNP model of care as an appendix to the application without page limit restrictions, revising it as necessary to reflect the Duals Demonstration. Provider Network. For the provider network description under the Model of Care (section 5), the language reflects the typical Medicaid/Medicare medical focus that omits other traditional behavioral health providers. This is a problem if the pilot is limited to this type of network, which we are not under current Medi-Cal.
289	Page 39	Consumer Choice - Section 5.1	I recommend that you make the following edit in order to be responsive to the consumer choice for people with dementia who cannot independently represent themselves. "Describe how beneficiaries *or their surrogates such as family caregivers for people with moderate to severe dementia* will be able to self-direct their care..."
290	Page 43	**Monitoring and Evaluation - Section 8**	Please consider adding a new bullet as follows: Describe your organization's capacity for reporting beneficiary outcomes by cognitive status (specifically, no cognitive impairment vs moderate to severe cognitive impairment). People with moderate to severe cognitive impairment are drivers of cost for Medicare and Medicaid. They cost Medicare 3 times more than other beneficiaries (Bynum et al, JAGS, 2004 - see attached). This is driven primarily by hospitalizations. They cost Medicaid 9 times more than other beneficiaries (Alzheimer's Association, 2009 AD Facts and Figures). This is driven by institutionalization. If we can measure outcomes for these beneficiaries, and if we can cut their hospitalizations and institutionalization, we can substantially save money.

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291	Page 44	Framework for Understanding Mental Health and Substance Use	Sentence in first paragraph: Patient-centered, coordinated care models should address the full continuum of services beneficiaries need, including medical care, mental illness and substance use services in a seamlessly coordinated manner. We recommend revising this sentence to include the text in bold below: Patient centered, coordinated care models should address the full continuum of services beneficiaries need, including medical care, mental illness and substance use services, **to include medication assisted treatment,** in a seamlessly coordinated manner. Sentence under item 4: For those with severe mental illness, that health home often will be located with a community mental health provider. We recommend revising this sentence to read: For those with severe mental illness and or a chronic substance use disorder that health home often will be located with a community a community-based organization that provides mental health and substance use disorder treatment.
292		General Questions	Under "Pharmacy benefits" it is stated that: *Demonstration Sites will be paid according to the regular Part D payment rules, with the exception that they will not have to submit a bid. The direct subsidy will be based on a standardized national Part D average bid amount. This national average will be risk adjusted according to the same rules that apply for all other Part D plans. CMS will provide additional guidance for plans in the Draft and Final Call letter for contract year (CY) 2013 in February and April 2012, respectively.* I am unclear as to where DHCS would be acquiring the figures for the national average, and is there an adjustment for the benchmark plans that might be substantially different?

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			Additionally, when folding the nursing facility patients into the demonstration project, is DHCS taking into account that with Part D the LTC pharmacies are reimbursed at a higher rate than the community pharmacies because of the specialized packaging for LTC patients, as well as the requirement to be available 24 hours in the event an emergent or urgent event occurs and a patient requires a stat order. It would be most helpful to understand how the benefit will be detailed prior to the Final Call Letter for the contract years.
293		General Questions	It is stated in Appendix F Framework for Understanding Mental Health and Substance Use: California's dual eligible population includes many individuals who need mental health services. This includes people with short-term needs and those with chronic needs who qualify for Medicare and Medi-Cal due to a psychiatric disability. Substance abuse frequently co-occurs among these individuals. Patient-centered, coordinated care models should address the full continuum of services beneficiaries need, including medical care, mental illness and substance use services in a seamlessly coordinated manner. Both in this appendix and elsewhere in describing requirements for benefits, network adequacy and care coordination there should be a reference to the model for care for those with psychiatric disabilities which is set forth in the Welfare and Institutions Code Adult System of Care (section 5800 and following sections especially section 5806.) Applicants must assure continuity of care through the same providers and those models of care for those currently served and include providers with that experience and that model within their networks either directly or through their contract with county mental health which currently funds these programs. Moreover, contracts must be written to integrate all of the funding for those programs which include non-medical supportive services necessary for recovery from a severe mental illness.

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			These services, which are not eligible for Medi-Cal or Medicare reimbursement, are funded through county mental health either directly operated or through a contract that also includes the Medi-Cal reimbursable services. The MOU with county mental health must include the means to include that funding and those services.
294		General Questions	There are two requirements in the Draft CA Dual Eligible Demonstration Request for Solutions that are problematic. 3.a. Two Plan Model Counties: At least one of the Applicants must operate a D-SNP in good standing with Medicare This requirement disadvantages Two Plan counties in which neither has a current SNP. Our company has participated for 28 years in Medicare Cost and managed a Dual SNP for 5 years until 1/1/12. Our company discontinued our SNP as of 1/1/12 due to CMS decreases in rates and the refusal to allow small plans the option to participate in the star ratings due to size. Our company more than meets the SNP requirements and with passive enrollment, membership size would no longer be a factor. We are willing to pursue a 3 way contract with CMS, DHCS and us, even if another organization is not. 4.a Two Plan Model Counties: For Applicants in Two Plan Model Counties, applications will only be considered if both plans submit an individual application. Our company has a long history of working with IHSS, ADHC, the Area Agency on Aging, and community agencies such as Meals on Wheels and has planned together with these entities to implement this Dual Pilot. This requirement in Two Plan Counties to force competitors to both participate in the

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			Dual Project, once again disadvantages our company and other Two Plan Counties where the LI has a lengthy history of collaboration with home and community service agencies and the indemnity plan has none. The real issue of patient choice is still one of allowing for a FFS option in a Two Plan County. Duals are not mandated into choosing this pilot. Passive enrollment with opt-out will still allow duals to remain on Medicare FFS and Medi-Cal FFS even if the indemnity provider does not choose to participate in this pilot.
295		General Questions	It is our strong position that compliance with the ADA and Section 504 of the Rehabilitation Act of 1973, requires more than qualification #9's requirement for contractual certification and "a plan to encourage" contracted providers to comply with federal federal law (and it should be noted that relevant state disability anti-discrimination law is also entirely applicable here). The 1115 waiver process included the development of physical access surveys for provider offices that plans were responsible for administering, and the information was to be made available to consumers via plan websites and documents. Such a basic requirement, and foundational consumer information, should also be required as an integral part of the duals implementation proposals, and the requirement for a programmatic survey and information (i.e., modifications to the policies, practices, and procedures in provider offices that are reasonably required as accommodations for a beneficiary's disabilities) on provider offices should also be included. While the narrative encompasses an element specific to "access" in section 5.2, a plan's provision for ensure accessibility in provider services must be included as part of section 7 and the idea of "network adequacy." A provider can be geographically available and accepting patients, but if s/he does not have an adjustable exam table or any clue as to how to provide effective communication, then that provider cannot really count as someone who makes the plan's network "adequate" for beneficiaries with various disabilities.

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			Similarly, section 8 on monitoring and evaluation must include provisions for tracking and reporting on how accessibility in provider networks is improved and how inaccessibility is redressed, or all the plans in the world will not result in constructive change for people with disabilities, including seniors who have increasing propensities for acquiring mobility and communication impairments. 2. I would suggest requiring more granularity in qualification requirement #11 and in Section 5.4 of the project narrative concerning stakeholder involvement. The non-homogenous nature of the dual population has been readily acknowledged, and certain sub-populations such as individuals with mental/behavioral health issues, Deaf individuals, and younger dual eligible with disabilities (e.g., <45 or 50) need to be explicitly included in the state's and plans' stakeholder processes.
296		General Questions	With regard to IHSS integration on p. 11 – where does accountability for IHSS services fall over the years? For example, as a demo site suggests expanding its role, will it acquire more accountability for IHSS services or will that accountability be immediately present?
297		General Questions	If Duals are transitioned into managed care, how will "Charpentier" rebilling be affected? We had a dual eligible who belonged to a Medi-Cal managed care plan. When we tried to submit a Charpentier TAR to Medi-Cal, the Medi-Cal TAR office denied our TAR stating that we must submit our TAR to the managed care plan. We then contacted the managed care plan and asked how we may submit a "Charpentier TAR." The health plan did not know what a "Charpentier" was and told us that we cannot get prior authorizations for a dual eligible – that we must bill Medicare first for denial. However, under the permanent injunction (Charpentier v. Belshé [Coye/Kizer]), providers were able to get prior authorizations for big ticket items under Medi-Cal.

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			Based on the above experience, we determined that Charpentier billing was not possible when dual eligibles belonged to managed care plans. However, at least dual eligibles were given the choice of whether to belong to a managed care plan or not. We are concerned that if all dual eligibles are transitioned into managed care, the permanent injunction (Charpentier v. Belshé [Coye/Kizer]) will no longer be available to duals and their providers. Will there be a mechanism in place that will preserve the permanent injunction (Charpentier v. Belshé [Coye/Kizer]) if duals are transitioned into managed care?
298		General Questions	Withdrawing from SNP Program. If selected as a pilot site, please confirm that pilot sites are required to withdraw their D-SNP plan from the SNP program as a condition of participation in the demonstration. We know DHCS and CMS' intent is not to make participation requirements prohibitive for Medi-Cal health plans with a SNP, as these plans are ideal partners for this demonstration because they already have experience with coordinating both Medicaid and Medicare benefits, financing and regulatory requirements. As a Medi-Cal managed care plan with an established (and successful) D-SNP, we have questions and concerns about this requirement. We welcome further discussion about possible solutions to address our questions and concerns. What happens after 3 years when the demonstration is over? There are no guarantees about what will happen beyond three years of the Duals Pilot, as SB 208 only authorizes the Duals Pilot for three years. If the Duals Pilot is not continued after the initial phase, we would have to re-enter the SNP market after a three-year absence. The MA marketplace is highly competitive. Without

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			safeguards in place, the Duals Pilot represents the possibility of our company having fewer SNP members in the future compared to our existing SNP membership. Could D-SNPs interested in participating as pilot sites receive protections to mitigate against a potentially unsuccessful pilot? For example, could pilot sites that have to exit the demonstration after three years be given the option of passive enrollment of pilot beneficiaries into the plan's new D-SNP? We are hearing mixed messages from CMS. At a November 15, 2011 meeting organized by the Association for Community Affiliated Plans (ACAP), CMS staff from the Division of Medicare Advantage responded to a question about potential plans leaving the SNP program to participate in a duals pilot by stating that their strong desire is for health plans to remain in the SNP program. It is unclear to our company whether CMS wants SNP plans serving duals to remain in the SNP program or leave to become a part of the duals pilot. Medicare Part C Risk Adjustment. The RFS provides no guidance on the expectation of pilot sites related to Part C, other than to state that pilot sites are responsible for the "full range of services currently covered by Medicare Parts C and D." Part D payments will be risk adjusted, but no information on whether Part C payments will be risk adjusted – and the associated risk adjustment methodology that will be used. Part C risk adjustment is absolutely critical, as pilot sites need protection against potential adverse selection due to the unknown mix of duals that will enroll in the pilot. Although the current Medicare Part C risk adjustment methodology is far from perfect, it is an established system that D-SNPs are familiar with and would be easy to implement for the demonstration. Also, the Part D risk adjustment methodology is much better at accounting for the costs of the senior population compared to the Medi-Cal risk adjustment methodology. Demonstration Population. The RFS clearly defines the eligible population as being Full Benefit dual eligibles who have Medicare Parts A, B and D coverage and Medi-Cal coverage for Medicare premiums, coinsurance,

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			copayments and deductibles as well as additional services that are covered by Medi-Cal that Medicare does not cover.
299		General Questions	However, the RFS does not address how the selected Plans will deal with lapses in Medi-Cal eligibility or barriers to full dual status, such as Medi-Cal Share of Cost, loss of or lack of Medicare Savings Program (e.g., QMB, SLMB, etc.) eligibility, failure to convert to Medicare entitlement. In our experience as a DE-SNP, these issues create significant barriers to a beneficiary's initial enrollment, continued eligibility, and continuity of care. We would like DHCS to consider critical elements that impact continuous dual eligible status as part of the Duals demonstration: Medi-Cal Eligibility The administration of Medi-Cal eligibility poses a significant obstacle to maintain continuity of care for dual eligibles. Unfortunately, beneficiaries and health plans like we have little to no control over the Medi-Cal eligibility process in California – as local county social services or in some cases, Social Security Administration (SSA), are administratively responsible for determining Medi-Cal eligibility. In our experience, the State and county social services are too narrowly focused on the Medi-Cal program without full understanding or responsibility for the experiences of dual eligibles. As a result, decisions are made that follow Medi-Cal rules but work against dual eligibles. The Duals demonstration can make great strides by reshaping the roles and responsibilities of Medi-Cal contracted entities, with respect to Medi-Cal eligibility and duals. For example, CMS allows a SNP up to six months of deemed continued eligibility if the beneficiary loses special needs status, such as loss of Medi-Cal eligibility. Our staff remains vigilant in monitoring changes to Medi-Cal eligibility, as we have found that many duals incorrectly lose their Medi-Cal eligibility, and thus lose their special needs status and their ability to remain enrolled in our D-SNP. This creates unnecessary confusion for duals and providers as well potential gaps in care as duals transition between managed care and fee-for-service Medicare. Local

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			county social services agency may be backlogged and a case may not be recertified within the six month timeframe. In instances where the Plan has information that indicates such a case would likely be recertified, we extend the deemed continued eligibility period because of the delay in administrative processing at the county social services agency. Unfortunately, because this falls out of the CMS six month window, CMS did send us a notice of noncompliance in June 2011. If our shared goals are to deliver high quality, seamless and cost effective care to duals, we recommend that DHCS and CMS allow pilot sites the flexibility to extend the deeming period beyond six months if it is shown that the beneficiary used due diligence to complete a timely Medi-Cal recertification but was delayed due to administrative processing or the beneficiary has good cause for not completing the recertification on time – such as hospitalization. We believe this meets the spirit of the requirements for Medi-Cal eligibility and special needs status. Medi-Cal Share of Cost California does not define Share of Cost (SOC) as Medi-Cal eligible until the beneficiary meets his/her SOC. This results in low-income/low-asset beneficiaries being barred from participation in a D-SNP unless they consistently meet their SOC. The SOC is analogous to a monthly deductible. It is difficult for Medicare beneficiaries to meet the monthly SOC because most qualified services are covered through Medicare, including medications and doctor visits. Beneficiaries have to specifically tell providers and pharmacies that they want to pay out of pocket for services in a given month in order to meet the SOC. Some beneficiaries purchase small vision and/or dental policies. A beneficiary who does not meet his/her SOC is at risk of being disenrolled from a D-SNP due to “loss of Special Needs Status” for over six (6) months. Local county social services are administratively responsible for determining Medi-Cal eligibility. We have found many instances in which the County Social Services Agency has incorrectly determined a cost sharing responsibility to a dual eligible. Beneficiaries should not be penalized for administrative errors made by

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			local social services agencies. The Medi-Cal Share of Cost is a barrier to coordination of Medicare and Medi-Cal benefits which is the very issue that this project is trying to overcome. The State should consider duals who have a Medi-Cal Share of Cost as part of the demonstration. Transition to Medicare Entitlement The Plan is aware when a Medi-Cal-only member turns age 65 and qualifies for the Plan's D-SNP through the CMS-approved seamless conversion process. However, Medi-Cal Plans do not know when Medi-Cal-only beneficiaries who are under age 65 and receiving RSDI (Retirement, Survivors, and Disability Insurance) and linked to Medicare due to disability have met their 24 month waiting period for Medicare. Therefore, the Plan cannot easily seamlessly enroll these beneficiaries into the D-SNP. The State would save money by rigorously working to transition Medi-Cal-only beneficiaries who have met the 24 month waiting period to dual eligible status. A focus of the demonstration should be to identify and outreach to this population. In addition, there are beneficiaries who receive Medicare Part B only benefits and Medi-Cal but do not qualify for free Medicare Part A. It is up to these beneficiaries to apply for the Qualified Medicare Beneficiary (QMB) program to pay for Part A. However, the QMB process is unduly complicated and is not automatic. The beneficiary must first complete an application for QMB during the annual open enrollment period from January through March; the application must be approved by SSA (Z99); and the local social services agency must process the QMB eligibility. The local social services agency may not prioritize these applications so that the 7/1 deadline is missed. DHCS should consider buying Part A for all potential duals to transition financial responsibility from Medi-Cal to Medicare. Access to Up-to-Date Medi-Cal Eligibility Information and Medicare Status The Medi-Cal Eligibility Data System (MEDS) is the repository of Medi-Cal eligibility information. Enrollment/eligibility data is entered into MEDS by the County Human Services Agency and Social Security Administration. All COHS plans currently have MEDS access. Through MEDS, we have access to the most up-to-date and complete Medi-

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			Cal eligibility information available. However, in a letter dated 7/13/2011, DHCS informed COHS Plans that MEDS access will be terminated in 9/2012. The rationale being that MEDS contains Social Security and related information which the HIPAA Compliance Officer has determined is unsuitable for Plans to access. The State did not justify this action by citing any breech in confidentiality or any beneficiary complaint about Medi-Cal managed care plans having access to this information. Access to MEDS is critical to our daily operations, particularly given the backlog at the county social services agency and the amount of relevant information that is only available through MEDS. This includes information regarding Medi-Cal termination and applications status, as well as Beneficiary Data Exchange information (BENDEX) between public assistance case files and Social Security records. We use the SSI and Medicare-related information to administer long-term care benefits as well as the D-SNP. BENDEX information is useful to determine if a beneficiary has conditional Part A entitlement through QMB and/or should be eligible for Medicare benefits or other Medi-Cal non-Share of Cost programs such as PICKLE (for SSI beneficiaries who are in danger of losing no Share of Cost Medi-Cal due to the annual SSA living allowance), DAC (Disabled Adult Child), QDW (Qualified Disabled Widow) or the 250% Working Disabled Program. Community stakeholders and advocates have become increasingly reliant on our staff to assist in resolving Medi-Cal eligibility issues which impact their clients' continued access to health care. The Plan is seen as the entity which can view the beneficiary holistically to assure access to quality care. We appreciate the State's efforts to work with the COHS Plans to develop a MEDS-lite alternative but the data available in MEDS-lite will not include critical information, specifically from BENDEX. When we're communicating these issues related to the administration of our D-SNP, the DHCS staff did not feel it necessary to consider other options because D-SNP eligibility is not part of the Plan's Medi-Cal contract with the State. This view is counter to the intent and goals of the Dual Eligibles

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			demonstration. Our continued access to MEDS must be a condition of participation in the Dual Eligibles Demonstration Project if we are to assure that dual eligibles remain continuously enrolled in the program without breaks due to unnecessary loss of Medicare and/or Medi-Cal status.
300		General Questions	Care management: Encourage care management plans to identify individuals who have an adequate system of care in-place and to allow them to maintain the respective care plan with no change, or incremental /evolving change that is designed to improve care and outcomes. This would act as one of the stratification levels and support consumer directed care – and address beneficiaries concerns about change from managed care if they have established a well-working care model for themselves. Care management resources would focus on individuals who needed more care coordination support.
301		General Questions	Rates: Implement rates with a multiyear method that targets more cost savings in later years. Use the early years to establish complete and accurate baseline amounts with minimal managed care savings and/or shared risk corridors. Increase the savings target over time. It will allow more time and claims experience to capture the full scope of services (some may be unusual) in one place. This will allow better continuity of care, more careful implementation of managed care interventions, and help mitigate against pent-up demand that may arise when coordinated care is implemented and identifies needs for additional preventive care services in the short term to stabilized health conditions.
302		General Questions	Rates: Require providers who are not in a health plan's contracted network (non-par providers) to accept the state Medicaid or federal Medicare standard fee schedule when they serve qualified enrollees. This will support increased access and continuity of care.

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303		General Questions	Qualified plans: Suggest revising the qualification requirements to allow more plans with LTSS and D-SNP expertise to participate in the demonstration. The current qualifications of a current Medi Cal plan and current D-SNP plan are very constraining and will severely limit who can apply. Perhaps, allow plans who have proven capabilities in other markets but do not meet the local requirements to be able to apply for the demonstration while also applying for a D-SNP and/or arrangements for them to obtain a special Medi Call contract to support this demonstration. I understand that the target start date for the program is January 2013 and you may additionally encourage and support qualified local plans to partner with other plans or companies who have D-SNP and/or LTSS qualifications and capabilities.
304		General Questions	Page limits: The 50 page limit is a big challenge for a program of this scope and complexity, and may adversely impact the ability to present a proposal that meets all the requirements for individuals in this market segment. This will in-turn limit the ability of the state to obtain complete plans and hold contractors accountable for proposed services. I understand the limit but suggest increasing it to 100 pages. If under Appendix D beneficiaries have control and choice then allow beneficiaries to hire and fire their own attendants. After all, we know our needs best. Some people with disabilities due to their disability, might need help making the decision on who to hire and fire but nonetheless if they are mentally capable of making a decision about their lives, the person with a disability should be brought in to the decision-making process as much as possible. 3. Keep the public authority system throughout the state passed year 2013. The public authority system is the first phone call IHSS consumers/providers call to solve

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			problems. The system works. DHS/CMS should think very carefully before they disassemble the public authority (statewide) after 2013 a system that work 4. What happens if my attendant does not show up to assist me? Solution: There needs to be an emergency services component for when attendants are sick or do not come to work. This should be statewide not just County to County. Having appropriate attendant care matters because people with disabilities can easily be stuck in their homes with an inability to move or go outside and live independently as one may wish without the appropriate attendant care. If there is not an appropriate emergency system in place when an attendant needs time off people with disabilities and seniors will get stuck in their homes and their health will become endangered. An emergency system of care or respite may seem like a lot of money but in the end it will save money. If an emergency or respite system is not put in place what are beneficiaries of IHSS supposed to do with their attendants do not show up to assist them? Are beneficiaries just supposed to arrange their own backup care? A responsive appeal process – The state has a responsive appeal process for programs such as IHSS, food stamps, and other state programs as well. Solution: keep the state appeal process. It works. The state process could be expanded for Medi-Cal and Medicare benefits. Nonetheless don't destroy a process that works. MEDI-CAL/MEDICARE ISSUSES Most of my doctors do not take Medi-Cal due to the low reimbursement rates. Solution: Either increase the reimbursement rates or allow me to continue going to my current doctors without any disruption.

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			Medicare covers chiropractic care. Some people think this is an alternative type of care. For people with disabilities and seniors such therapies as chiropractic care and acupuncture assist in pain relief. I hope chiropractic care is still covered under Medicare because alternative therapies are very important to maintaining good health. A responsive appeal process – The state has a responsive appeal process for programs such as IHSS, food stamps, and other state programs as well. Solution: keep the state appeal process. It works. The state process could be expanded for Medi-Cal and Medicare benefits. Nonetheless don't destroy a process that works. In terms of medication, there should be an appeal process for medications we so desperately need? A TAR, for example? For people who need DME (Durable Medical Equipment) currently in California people with disabilities are able to get new wheelchairs every five years. This is because shares start to fall apart and breakdown after five years and repair costs outweigh the costs of getting a new chair. People with disabilities and seniors still need to be able to get quality wheelchairs that meet their needs medically and physically every five years this policy should not change.
305		General Questions	Demonstration Goals SB 208 Goals*:* Coordinating benefits and access to care, improving continuity of care and services. Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services and supports in lieu of institutional care. Increasing availability and access to home- and community-based alternatives. Our company supports the Demonstration's goals as articulated in SB 208. These objectives reflect our guiding mission since our founding over 30 years ago to provide the care and supports necessary to enable our members to continue to live

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			independently and within the community as long as possible. Other DHCS Suggested Demonstration Goals: *1. Preserve and enhance the ability for consumers to self-direct their care and receive high quality care.* *2. Improve health processes and satisfaction with care.* *3. Improve coordination of care.* *4. Improve timely access to care.* *5. Optimize the use of Medicare, Medi-Cal and other State/County resources.* We agree with these additional Demonstration goals, with the following clarification: while self-direction is effective and appropriate for the vast majority of dual eligibles, individuals who lack the capacity to manage their care must have the ability to delegate that responsibility to a care management team or to an appropriate surrogate. Whether or not an enrollee is capable of self-direction, he or she is entitled to coordinated, high-quality care. It is important that the State establish evidence-based definitions and measurements to ensure the delivery of this high quality care. All too frequently, anecdotal information becomes a surrogate for quality care expectations and the impact can be detrimental to this vulnerable population.
306		General Questions	Demonstration Population Allowing for Potential Carve Outs of Specified Services. Our company believes that all chronic care patients can benefit significantly from patient-centered care management. Carve-outs for particular disease states should be limited. The RFS draft asks specifically for comments about excluding the following groups from the Demonstration: End-Stage Renal Disease, HIV / AIDS, dual eligibles institutionalized for over 90 days, and developmental services. While these are more discreet and intense conditions which require specialized attention, SCAN's

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			experience is that they can benefit from integrated and coordinated care services.
307		General Questions	Demonstration Population End-Stage Renal Disease (ESRD) Carve Out. Our company has operated a successful ESRD Medicare managed care demonstration for five years, providing coordinated, integrated services (including intensive case management) to about 600 beneficiaries with ESRD. (Approximately 80% are dually eligible.) Our ESRD Program has consistently achieved a high level of member satisfaction, and has exceeded quality metrics set at FFS benchmarks. Members receive specialized treatment and monitoring, and their health status has proven to benefit greatly from the specialized care coordination and integration of the medical services.
308		General Questions	Demonstration Population Developmental Services carve out. We believe that it is appropriate to carve out the care centers initially. As with the other suggested carve out services on this list, specialized managed care plans should be developed to eventually eliminate the carve out of the Regional Centers and allow for more fully integrated care delivery to dually eligible developmentally disabled beneficiaries.
309		General Questions	Demonstration Population Carve Out of Dually Eligible Beneficiaries Institutionalized for Over 90 Days. Our experience managing the care of dual eligibles suggests that those duals who have been institutionalized for longer than 90 days will still benefit from the patient-centered care management model created through the Demonstration. Certain of these individuals, many of whom have complex physical and functional needs, may be able to transition into the community with the right supports. This will not only fulfill their personal preferences, but also curb the State's costs to provide support. This recommendation also aligns with the Olmstead decision, which requires states to have in place a working plan to provide opportunities that allow individuals to live in the least restrictive setting.

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310		General Questions	Enrollment Phase in and readiness for October 1, 2012 Annual Enrollment. Our company supports the Department's proposal to phase in enrollment of dual eligible beneficiaries over the first year of the Demonstration, on the basis of the beneficiary's birth month. However, we recommend that the timing for the initial introduction of an annual enrollment period be delayed until October 2013 to ensure that plans will be able to dedicate the resources necessary to properly develop explanatory materials for this complex new product and to design the new product in a manner that effectively integrates with the plans' current Medicare products. A critical part of success will be the education and acceptance of the program by the beneficiaries and their caregivers. This includes understanding all options, including how they can transition to the new model with minimal disruption and maximum continuation of their primary providers.
311		General Questions	Enrollment PACE and Other Current Fully Integrated D-SNPs. The PACE program has extensive experience offering a full continuum of medical, behavioral, social, and long-term care services on a capitated, full-risk basis to dual eligibles approved for a nursing facility level of care. We are a fully integrated D-SNP which also offers this full continuum of services but does so on a non-facility based, county-wide network basis, as envisioned by the Department's proposal. Any fully integrated D-SNP or PACE currently operating in California should be allowed to continue to provide these important services to beneficiaries, independent of the Demonstration. These plans (including ours) could serve as a benchmark against which the State can evaluate the efficacy of dual demonstration sites in the areas of cost, quality, and member satisfaction. Currently, we have over 8000 dual eligible members in its D-SNPs and the PACE programs have only 2,200 in multiple CA locations. These successful programs should be allowed to continue and grow, as an alternative to the Demonstration, to the benefit of both models.

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312		General Questions	Integrated Financing Risk Adjustment of Payment. To avoid problems relating to adverse selection and risk avoidance, CMS currently adjusts its payments to Medicare Advantage (MA) plans and D-SNPs based on the level of risk borne by each plan in relation to its enrolled population. This structure of plan payment should be replicated within the pilot demonstration. Incenting plans to accept and to manage the care of high-cost individuals with complex health conditions is paramount to plans' ability to deliver patient-centered, high-quality care to this population. We currently accept risk for providing care to medically fragile populations in California, and would require an appropriate capitated rate to provide a comprehensive set of services for this medically complex population. Providing appropriate care and access to services requires that the reimbursement rate reflect the intensity and quality of services for individuals with extensive medical conditions. The rates developed for the pilots must be transparent and accurately reflect the historical cost of institutional and non-institutional care required by the dual population. They should be actuarially sound, and each participating plan/pilot must have adequate time to review the rates and if necessary, request modifications. The successful contracting entities, with an adequate capitated rate, should be expected to align incentives with contracting providers and make value-based purchasing decisions that improve the quality of care for the dual eligible population.
313		General Questions	Integrated Financing Supplementary Benefits. The RFS cites the importance of supplementary benefits within the context of the demonstration plan model. We have a long and successful history of offering supplementary benefits through community vendors to our most vulnerable members. These services include home delivered meals, transportation, and home safety improvements. Our experience has shown that providing these benefits enables our most at-risk members to continue to live safely in their homes, avoiding institutionalization and unnecessary hospital admissions. Our fully integrated D-SNP offers a comprehensive benefit package that encompasses primary, acute, behavioral health, and long term services

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			and supports. In addition, comprehensive home and community-based services (HCBS) enable individuals to remain or return to their homes or setting of choice safely. Such benefits support independence, but also help prevent declines in health status and hospitalizations. They also play an important role in avoiding nursing home stays that can easily become much more costly than the provision of the HCBS themselves. The long-term supports and services must address the needs of beneficiaries across the continuum of care and emphasize patient-centeredness, hands-on care coordination, linkages between primary care and other clinical, behavioral, and supportive services with an emphasis on home and community-based services rather than institutional care. To allow for the greatest degree of patient independence, these services must include, at a minimum: Attendant care Home-delivered meals Home health services Home/domestic assistance Personal care Respite care Home modifications Support in navigating health care and community resources (e.g., assistance with scheduling appointments, arranging for prescriptions, transportation, or durable medical equipment) we applaud the flexibility granted by the State to plans within the Demonstration to offer supplementary benefits. Historically, it hasn't always been clear that plans had the flexibility to provide all the benefits necessary to accomplish the desired objective of maximizing patient independence. We and any other plans' ability to offer these supplementary benefits depend upon a known and predictable funding stream for the most at-risk members. To continue to make these benefits available to the beneficiaries who need them, we and other potential Demonstration participants would require the necessary funding information in advance of the 2013 plan development process. There is currently no mention in the timelines or the RFS indicating when the rate information will be available to plans. This should be clarified as soon as possible and in any event

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			before the RFS is finalized.
314		General Questions	Integrated Financing Need for earlier plan payment information than in the draft RFS. The draft RFS does not include in its timeline when plan rate information will become available this year. State representatives at stakeholder meetings have indicated that rate information will be revealed very late in the Dual Demonstration Development process. Currently, Dual Special Needs Plans develop their plan benefits using current rates from Medicare and Medicaid as a proxy for the following year's rate and adjust if necessary when the final rates are announced in June. However, the Draft RFS indicates that the payment scheme will be completely different from the Medicare Advantage calculation. To the extent that the new payment model significantly differs from that historically used by D-SNPs, it is likely that plans will be required to enter into new contracts with physicians, hospitals, nursing facilities, and other providers within their existing network. We are concerned that the timeline contemplated by the draft RFS will not allow plans adequate time to develop benefit packages and publish the beneficiary notice material that must be reviewed and approved by CMS prior to the October 1, 2012 publishing date. To enable plans to make benefit determinations in a timely manner, site payment arrangements should be clearly determined and articulated to Demonstration participants as early in the application process as possible. This is especially important in the context of enhanced benefits that plans seek to offer to individuals at risk of institutionalization. Many of these benefits are non-mandated and must be financed out of available capitation funds. Development of and commitment to these ancillary benefits by Demonstration participants will require a predictable level of funding.
315		General Questions	Integrated Financing Quality Incentives. To encourage continuous improvements in quality within MA plans and D-SNPs, CMS provides enhanced payments to plans

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			that reach established quality benchmarks via its Star Rating System. In our experience, aligned incentives shared with provider groups provide a higher level of quality of care for beneficiaries. Structuring provider payment for patient care on a performance-based reimbursement system such as CMS' Star Rating System aligns financial incentives with quality improvement. We encourage the Department to include a similar system within the pilot demonstration. The Demonstration should include innovative rate structures that provide incentives for quality outcomes and cost efficiency. These could include, but would not necessarily have to be limited to, bonuses for reaching specific quality benchmarks or certain levels of savings.
316		General Questions	Qualification Requirements**.** We would maintain that any pilot program require a contracting entity to include at least the following types of providers in their network: Hospitals University Medical Centers Pharmacies Durable medical equipment and other ancillary providers and services Home and community-based care providers and services Skilled nursing facilities and other long-term care providers and services End-of-Life, palliative care and hospice services Home Health Agencies Regional Centers (for services for the developmentally disabled) In light of the Governor's budget, we applaud the intent to move all dual eligibles to managed care models but cautions that attention be paid to network capacity and impact on the other populations (commercial, Medicare Advantage, Medicare FFS, MediCal, CalPERS) served by the current network. We recommend expanding to additional plans, and by extension, many additional providers, in the counties selected for the pilot to absorb this additional population. This will also insure greater patient access and choice. Also, importantly, given the prevalence of mental/cognitive diseases and conditions among dual eligibles, contractors participating in the pilot program should also demonstrate how they will manage these conditions in a medical home environment. Providers must recognize that behavioral health services can vary greatly depending on the age and diagnosis of the individual and must not have a one size fits all model. This will require

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			additional behavioral health services that coordinate with the patient's primary care medical home and serve as an active participant of the multi-disciplinary team. The behavioral health interdisciplinary team should be comprised of a pharmacist, licensed behavioral health providers such as Licensed Clinical Social Workers (LCSW), Marriage/Family Therapists (MFT) or psychologists, registered nurses, social workers and care coordinators. For behavioral health services that are not delivered at the patient's primary care location, alternative treatment sites must meet the beneficiary's medical, psychological and functional status needs and preferences and may include a medical office where medical and psychiatric care are co-located, or in the member's home (includes a nursing home, assisted living facility, private residence or telephonically). The pilots should provide a range of culturally- and linguistically-appropriate management programs specifically designed to enhance the beneficiary's behavior and appropriate use of services using: Care management programs that include behavioral health care coordination, dementia case management, in-person and/or telephonic case management services, medication therapy management, skilled nursing facility case management and inpatient complex care management. Collaboration with other community and state agencies such as state Regional Centers for the care of individuals with developmental disabilities to avoid duplication of case coordination activity, coordinate benefits and ensure access in a timely manner. Care transitions including reconciliation of medication regimens across care settings, physician follow-up after hospital discharge, and teaching home caregivers about warning signs and care plans. Disease management programs specific to the needs of the individual patient such as diabetes, behavioral health, congestive heart failure and chronic obstructive pulmonary disease. Whenever possible, a disease management program should provide an educational pathway or protocol focused on the disease state, including disease process and management, recognizing disease-specific symptoms and actions to take, when to call the doctor or seek urgent/emergent care, medication management, nutrition, self-management and healthy behaviors. Consumer and

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			caregiver engagement
317		General Questions	Care Coordination and Risk identification. We recommend that all members be evaluated using a risk identification process and that individualized required care plans and follow-up be developed based on the results of that process. Requiring that all members have intensive care plans and care management will create unnecessary expense and interference in the beneficiaries' lives. Many dual eligible seniors are actually quite healthy and live a long and normal life with no need for these services. The plan needs to ensure that beneficiaries have a process in place to identify when a care plan is needed or to respond to the member as and when the member feels the need for such intervention/services.
318		General Questions	NCQA Accreditation. We applaud the states position that requires plans to have outside quality certifications. NCQA does separate requirements for commercial, Medicaid and Medicare plans. The most significant standards of quality for duals are around the Medicare process and it should not be assumed that commercial or Medicaid accreditation means that quality standards will be met on the duals population. It can easily take 3 years or more for a plan to change the processes and measurement to reach accreditation, so the requirement should be extended. The NCQA certification for the SNP MOC, however, can be reached in 1 year and should be required at the end of the first year of the pilot.
319		General Questions	Frameworks. We commented extensively, and positively, in October regarding the three frameworks on consumer protections, long-term care coordination, and mental health and substance use. We attach those comments as an appendix. I wanted to point out that in this section of the document below, it mentions for beneficiaries to partner with local Aging and Disability Resource Center (ADRC) which is great, but I would like to state that Independent Living Centers (ILC) are also capable of providing these services; to help beneficiaries in connecting to community social support programs.

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			Therefore, I must insist that ILC's be included and listed as a resource for this Dual Demonstration Project. Our job as an ILC is to be a resource for people with disabilities to help them get connected to these supports and help them live in their own homes and in the community and must be included as a resource for the beneficiaries of this demonstration.
320		General Questions	Section 2.3: Social Support Coordination. Applicants must: Describe how you will assess and assist beneficiaries in connecting to community social support programs (such as Meals on Wheels, CalFresh, and others) that support living in the home and in the community. Certify that you will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics. Describe how you would partner with the local Aging and Disability Resource Center (ADRC), or how the Application demonstrates capacity to establish an ADRC or ADRC-type model that operates multi---disciplinary care teams capable of meeting the full range of a beneficiary's needs.
321		General Questions	Active and Informed Choice Is a Must. Our main concern is with Section 5.5 of the Project Narrative under Enrollment Process. It appears that DHCS will allow sites to passively enroll duals into the pilot program, to which we object. Instead, we encourage an active enrollment, or an "opt-in", for beneficiaries who choose to enroll in the pilot program. It also appears that DHCS will allow for pilot programs to lock beneficiaries into enrollment or a health plan for as long as six months, to which we also object. In evaluating other managed care transitions, we have seen too many cases where persons with complex health needs were enrolled in a health plan to which their existing provider (or many times, multiple providers) did not belong. Locking beneficiaries into plans would further exacerbate this problem. Frequently these patients had standing prescriptions, appointments, and diagnoses that their previous provider had approved, but that their new health plan did not. These beneficiaries

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			reported that obtaining either continuity of care exemptions or Medical Exemption Requests was extremely difficult and forced them to delay or forgo care. We are extremely concerned that such cases will repeat themselves should the state attempt to pilot these projects too quickly. As such, beneficiaries should have the choice to enroll in a pilot health plan and be able to change plans as often as they need so as to avoid confusion and keep access to their trusted providers.
322		General Questions	Due Process and Consumer Protections. Medi-Cal beneficiaries currently have a strong protections process in place when they cannot get a treatment or medication they need, they are dissatisfied with the care they receive or how they are treated by the medical provider, cannot get a doctor's appointment or referral when they need it, or if they receive a bill for which the plan should properly pay. Medi-Cal managed care beneficiaries in a health plan have the right to file a complaint with their health plan and can ask for an Independent Medical Review (IMR), which has timelines in place to ensure that beneficiaries are treated fairly in a timely manner so that care is not delayed. Medi-Cal beneficiaries in any delivery system of care also have the right to file a Medi-Cal state hearing. The hearing and appeals process in Medicare is quite different from that in Medi-Cal, and consumer safeguards that establish a clear process incorporating the Medi-Cal appeals and due processes must be in place prior to establishing any pilot programs. We concur with the comments of the National Senior Citizens Law Center that DHCS and CMS develop a uniform process so that beneficiaries will not be required to undergo different processes when attempting to remedy situations in regards to their right to obtain health care.
323		General Questions	Start Slowly, Learn from Experience. Transitioning even four pilot counties will be a large change for DHCS, counties, health plans, and most importantly to the beneficiaries involved.

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			We ask that Department commit to keeping the pilot to four counties and that evaluations and stakeholder input be taken into account prior to transitioning any more beneficiaries. We understand that the Governor's 2012-13 budget proposal includes what will ultimately be a full transition for all 1.2 million duals in California. We ask that the selection of pilot sites stay autonomous from budget negotiations and that DHCS fully commit to the successful implementation of four pilot counties prior to selecting more sites.
324		General Questions	Demonstration Population: In response to the questions posed by the DHCS in the RFS, we believe that our members would be best served if the Demonstration applied to the most inclusive population possible. High need and high risk members, such as those with HIV/AIDS or ESRD, are also those who may benefit most from a coordinated care approach. In the counties with County Organized Health System (COHS) plans such as ours, all duals, including those members with HIV/AIDS and ESRD are enrolled in the plan for Medi-Cal services. Medicare Advantage plans can receive waivers to enroll ESRD patients. These are models of coordinated care for these high need members that can be improved with an integrated model.
325		General Questions	Scope and management of benefits**.** We commend DHCS for the comprehensive benefit set envisioned for the Demonstration. While we understand and agree with the phased-in approach to the long term care support services, we are concerned that plans are being asked to assume financial risk for benefits such as In Home Supportive Services (IHSS) without the ability to actually manage them. For plans to be financially at risk for any benefit, they must assume administrative and/or utilization management responsibilities for that benefit. This is critical to the success of this Demonstration. We look forward to working closely with DHCS and other stakeholders to develop an appropriate approach to phasing in these responsibilities in a way that will ensure continued and quality care for duals. As we develop our response to the forthcoming RFS, we request clarification on the following issues: As part of the proposed FY 2013 state budget, the State intends to transition long

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			term care (LTC) support services, including IHSS, to Medi-Cal managed care. As the only Medi-Cal provider in their counties, COHS will be responsible for LTC support services for all Medi-Cal members, including those duals participating in the pilots and those that opt out. • Will COHS be required to offer a distinct Medi-Cal product for participants in the Demonstration? • Will this include unique member identification and enrollment processes? Another key component of the Demonstration, as discussed in the RFS, is the provision of supplemental services. The State clearly recognizes the importance of permitting pilot sites the flexibility to offer services that will best meet the needs of its participants. Flexibility in the provision and administration of benefits will be an important component of the Demonstration. We request that the State ensure that pilot sites are afforded the necessary flexibility to work with local stakeholders and, with local support, develop administrative and/or contracting arrangements that will best meet the needs of that community and its providers. Examples of where this flexibility will be critical include; the IHSS program, MSSP, assisted living, and the provision of behavioral health services and services provided in institutions for mental disease (IMDs).
326		General Questions	Rate development. We recognize that the rate development process is in its early stages and DHCS has many important variables to consider. We look forward to working closely with you and your staff to support these efforts and respectfully request that DHCS continue to maintain an open and transparent rate development process. As stated by DHCS in the RFS, duals are among the highest need users of health care services. Given Medi-Cal managed care plans lack of clinical experience with these beneficiaries, particularly for Medicare services, additional data from the Centers for Medicare & Medicaid Services (CMS) and the State will be critical to

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			developing an informed response to the RFS. We appreciate DHCS' willingness to work with potential applicants seeking additional Medicare and Medi-Cal data. As we develop our response to the forthcoming RFS, we request clarification on the following issues: *Rate setting:* • How will be IHSS and/or BH be reflected in the integrated rates? Is the State proposing a phased-in approach? • Will the LTC facility payment be integrated into the blended capitation rate or remain as a pass-through payment? • How will the provision of supplemental benefits be reflected in the integrated capitation rate? • How does the State plan to calculate anticipated savings: using reduced administrative and/or medical expenses? We reiterate the importance of ensuring that pilot sites not be at financial risk for benefits over which they have no administrative responsibility. We recommend that payments for these services be structured as pass-through payments until plans assume some level of administrative responsibility. *Risk adjustment* Recognizing Medi-Cal managed care's limited experience providing comprehensive services to duals, we strongly encourage the State to develop a risk adjustment approach that mirrors Medicare's hierarchical condition categories (HCC) risk adjustment model or the Program of All Inclusive Care for the Elderly (PACE)

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			risk adjustment model. This will account for the unique and complex needs of this population and ensure that pilot sites are able to gain needed clinical experience to improve care management. Additionally, we understand that there are many outstanding questions related to how currently institutionalized beneficiaries will be integrated into the Demonstration. We recognize the importance of having a care transition plan available for those members that are able and willing to transfer back into the community; however, we do not believe that it is feasible for the State to anticipate any savings from these care transitions until we have established a baseline of experience. *Risk protection* For reasons identified above, participating plans will need risk protection in the early years of the Demonstration. We encourage the State to provide risk protection to participating plans through risk corridors. We believe that, particularly in the early years of the Demonstration, savings should not be assumed until the pilot site has gained adequate experience to project savings. Maintaining current funding levels and permitting plans to reinvest savings into the program will establish a clear baseline for future rate setting and allow both the State and plans to realize long term savings. • What opportunities for shared savings are there for potential pilot sites? • Would the State be willing to consider an approach where savings are anticipated and actual savings are shared at the end of the demonstration year rather than from the outset?
327		General Questions	Operation of D-SNPs. Under a passive enrollment model, all duals will be enrolled with the pilot site. This model raises many questions for the D-SNPs operated by the pilot sites and the other D-SNPs competing in the same geographic area. As we develop our response to the forthcoming RFS, we request clarification on the following issues:

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			• Will D-SNPs continue to be operational in the pilot counties? Will participating duals be rolled into the pilot site's D-SNP? • Will the enrollees of the D-SNP be rolled into the Demonstration? • If CMS/DHCS intends to enroll all duals into the Demonstration in a pilot county, what will be the process to phase out the D-SNPs operating in that county? When will those SNPs receive notice? What will the impact be on those D-SNPs that have already submitted bids for 2013? • Will CMS/DHCS consider excluding duals currently enrolled in a SNP from the passive enrollment process? We respectfully request that DHCS consider a phase-out of D-SNPs in pilot counties. This approach will allow for continuity of care and a smooth transition into the new integrated service delivery model for duals. We propose that in Phase I of the Demonstration, all current SNPs will be maintained with the pilot site coordinating care in connection with these SNPs. In Phase 2, we would propose a gradual "rolling in" of D-SNP members into the pilot, using a collaborative stakeholder process to establish criteria for how duals will be transitioned. Additionally, DHCS has proposed an aggressive timeline for National Committee for Quality Assurance (NCQA) accreditation by pilot sites. While we support the State's effort to ensure the highest quality of care and are in the process of achieving NCQA accreditation, we recommend that the State consider allowing plans that have met the strict quality requirements of becoming a D-SNP to be given additional time to secure NQCA accreditation.

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328		General Questions	Demonstration Population. The demonstration project should include individuals who have HIV/AIDS, End-Stage Renal Disease (ESRD), Amyotrophic Lateral Sclerosis (ALS), and individuals who have been institutionalized for more than 90 days, but only if participation for these individuals is purely voluntary. Because of the complexity of these situations, individuals who have one of these listed conditions or who are institutionalized should be not be locked into a demonstration project for any period of time or passively enrolled into the Demonstration. While we oppose both passive enrollment and a lock in period for all dual eligibles, we would suggest that if these models are adopted, that duals with any of these listed conditions or who are institutionalized for more than 90 days be exempted from passive enrollment and any lock-in period. Instead we suggest they be offered the opportunity to voluntarily opt in to the Demonstration.
329		General Questions	Enrollment. We support a voluntary/“opt-in” enrollment model rather than a passive enrollment/“opt-out” model for the Demonstration sites. This allows beneficiaries to preserve the right to choose their providers and the manner in which they receive care. It also allows dual eligibles who have complex medical conditions to access providers they may not be able to under an integrated care model. In addition, given the mental health, cognitive health, literacy, and language access issues many dual eligibles face, an “opt-out” model may prove to be too difficult for them to navigate. Based on CHCR’s experience with Medicare Part D and dual eligibles, which is essentially an “out-out” model, we find that duals undergo a very difficult transition from Medi-Cal drug coverage to Part D coverage. Many duals who are auto-assigned to a Part D plan do not realize there has been change in their drug coverage and that they have been autoassigned to a Part D plan, and do not understand how to obtain drug coverage through their auto-assigned drug plan. In addition, many dual eligibles remain in auto-assigned plans that do not cover all their medications even though they are experiencing drug access issues because they do not understand how to change plans, and are only able to do so with outside assistance. We have also

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			seen numerous issues with the transition to mandatory managed care enrollment for Seniors and Persons with Disabilities (SPD) which uses a model that defaults SPDs into Medi-Cal managed care plans if they do not select a plan on their own. We have encountered numerous SPD beneficiaries who experience serious continuity of care issues because they have been defaulted into a plan they know little about. We anticipate that if a passive enrollment model is adopted for the demonstration that many dual eligibles will face similar problems. Overall, passive enrollment models are too significant a change to be imposed on a large scale. If passive enrollment models are adopted, they should only be adopted after a phased-in process which results in quantifiable improvements to integrated and coordinated care for dual eligibles. We also oppose any type of enrollment lock-in for duals in the Demonstration. Lock-in prevents beneficiaries from exercising the right to choose their providers and the manner in which they receive their health care. Imposing a lock-in period would also treat dual eligibles in the Demonstration differently than other dual eligibles who are entitled to a continuous Medicare Part D Special Enrollment Period (SEP) that provides them with the ability to change their Medicare Part D enrollment on a monthly basis. Dual eligibles enrolled in the Demonstration project should have all the same rights and protections afforded to other dual eligibles. A passive enrollment model and a lock-in period are flawed methods of ensuring sufficient participation in the Demonstration project precisely because it takes away beneficiary choice. The best way to ensure sufficient participation in the Demonstration project is through an attractive benefits package and a robust provider network that provides a high quality of care, and strong care coordination. The Draft RFS leaves a number of questions regarding enrollment issues unanswered that should be clarified in the final RFS. These include: 1. Which entity will be responsible for processing enrollments and disenrollments?

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			Will DHCS, CMS, or the Demonstration sites be responsible for enrollments? 2. Will Health Care options be responsible for enrollments and disenrollments? 3. Will a separate entity be created to process enrollments and disenrollments? 4. Will dual eligibles who are already enrolled in Medicare Advantage plans be exempted from the Demonstration project?
330		General Questions	Geographic Coverage. We suggest that DHCS avoid selecting Demonstration sites in large counties like Los Angeles, San Diego and Alameda that do not operate under a County Organized Health System (COHS). Implementing a pilot project in large counties with extremely diverse and challenging dual eligible populations poses a number of issues for Demonstration sites. These large counties tend to be very geographically spread out and are more likely to have dual eligible beneficiaries with more complex medical conditions and who speak multiple languages. The relatively short transition time when DHCS expects that individuals will be enrolled into the Demonstration sites in 2013, provides the selected sites with little time to adequately prepare for such large and complex populations. The level of integration proposed in the RFS does not exist in any current model. We would encourage DHCS to take a more gradual approach to developing the Demonstration by selecting counties with more manageable dual eligible populations. If a large county is selected, we would suggest that the Demonstration site only serve a discrete geographic area in that county based on zip code. We would also suggest that the Demonstration not be expanded to more than four counties at this time.
331		General Questions	Integrated Financing. An integrated financing model should not shift financial responsibility from Medi-Cal to Medicare for Medi-Cal covered services. An integrated financing model must include adequate incentives for plan participation and provide for competitive provider reimbursement to ensure that Demonstration sites will have robust provider networks and provide access to specialty services for such a high-need population. An integrated financing model should also provide

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			incentives for providing participants with home and community based services that allow participants to remain safely in the community rather than entering an institutional setting. Savings achieved through an integrated financing model should be reinvested to expand the availability and quality of health care services and long-term care supports and services (LTSS). CMS and DHCS should require plans to collect and make available data measuring health outcomes, quality of care, consumer satisfaction and consumer complaints, and provide financial incentives to high-performing Demonstration sites.
332		General Questions	Benefits. The Demonstration model states that the sites will be responsible for providing enrollees with access to the full range of services to all Medicare C and D services and all State Plan benefits and services covered by Medi-Cal which includes the provision of long term care support sand services (LTSS). The Center for Health Care Rights has direct experience with assisting dual eligibles obtain Medicare and Medi-Cal covered services within Medicare Advantage plans and Medi-Cal health plans. We frequently assist dual eligibles who are experiencing serious access to care problems because the plans or their contracting providers are not using Medicare and/or Medi-Cal guidelines to determine access to medical services. In addition, access to care problems frequently occur because decision making regarding access to medical services is delegated to the contracting IPA/medical group with little evidence of oversight by the plan. Based on this experience, we ask DHCS to modify the demonstration model to require site plans to provide the following information: 1. How will sites insure the delivery of Medicare and Medi-Cal services if they delegate decision-making regarding access to services delegated to contracting IPA/medical groups? Will IPA/medical group denials be automatically reviewed by the site plan to insure that Medicare and Medi-Cal regulations and guidelines are being used to determine access to care?

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			2. With regard to providing access to Medi-Cal LTSS benefits, the site plans will work with IHSS, CBAS service providers, long term care facilities and MSSP providers to provide access to these services. Will the site plans primarily play a referral role to providing access to these services? What role, if any will site plan IPA contracting providers play in providing access to or coordinating these services? 3. Similarly, with regard to ensuring access to mental health and substance abuse services, what steps will the site plans take to insure that enrollees will obtain timely access to the most appropriate and mental health or substance abuse services, including those provided by County administered mental health agencies? 4. With regard to enrollee access to mental health, substance abuse and Medi-Cal LTSS, will site plans be required to take into consideration the enrollees past medical utilization in determining the appropriate linkage to needed services and maintaining continuity of care? 5. DHCS proposed to impose mandatory copayments on Medi-Cal beneficiaries. DHCS should clarify whether they intend for these copayments to apply to the Demonstration project. Because of the severe financial burden on dual eligibles, CHCR strongly opposes the imposition of any cost sharing on beneficiaries enrolled in the Demonstration project outside of the appropriate Part D copayments.
333		General Questions	Pharmacy Benefits. The Demonstration model states that the sites will use Medicare Part D payment rules for pharmacy benefits. However, there is no discussion in the draft request regarding the coordination and provision of Medicare Part B or Medi-Cal pharmacy benefits. We ask DHCS to modify the draft document to provide explain whether Medicare Part B and Medi-Cal formulary, coverage guidelines and payment rules will also be integrated into the

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			demonstration model. In addition, CHCR strongly recommends that the Demonstration model continue to use the current Medi-Cal formulary without limitations due to the integration of the Medicare Part B and D benefits into the model.
334		General Questions	IHSS. The draft Demonstration model summary states that site plans will be required to use state law process to for the first year and contract with local social service agencies, but that in subsequent years demonstration sites may be able to expand their role. We ask DHCS to provide clarification regarding what is meant by role expansion.
335		General Questions	Behavioral Health. The draft Demonstration model states that sites must have a plan for full integration of behavioral health services by Jan. 2015 using an integrated capitated model. The integrated model must include incentives that promote shared accountability for coordination and set performance objectives. We ask DHCS to modify the draft document to include a discussion of the checks and balances that the sites will use to promote shared accountability for coordination and the delivery of services to enrollees. In addition, we ask DHCS to modify the draft Demonstration model to address how local County administered Department of Mental Health programs will be integrated into the Demonstration project services.
336		General Questions	Care Coordination. The draft Demonstration model states that sites must demonstrate that they have the capacity to provide care coordination to meet the complex medical and behavioral health and long term care needs of dual eligibles. Based on our experience with dual eligibles in Medicare Advantage plans, simple evidence that plans have systems in place for care coordination does not provide any information on how the plans will evaluate and monitor the effectiveness of their care coordination systems and identify enrollees who may get lost in the care

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			coordination system. We ask that this section of the Demonstration model be modified to require sites to provide more detailed descriptions of how their care coordination systems will be monitored and evaluated to assess the effectiveness of the care coordination system. For example, sites might use enrollee data on use of emergency room services, inpatient hospital stays, Adult Protective Services referral, to identify higher risk enrollees who may need more intensive care coordination services.
337		General Questions	Supplemental Benefits. The Demonstration model encourages sites to offer additional benefits to enrollees such as transportation, vision and dental care. We ask DHCS to consider the following questions in better defining the definition, scope and cost sharing for these supplemental benefits: 1. Will sites be permitted to charge copayments for supplemental benefits? If yes, will DHCS place any restrictions on beneficiary cost sharing. 2. Are there any limitations on the types of benefits that a site can propose? In addition, this section states that sites are encouraged to contract with community based services to provide supplemental benefits. Although CHCR strongly supports the use of community based services, sites should not propose the use of these services as an alternative to delivering needed Medi-Cal LTSS services to enrollees.
338		General Questions	Technology. The Demonstration sites that include such technologies in their models such as home telehealth technologies (i.e. daily health vitals monitoring, medication optimization, care consultations), remote monitoring of activities of daily living and safety technologies must have proper training for staff, as well as proper training for the patients.
339		General Questions	Beneficiary Notification. With regard to the approval of outreach and marketing materials, we ask DHCS to require consumer/advocate input into the review of these materials. The Demonstration model states that alternative forms of communication

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			with enrollees are required. We ask DHCS to more clearly define these alternative forms of communication. Proper notification will require a minimum of three letters mailed out prior to the date of enrollment and three phone calls to the beneficiary to ensure proper notification. Materials must be mailed out in the appropriate language or Braille, and calls must be made to hearing impaired with use of video conferencing. There must be clarification as to the agency responsible for the notification and who is responsible for fielding calls once notification begins. In May 2011, the State of California rolled out a mandatory managed care program for Medi-Cal only patients. The notification process included two phone calls and three mailings. Since May, we have received many calls from Medi-cal beneficiaries with questions about their change in coverage. CHCR noticed the communication from the state that prompted the most calls to our agency was a short, one page notification. Given the beneficiaries' response to the mandatory managed care program notification process, we ask that the site plans include a minimum of three written notices, at least one of which is a short one page notice that briefly explains passive enrollment process. The one page notice must include a 1-800 number for beneficiaries to call with questions. The sites plans should also make a minimum of three phone calls to the beneficiaries. Additionally, there must be a properly staffed call center to field the phone calls after the notification is sent out. Further, if the beneficiary notification is sent out late because of system errors or other issues, the beneficiary's enrollment should be delayed in conjunction with the time notification is mailed out to ensure that enrollment is always six months from the date the notification is mailed out. During the implementation of mandatory Medi-Cal managed care enrollment for the SPD population, CHCR encountered a number of affected beneficiaries who did not receive notices in a timely manner. Consequently, the beneficiaries were not afforded sufficient time to make a selection on their own and were instead defaulted into a plan.

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			Lastly, the Demonstration model states that the Part D marketing requirements apply. We also ask that the Demonstration model be modified to state that these marketing standards apply to Medicare Part C and D benefits.
340		General Question	13. Appeals. The Demonstration model states that a uniform appeal process will apply across Medicare and Medi-Cal benefits and will use Medicare model standards. First, we ask that the DHCS modify the model language to explicitly state that the expedited appeals process available within Medicare Part C and D will be available. Second, the Demonstration model must require strict response/decision time frames that are enforced. (i.e. a decision to a claim request must be made within 48 hours in emergent situations.) Third, the beneficiaries should be informed **prior to** enrollment about the appeal process. Specifically, the appeal process should be described in the materials that are mailed prior to their enrollment in the Demonstration. Fourth, all denials from the site plan must include specific instructions on how to appeal in the decision, including any prescription drug denials. Specifically, in the event of a prescription drug denial, instructions should be provided to the beneficiary at the point of sale. Further, we ask for clarification as to the agency that will be conducting the independent review. Lastly, Medicare provides beneficiaries with a complaint process in which complaints can be filed against Medicare Part C and D providers by contacting the 1-800 Medicare hotline. This complaint process provides an important mechanism for beneficiaries to seek relief when the plan internal complaint and

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			appeal processes are not working. Moreover, the complaints are tracked by CMS through the Complaint Tracking Module (CTM) system, which provides CMS with an independent source of data regarding beneficiary complaints and plan compliance with Medicare requirements. To continue with this type complaint tracking system, CHCR asks DHCS to allow for a beneficiary complaint system that will be part of this demonstration project.
341		General Question	Network Adequacy. We understand that DHCS intends to follow Medicare standards for network adequacy for medical services and prescriptions, Medi-Cal standards for LTSS, and an "exceptions process" for areas where Medicare network standards may not reflect the number of dual eligible beneficiaries. We ask DHCS to provide a more detailed discussion of the exception process that is recommended and a more explicit description of the Medicare network standards. This must be made clear prior to implementation in 2013.
342		General Question	Monitoring and Evaluation. Although this section of the demonstration model states that "all sites will be required to participate in an evaluation process organized by DHCS and CMS", we ask DHCS to explicitly state how frequently the sites will be monitored. Additionally, DHCS must clarify what will be the impact on site services if monitoring and evaluation activities result in sanctions or corrective action plans for site plans. Further, DHCS and CMS should involve the stakeholders in the monitoring and evaluation process. The beneficiaries should be given written notification about how to file a complaint. Additionally, the repercussions for egregious violations committed by site plans should include plan suspension, fine and or termination of contract.
343		General Question	Quality Incentives. The Demonstration model states that participating sites will not be eligible for Medicare star bonuses but will be subject to an increasing quality withhold. We ask DHCS to clarify if the quality withhold is based on a Medicare Advantage quality incentive measure or on a state measure. In addition, we ask that

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			quality incentives that are used in this Demonstration project should incorporate consideration data on member satisfaction, the number of appeals filed by members and the number of complaints filed by members. Additionally, we ask DHCS to clarify the measure used to determine quality care and also, who is monitoring the quality of the site plans.
344		General Question	Medical Loss Ratio. The Demonstration model states that no minimum medical loss ratio is required. We strongly recommend that DHCS adopt Medicare's Medicare Advantage plan requirement that plans must meet an 85% medical loss ratio.
345		General Question	Ongoing Stakeholder Involvement. We strongly support DHCS's requirement of meaningful involvement of external stakeholders, including consumers, in the development and ongoing operations of the program will be required. This should include regularly scheduled meetings and also more transparency into the operations of the site program, including site performance and timely access to the information. We also asks that consumers , advocates and other stakeholders also have access to information on site performance that is gathered by DHCS. Selection of Demonstration Sites: 1. Qualifications: Successful applicants for Demonstration sites should demonstrate the following experience: 1) Include a Medicare SNP plan with a Medicare star rating of 3.5+ or better. In addition, this SNP plan should have no record of Medicare non-compliance, sanctions, corrective action plans or other evidence of poor plan performance in the last 3 years. 2) All site plans should have strong HEDIS performance results. 3) NCOA or Medi-Cal plan accreditation.

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			4) Include plans that have strong performance track record as a Medi-Cal contractor. 5) Include the use of provider networks, medical groups, and IPAs that have no evidence of poor performance. 2. Current Medi-Cal Mangaged Care Plan. We recommend that applicants must have a current contract with DHCS to operate a Medi-Cal Managed Care contract in the same county in CA as the proposed dual eligible site. 3. Integrity. Any applicant that has had sanctions or penalties taken by Medicare or a California agency in the last three years should not qualify as an applicant. CHCR asks DHCS to state in the request what impact Medicare sanctions or penalties will have on a demonstration site's eligibility to participate in the program. 4. County Support. Letters of agreement should state clearly the working relationship between the county agency and the applicant. Evidence of contracts or formal agreements will provide stronger evidence of collaboration. 5. Stakeholder Involvement. Successful site applicants must certify that they meet all of the stakeholder involvement criteria as outlined in the demonstration model. 6. Selection Methodology. We also ask DHCS to clearly state how the project application for each site will be graded and scored using a point system or other scoring methodology.
346		General Question	Person-Centered, Independent Assessment (We are concerned that this essential consideration is addressed only in passing within the RFS). Person-centered assessment, which in our view should be central to the dual eligible

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			demonstration, receives scant attention in the RFS, being a matter left to the plans (*"Describe how you would use your Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical care and LTSS"* p. 25). The neglect of this central issue is a serious flaw of the RFS. We believe that the State should re-think the central role of assessment in care planning, strengthen the assessment processes, and design a system of independent assessment to that provides access to the services delivered by the health plans. AARP California has put forth a recommendation that the State consider the Personal Experience Outcomes – Integrated Interview and Evaluation System (see http://chsra.wisc.edu/peonies) used in Wisconsin. This assessment focuses on the desires of based on the consumer's experience and creates a credible basis for LTSS evaluation and care planning. We strongly concur with this suggestion. Furthermore, we believe that it is a best practice that the entity which is financially responsible for delivering services is not the entity tasked with assessing the need for services, and as such, the state should develop a system for independent assessment of consumer needs. New Jersey has tasked Aging and Disability Resource Centers (ADRCs) with providing independent assessment for MLTSS, and we believe that this it is worthwhile to explore ADRCs as a disinterested, independent "single point of entry" and assessment for the dual eligible demonstration. In areas of the state where an ADRC is not yet established, other existing community agencies with a similar function could take the lead on conducting an independent, person-centered assessment process, that health plans would use as the basis to formulate a plan of care. We support the use of an independent and person-centered assessment process in the dual eligible demonstration, and recommend the Wisconsin Personal Experience

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			Outcomes – Integrated Interview and Evaluation System as a model. We also recommend ADRCs as a centralized, single point of entry to services that could conduct an independent MTLSS assessment process.
347		General Question	Housing (We are concerned that this essential consideration is not addressed within the RFS). We have on numerous occasions raised the central issue of the lack of affordable housing options as a key factor in inappropriate institutionalization, as well as the importance of policies such as home modification and home upkeep allowance that allow people to retain their current housing when a health crisis impacts their living situation. It is a disappointing that we do not see this addressed in the RFS, and we question the State's central assumption that it can create cost-savings without understanding the critical role of proactive housing policies in reducing inappropriate institutionalization. States that have made strides in reducing inappropriate institutionalization have created housing policies that California should note: see a description of Pennsylvania's multi-faceted housing policies to support community living here: http://tinyurl.com/7jotjq8 (18. Mildred PA Handout). Housing strategies can also be created within managed care systems: for example, Tennessee includes home modification, assistance securing housing and pest control services within its array of MTLSS, in order to assist individuals to secure and keep housing and prevent inappropriate and costly institutionalization. We support a full range of housing policies inside and outside of the dual eligible demonstration that support individuals to find and keep housing so that they do not need to rely on costly institutions for housing options.

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348		General Question	<OMCPRFP9@dhcs.ca.gov> I am a dual beneficiary that is a consumer of IHSS as well as a Regional Center client that receives (Supportive Living Services, these are additional attendant services from The Regional Center.) I am deeply concerned about proposed changes to the IHSS program under what is now being termed "managed care." I have read Appendix D – Framework for Understanding Consumer Protections. I have the following comments and suggestions: 1. If under Appendix D beneficiaries have control and choice then allow beneficiaries to hire and fire their own attendants. After all, we know our needs best. 2. Some people with disabilities due to their disability, might need help making the decision on who to hire and fire but nonetheless if they are mentally capable of making a decision about their lives, the person with a disability should be brought in to the decision-making process as much as possible. 3. Keep the public authority system throughout the state passed year 2013. The public authority system is the first phone call IHSS consumers/providers call to solve problems. The system works. DHS/CMS should think very carefully before they disassemble the public authority (statewide) after 2013 a system that work 4. What happens if my attendant does not show up to assist me? Solution: There needs to be an emergency services component for when attendants are sick or do not come to work. This should be statewide not just County to County. Having appropriate attendant care matters because people with disabilities can easily be

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			stuck in their homes with an inability to move or go outside and live independently as one may wish without the appropriate attendant care. If there is not an appropriate emergency system in place when an attendant needs time off people with disabilities and seniors will get stuck in their homes and their health will become endangered. An emergency system of care or respite may seem like a lot of money but in the end it will save money. 5. If an emergency or respite system is not put in place what are beneficiaries of IHSS supposed to do with their attendants do not show up to assist them? Are beneficiaries just supposed to arrange their own backup care? 6. A responsive appeal process – The state has a responsive appeal process for programs such as IHSS, food stamps, and other state programs as well. Solution: keep the state appeal process. It works. The state process could be expanded for Medi-Cal and Medicare benefits. Nonetheless don't destroy a process that works. MEDI-CAL/MEDICARE ISSUSES 7. Most of my doctors do not take Medi-Cal due to the low reimbursement rates. Solution: Either increase the reimbursement rates or allow me to continue going to my current doctors without any disruption. 8. Medicare covers chiropractic care. Some people think this is an alternative type of care. For people with disabilities and seniors such therapies as chiropractic care and acupuncture assist in pain relief. I hope chiropractic care is still covered under Medicare because alternative therapies are very important to maintaining good health. 9. A responsive appeal process – The state has a responsive appeal process for

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			programs such as IHSS, food stamps, and other state programs as well. Solution: keep the state appeal process. It works. The state process could be expanded for Medi-Cal and Medicare benefits. Nonetheless don't destroy a process that works. 10. In terms of medication, there should be an appeal process for medications we so desperately need? A TAR, for example? 11. For people who need DME (Durable Medical Equipment) currently in California people with disabilities are able to get new wheelchairs every five years. This is because shares start to fall apart and breakdown after five years and repair costs outweigh the costs of getting a new chair. People with disabilities and seniors still need to be able to get quality wheelchairs that meet their needs medically and physically every five years this policy should not change.
349		General Question	California's dual eligible demonstration is a very important project designed to develop better coordinated delivery models for dual eligible beneficiaries for the benefit of beneficiaries and payers. We have almost thirty years of experience in developing and operating the PACE (Program of All-inclusive Care for the Elderly) model of integrated financing and care for vulnerable individuals who meet Medi-Cal's criteria for nursing home eligibility. PACE is a person-centered care model that integrates all Medicare and Medi-Cal covered benefits and is fully accountable for the financing and delivery of care. By aligning incentives between participants, payers and the PACE organization, PACE maximizes participants' ability to remain in their homes and communities through better management of chronic conditions and timely access to a full range of home and community-based services. PACE already achieves the demonstration goals outlined on page 6 of the draft RFS for a sub-group of the dual eligible population. On Page 8, the draft RFS states: "In the Demonstration areas where the Program of

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			All Inclusive Care for the Elderly (PACE) is available, PACE will remain a separate program, and dual eligible meeting the eligibility requirements for PACE will be able to select PACE, the Demonstration plan or may opt-out of both." While we appreciate this confirmation that PACE will continue to be an option for eligible beneficiaries as stated in SB 208, we believe the RFS must go further in ensuring PACE eligible individuals are informed of their ability to select a PACE plan. Whether the Demonstration plan adopts an opt-in or opt-out enrollment process, it is critical that potential eligible dual eligible beneficiaries are informed of their ability to select PACE plan not just at initial enrollment but at reassessment and when changes in health condition occur after enrollment in a Demonstration plan. Specifically: Enrollment materials must include a description of PACE and list PACE as an option for dual eligible beneficiaries to select in the demonstration counties where PACE is available. PACE plans need to be treated equally with other plans serving dual eligible beneficiaries. Before dual eligible beneficiaries opt-out of the Demonstration plans, individuals potentially eligible for PACE should be informed of their ability to select a PACE plan in areas where one is available. Dual eligible beneficiaries enrolled in Demonstration plans should be informed of their ability to select a PACE plan when beneficiaries meet the Medi-Cal nursing home criteria at reassessment and when changes in their health status occur. Demonstration plans should be required to coordinate with PACE plans to ensure a "warm hand-off" for individuals into the PACE plan similar to the process described in Section 3, page 26, for Mental Health and Substance Use Services. This notification should occur when an individual becomes nursing home eligible but still living in the

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			community rather than waiting until nursing home placement occurs. Furthermore, we urge DHCS to include a requirement for Demonstration plans explain in their application how PACE eligible individuals will be informed of their ability to select a PACE plan and how the plan will work with the PACE plan to coordinate disenrollment from the Demonstration plan to enroll in PACE for individuals choosing PACE in counties where PACE is available. We have the following additional comments on the draft RFS: We support starting the Demonstration in four counties as described in the draft RFS prior to expanding to additional counties. Given the experience of the mandatory enrollment of seniors and people with disabilities in Medi-Cal managed care, the enrollment of dual eligible beneficiaries in managed care plans that have not been responsible for the full range of Medicare and Medi-Cal benefits will be challenging. It will be critical to learn from these initial four pilots prior to expanding to additional counties. We strongly support an aggressive education and outreach period to enable beneficiaries to make an informed choice in selecting a plan that best meets their needs. Demonstration plans proposing a passive enrollment approach with voluntary opt-out must be required to meet a high standard for ensuring lower default rates rather than the high rates experienced in the mandatory enrollment of seniors and people with disabilities. We support the creation of a uniform assessment instrument and single point of entry system in the Demonstration counties to ensure dual eligible beneficiaries are informed of the options available. We would be happy to work with DHCS and other

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			stakeholders on the development of such an instrument and system. We do not support DHCS allowing Demonstration plans to lock-in beneficiaries for as long as six months as stated on page 28. We believe that the special election period for Medicare Advantage plans that allows dual eligible and PACE eligible individuals to enroll or disenroll on a monthly basis is an important quality control mechanism.
350		General Question	We support many aspects of the draft proposal to improve care coordination for dual eligible beneficiaries. The California initiative provides a significant opportunity to improve the coordination of care for these vulnerable individuals. This increased coordination offers the potential to both achieve higher quality of care and to realize savings. We also believe that California's efforts to incorporate elements of the Medicare Part D benefit into the Demonstration are critical to ensuring that California residents continue to have access to the full range of benefits and protections currently available to them through the Medicare Part D program. In addition, we strongly support California's commitment to include important consumer protections in the Demonstration and urge the State to ensure that the protections of Part D, the Knox-Keene Act, and Medi-Cal continue to apply. We are concerned, however, by the lack of information provided with respect to the financial methodology for this program at this early stage of its development. Some of the statements could be read as creating unintended consequences both for the Demonstration sites and for non-dual Medicare beneficiaries in California. We would also suggest that California consider using an "opt-in" mechanism for purposes of enrollment, at least in the initial months or in those counties where the Demonstration sites have less experience in dealing with the special needs of this population.

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351		General Question	Part D Is an Established and Effective Method of Prescription Drug Delivery The medical needs of dual eligible beneficiaries are significant, which means that they justifiably account for a significant share of Medicare and Medicaid spending. Nonetheless, we agree that the use of "organized systems of care that are responsive to beneficiaries' needs and overcome existing fragmentation and inefficiencies created by current categorical funding and service structures" has the potential to improve care coordination and quality while reducing costs. We further believe that the integration of important Medicare Part D requirements into the Demonstration, including the SNP requirements, is an important step in ensuring that dual eligibles continue to receive prescription drug coverage in a tested and effective manner. We urge California to adhere to these principles and requirements as the program draft develops to ensure that the creation of this new program does not unduly disrupt continuity of care for the state's dual eligible population. The Medicare Part D benefit effectively provides access to robust prescription drug coverage for all Medicare beneficiaries in California, including dual eligible beneficiaries. It has tested procedures for protecting patient access. Furthermore, the Part D benefit has resulted in substantial savings for other parts of the Medicare program. Indeed, a recent study by the Journal of the American Medical Association ("JAMA") found annual savings of $1,200 on other Medicare costs for seniors who previously had no drug coverage or limited drug coverage prior to the creation of Medicare Part D.3 The potential for Part D plans to achieve savings with respect to the dual eligible population will be magnified by the improved coordination of all of a patient's care in this dual eligible demonstration program. Dual eligibles have varied and complex healthcare needs, including the management of multiple prescription drug medications, and changing a prescription for a patient without considering other conditions and prescriptions has the potential

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			to exacerbate the patient's problems. We believe that incorporating Part D requirements into the Demonstration will enable the state, the federal government, and the newly formed Demonstration sites to capitalize on the successes and efficiencies of the current Medicare Part D program in providing care to California's dual eligible population. Because some of the Demonstration sites will be coming into compliance with the Part D standards over the first year of program operation, to protect these patients it will be important for California to establish procedures for ensuring that the standards are brought on line promptly.
352		General Question	The Consumer Protections of Medicare Part D and Medi-Cal Should Continue to Apply Throughout the process of designing the dual eligible Demonstration project, California has shown a strong commitment to consumer protection. In fact, one of the first documents prepared by the state with respect to the Demonstration was a "Framework for Understanding Consumer Protections," which appears on page 42 of the draft RFS. According to this "Framework," the concepts to "set the stage for a conversation about consumer protections" include: • Beneficiary control and choice; • Beneficiary-centered models; • Comprehensive benefit design; • Responsive appeals process; • Transition rights to avoid care disruptions; • Meaningful notice; • Oversight and monitoring; • Appropriate and accessible; and

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			• A phased approach. We strongly supports the inclusion of these and other consumer protections in the Demonstration and urges California to ensure that the protections of both Medicare (including Part D) and Medi-Cal continue to apply to the dual eligible population enrolled in the Demonstration. For example, in defining the uniform appeals process in the forthcoming Demonstration Proposal and MOU, we urge California to rely on the most protective aspects of the appeals processes under the Medicare and Medi-Cal programs. Related to the issue of consumer protections, we strongly support the proposed requirement that Demonstration sites have a current unrestricted Knox-Keene License. The Knox-Keene Health Care Service Plan Act of 1975 requires health plans to provide certain important consumer protections and will further ensure that participating Demonstration sites adopt consumer protections, including those outlined above."
353		General Question	California Should Consider Unintended Consequences of Its Payment Methodology The draft RFS proposes that "Demonstration Sites will be paid according to the regular Part D payment rules, with the exception that they will not have to submit a bid. The direct subsidy will be based on a standardized national Part D average bid amount. This national average will be risk adjusted according to the same rules that apply for all other Part D plans. CMS will provide additional guidance for plans in the Draft and Final Call Letters for the contract year (CY) 2013 in February and April 2012, respectively." This methodology may work effectively; however, we note that today, Part D plans bids are based on the entire Medicare population including dual eligibles. Because dual eligible prescription drug needs tend to be higher than the rest of the Medicare

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			population, removing them en masse from the pool on which the plans submit their bids could cause the plans' bids for the non-dual population to be lower than they otherwise would have been. This would place considerable pressure on the risk adjustment methodology in order to prevent the Demonstration sites from experiencing financial problems that could translate into access restrictions that undermine the quality of care.
354		General Question	California Should Consider Use of an Opt-In Enrollment Mechanism Given the size of the population that will be transitioning to this new program and the relative inexperience of at least some of the plans, we urge California to consider that it might be better in the long run if patients are given the choice of whether to enroll in the Demonstration - following sufficient education - rather than allowing Demonstration sites to automatically remove beneficiaries from their current care system." It is important for these fragile patients and their caregivers to trust and have confidence in the new program, lest everyone exercise the opt-out right and undermine its efficacy. A slower transition to operation may help improve confidence as well as minimizing the disruptions that necessarily will attend the migration of such a large population of patients. Considering that California intends to enroll approximately 150,000 beneficiaries initially (and up to 1.1 million beneficiaries by 2015), over one-third of whom are severely mentally ill, we believe that patient choice could prove to be an important mechanism for building public confidence in the demonstration.

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