aging services of california®
Advocating Quality Senior Living and Care
A Partner of LeadingAge

October 28, 2011

TO: Harbage Consulting Group
FR: Jack Christy, VP of Policy
Aging Services of California
RE: Comments - Framework for Understanding, Consumer Protections

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Thank you for the opportunity to comment on Consumer Protections in California's Duals Demonstration. While the draft document states it wants an open dialogue on consumer protections, it is vague about how the concepts identified translate into consumer protections.

1) **Beneficiary control and choice**
Aging Services believes that given the dominant role of managed care in this demonstration consumers will have to give-up some control and choice to be in a managed care plan. Just how much control and choice remains to be seen. The last sentence of the draft's first point in this section states: "Choice begins with the decision to opt out of the demonstration." Why are we going through this exercise if the encouragement is to drop-out of the demonstration?

2) **Beneficiary-centered models**
Agree with this statement.

3) **Comprehensive benefit design**
Comprehensive benefit design is more than home and community-based services, the only services mentioned in this draft section. What financial incentives are envisioned for keeping people in their home or community?

4) **Responsive appeals process**
What does a responsive appeal process look like? Beneficiary must be able to hold the managed care plans accountable for refusing services in a timely way. Process is the essence of democracy and the rights and benefits at stake require a fair process for quick adjudication.

5) **Transition rights to avoid care disruptions**
Existing law has safeguards for transitioning care between care settings. These laws still apply to the demonstration. How will the State's contracts with managed care plans incorporate existing transition of care rules into the demonstration?

6) **Meaningful notice**
   Informative and timely information about the managed care plans and other options available to beneficiaries is crucial. This is a huge task and deserves something like the Title 18 HICAP program to provide the insurance counseling and information dual eligible beneficiaries will need to select a plan. Moreover, such a capacity can help identify problems earlier than otherwise possible.

7) **Oversight and monitoring**
   Aging Services agrees with draft statement for this section.

8) **Appropriate and accessible**
   Aging Services agrees.

9) **Phased approach**
   Such an approach seems prudent to Aging Services.

10) Consumer as Part of the Coordinated Care Team

This section needs a lot more fleshing-out. How is the improved understanding of this population's needs to occur? This section, like the document, appears to assume that *all* dually eligible beneficiaries should be in home and community-based care. While caring for people in the least restrictive setting possible is a worthy goal, it will not be for everyone. This Framework for Understanding Long-Term Care Coordination makes conclusions from facts not in evidence. A more balanced approach is recommended.

11) Oversight and Monitoring

What mechanism(s) is the new system bringing that will stop cost shifting? What are the issues that quality of care monitoring must pick-up? What role will the managed care plan play in oversight and monitoring? How will the state assure contract compliance by managed care plans? Medicare changed the incentives in the Part A program when it moved to diagnosis related groups (DRGs) in the 1980s. With DRGs, Medicare moved from paying costs for hospital care (an incentive to provide more care) to paying a pre-determined set amount for care by diagnosis (an incentive to provide less care). Medicare set-up Peer Review Organizations to review pre-mature hospital discharges. Medi-Cal patients deserve the same level of protection for their health rights.

12) Workforce Training

The dually eligible population is one of the most difficult to identify and reach. Their health conditions are multiple and chronic. They require a variety of professional medical services encompassing many providers. Training is essential to have the workforce required to care for a growing senior population.

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TO: Harbage Consulting Group
FR: Jack Christy, VP of Policy
Aging Services of California
RE: Comments - Framework for Understanding, Mental Health and Substance Abuse

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Thank you for the opportunity to comment on Mental Health and Substance Abuse section of California's Duals Demonstration.

1) **One-size does not fit all**
   Aging Services agrees.

2) **Support care management**
   Not sure about what is meant by "recovery" trajectory. For many LTC patients "recovery" is not in the realm of possibility. What happens if the trajectory is negative?

3) **Screening and links to services**
   Aging Services agrees.

4) **Person-Centered health homes**
   Aging Services agrees.

5) **Finances should focus on aligning incentives**
   The devil is in the details .

October 28, 2011

TO: Harbage Consulting Group
FR: Jack Christy, VP of Policy
Aging Services of California
RE: Comments - Framework for Understanding, Long Term Care Coordination

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Thank you for the opportunity to comment on Long Term Care Coordination in California's Duals Demonstration. While the draft document seeks to "set the stage for a conversation around coordination of long-term care and support services", only one provider of services, IHSS, appears worthy of mention. Coordination of long-term care and supportive services includes considerably more than just IHSS. Moreover, the managed care organizations serving the dual elderly will surely have "views" on all the issues raised in this document, yet they are not even mentioned. What recourse will the beneficiary have against the managed care plan that denies a needed service?

13) Consumer Choice

Aging Services believes that given the dominant role of managed care in this demonstration consumers will be allowed to choose their health care provider . . . from an approved network of providers. Beneficiaries that choose IHSS independent providers need a mechanism to demonstrate competency of the provider.

14) Care Coordination

The importance of this activity is not reflected in the one sentence statement about it. Aging Services would add the following points:

- Each beneficiary assigned a lead case manager who coordinates all sites of care through which the beneficiary moves.
- The case manager should be based either in the primary care practice or in the community, even if they are employed by the managed care plan.
- Case manager should have some face-to-face contact with the beneficiary, including a home visit (not just telephone contact).

15) Access to Services

Given the dominant role of managed care, access to services is at issue. Yes, HCBS are important for appropriate beneficiaries. Beneficiaries need a mechanism, independent of the managed care plan, that will provide timely review and decision on denial of care or supportive services.

16) Consumer as Part of the Coordinated Care Team

This section needs a lot more fleshing-out. How is the improved understanding of this population's needs to occur? This section, like the document, appears to assume that *all* dually eligible beneficiaries should be in home and community-based care. While caring for people in the least restrictive setting possible is a worthy goal, it will not be for everyone. This Framework for Understanding Long-Term Care Coordination makes conclusions from facts not in evidence. A more balanced approach is recommended.

17) Oversight and Monitoring

What mechanism(s) is the new system bringing that will stop cost shifting? What are the issues that quality of care monitoring must pick-up? What role will the managed care plan play in oversight and monitoring? How will the state assure contract compliance by managed care plans? Medicare changed the incentives in the Part A program when it moved to diagnosis related groups (DRGs) in the 1980s. With DRGs, Medicare moved from paying costs for hospital care (an incentive to provide more care) to paying a pre-determined set amount for care by diagnosis (an incentive to provide less care). Medicare set-up Peer Review Organizations to review pre-mature hospital discharges. Medi-Cal patients deserve the same level of protection for their health rights.

18) Workforce Training

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