January 11, 2012 Filed electronically: OMCPRFP9@dhcs.ca.gov

Toby Douglas, Director
Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413

**Re: California's Dual Eligible Demonstration Request for Solutions December 22, 2011 Draft**

Dear Director Douglas:

The Disability Rights Education and Defense Fund (DREDF) is a leading national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. Most recently in California, we have actively participated in panels, roundtable discussions, and teleconferences initiated by the state as part of its Dual Eligible Demonstration Project. DREDF also provided input during California's earlier 1115 Waiver Proposal process, and continues to participate in discussions among advocates and with the state in regard to 1115 implementation issues. Thank you for the opportunity to comment and ask questions on the state's Draft Dual Eligible Demonstration Request for Solutions (RFS).

We recognize the need for a degree of brevity in the RFS, but the state must provide greater guidance to achieve its stated goal of providing "seamless access to the full continuum of medical care and social supports and services dual eligibles need to maintain good health and a high quality of life in their homes and communities for as long as possible." In particular, DREDF strongly advocates for greater clarity and safeguards concerning the comprehensiveness of the demonstration population, enrollment, the planned incorporation of the state's In-Home Supportive Services (IHSS) program, the demonstration's appeals process, beneficiary notification, physical and programmatic accessibility as a necessary component of network adequacy, and monitoring and evaluation. These are all crucial parameters for dual eligibles, many of whom have functional impairments and complex care conditions, and cannot simply be left to the will and imaginations of managed care entities, many of whom have very limited experience with care coordination for both this population, and all of whom have no experience with IHSS.

At the outset, we feel it necessary to comment on the difficulty of drafting and advancing comments on the RFS in the face of Governor Brown's recent budget, which anticipates changing many of the underlying parameters for California's dual eligible demonstration projects. In particular, the budget's proposed scale for the enrollment of dual eligible individuals into mandatory managed care with a one year lock-in period appears to ignore the consistent advocate and beneficiary feedback that has been garnered through the duals stakeholder process so far. Disregard is a strong disincentive to

further participation. Nonetheless, the potential for achieving truly integrated, person-centered Medicaid and Medicare services that are rebalanced away from institutionalization and toward home and community-based services (HCBS) for people with disabilities of all ages drives our continued involvement. We sincerely hope that the administration's commitment to this potential goes beyond lip service.

DREDF has the following specific comments/questions on the RFS.

1. *Demonstration Population, page 9*

The RFS seeks comment on excluding beneficiaries with specific conditions (i.e., HIV/AIDS, End-Stage Renal Disease (ESRD), and *Amyotrophic Lateral Sclerosis* (ALS), and beneficiaries who have been institutionalized for longer than 90 days at the point of initial enrollment (clarified on DHCS' January 5, 2012 call on the RFS).

The disability community has spent much time and energy fighting the idea that individuals can be categorized purely according to diagnosis. We freely acknowledge that beneficiaries with HIV/AIDS, ESRD, and ALS can have multiple functional limitations and complex care coordination needs that may challenge the capacities of managed care entities, but must also emphasize that people with other disabilities and diagnoses may have care coordination needs of equal complexity. The best way to ensure effective care for dual eligibles with various disabilities is not to "carve out" specified populations, but to:

- Effectively communicate enrollment information and safeguard enrollee choice to enroll in managed care;
- use a broad, multi-faceted, in-person assessment tool that focuses on functional needs;
- provide effective long-term continuity of care mechanisms;
- develop and broadly disseminate procedurally fair and generously applied managed care exemption mechanisms for individuals who cannot receive adequate care through their managed care alternatives.

All too often, the carving out of a sub-population results in that population being ignored, or losing out on hard-fought advantages of new programs. At the very least, if the state insists on different treatment for individuals with the above specific diagnosis due to the historic complexity of separate funding streams or for other reasons, the affected beneficiaries must continue to be given information and the ongoing opportunity to join the duals demonstration if that is their choice.

For distinct but no less critical reasons, DREDF does not believe that individuals who are institutionalized should be excluded from the Demonstration. We strongly advocate that the state's *Olmstead* deinstitutionalization obligations extend to the health care arrangements and contracts that the state enters. No individual should be forced to stay in or enter an institution in order to get needed health care. The RFS acknowledges the need to rebalance financial incentives away from avoidable institutionalization, but

carving out dual eligible individuals who have been institutionalized for 90 days arbitrarily consigns those individuals to a separate category for which managed care entities have no financial or legal responsibility. Instead, the state should proactively and appropriately incentivize, reward, and otherwise motivate managed care entities to assume the intense assessment, consumer education, and care coordination tasks, as well as linkages with such relevant community-based organizations as independent living centers, that are likely needed for assist someone who has been institutionalized to return effectively and safely to the community as desired. Both the RFS and the Governor's budget clearly speak to the state's ongoing and growing reliance on managed care as the foundation for California's healthcare delivery system. In light of this systemic transformation, the RFS rightly requested at p. 25 that applicants describe both their "transition plan for moving individuals out" of institutionalized care settings, and the "processes, assurances [that they] have in place to ensure proper care." A carve out of individuals who have been institutionalized for over 90 days renders this question moot and will appear to exempt many of the major players in California's healthcare system from their *Olmstead* obligations.

2. *Enrollment, page 9*

We were surprised to see the RFS's request that applicants explain their possible pursuit of a passive enrollment process with up to a six month lock-in period. The administration had not raised the possibility of a lock-in period at any point during the entire stakeholder process. In common with the vast majority of our fellow advocacy organizations, DREDF opposes both passive enrollment and any lock-in period.

The functional ability and health of many dual eligibles depends upon maintaining uninterrupted relations with a potentially wide range of providers, including specialists and mental and behavioral health professionals, as well as uninterrupted access to such critical benefits as durable medical equipment and prescription drugs. One of the key lessons that should have been learned from the implementation of the California's 1115 waiver is that with all the best intentions in the world, enrollment and data transference issues will arise. Enrollment packages will be sent to incorrect addresses, packages will be misplaced or lost, enrollment agencies will make mistakes, alternative formats and languages other than English will not be provided, and federal beneficiary information will be incomplete or untimely. For all these and other reasons, there will inevitably be individuals who either do not choose a plan or fail to disenroll in time after being defaulted into a plan. A lock-in period will greatly exacerbate the chances that dual eligible individuals will be forced to simultaneously confront such barriers as a new network of providers who are unfamiliar with their care needs and health risks, different drug formularies, and new co-pay rules, and undergo the risk of not having the level and specificity of their care needs met for an extended time.

3. *IHSS, pages 11 and 25-26*

The short paragraph in the RFS with regard to IHSS integration raises far more questions than it answers. DREDF appreciates the RFS's indication that the status quo

for IHSS, a consumer-directed personal assistance system that has taken decades to develop in the state, will be maintained for the first year of the demonstration. However, this does little to reassure people with disabilities who depend on IHSS to live as independently as possible and remain in their communities that the levels of hours, consumer control, and quality of service that they need will be protected in years 2 and 3 as managed care entities potentially assume greater control over IHSS. Will IHSS consumers continue to maintain the ability to individually hire, fire, and direct IHSS employees? Which entities will be held legally and financially accountable for IHSS services over the years? Who is responsible for "Plan B" if an IHSS worker cannot come to work for the day? What will be the financial incentives to managed care to, at minimum maintain current levels of HCBS, and ideally, further develop and offer a gamut of home and community based long term services?

It would be difficult to overemphasize the importance of IHSS, and HCBS to the disability community, and equally difficult to overstress that most managed care entities *have no experience* integrating HCBS and home and community based long term services with the delivery of medical care. The RFS's seeming confidence that managed care entities on their own will stumble upon the best way to integrate, preserve, and expand IHSS in a way that will benefit dual eligibles after the first year of the demonstration project is not shared by beneficiaries, who will bear the consequences of failure in their lost health and independence.

4. *Beneficiary Notification, pages 12 and 28*

Effective communication is a critical component of beneficiary notification, education, and outreach. DREDF appreciates the RFS's explicit references to the use of alternate formats and the need to meet beneficiary linguistic and cultural needs. At the same time, we emphasize that explanations on paper are very different from the dissemination and adoption of policies and procedures for capturing individual beneficiary communication needs, and consistently meeting those needs over time for the gamut of communications and individualized notices.

Applicants should bear a proactive obligation to notify all applicants and beneficiaries of the availability of alternate formats and languages, and must specify how *both* managed care information and notices and individual provider/healthcare information and notices will be effectively communicated to beneficiaries. Electronic websites must be fully accessible and online applications should be readable, fillable, and submittable online in accordance with federal and state accessibility law. Finally, given the high degree to which effective communication, like all policy modifications and accommodations other than obvious permanent structural changes, depends upon staff training and awareness, applicants must detail how plan staff and providers will be trained and have that training refreshed over time, and this component must be subject to state monitoring and data collection.

5. *Appeals Process, page 12*

The complexity of existing, divergent Medicare and Medicaid appeals procedures makes a uniform appeals process highly appealing. While we believe this is an appropriate goal to work toward, DREDF is highly concerned that existing levels of consumer protections and complaint/appeal procedures be safeguarded. Administrative forums that have developed competent levels of subject matter expertise, procedural fairness, and familiarity with beneficiary needs must not be obliterated in the name of less competent uniformity.; this is especially true of Medicare appeal procedures since the state has not historically dealt with Medicare. Moreover, a uniform process must ensure that beneficiaries have clearly defined and cross-referenced routes to pursue the resolution of a wide variety of possible complaints, ranging from disagreement with treatment or prescription denials to provider disputes, civil rights issues concerning a lack of interpreters or other discrimination to co-payment disputes, violation of Knox-Keene regulations to violation of Medicare reimbursement rules.

Additional consideration must also be given to ensuring that a uniform appeals process have sufficient capacity to deal with the sheer numbers of beneficiaries and issues that may arise in an integrated system. How will the uniform appeals process interact with the purview of the managed care complaint process, or the state ombudsman? How will the process interact with HHS administrative complaints? Will providers be able to access the uniform Medicare and Medicaid appeals process? How will we ensure that the uniform appeals process not place any administrative barriers or exhaustion requirements in the way of civil rights judicial complaints? These are all questions that must be resolved before an acceptable integrated appeals process can begin to be developed.

6. *Accessibility and Network Adequacy, pages 12 & 21*

We strongly submit 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 law (and it should be also noted here that excellent California disability anti-discrimination provisions are entirely applicable here and need to be incorporated within the RFS requirements). 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. The waiver terms and conditions issued by the Centers for Medicare and Medicaid Services explicitly referenced the need for "physical and programmatic accessibility of the plan (including completion of facility site reviews before readiness)" as a component of plan readiness.[1] Such a basic accessibility requirement, and foundational consumer information concerning provider accessibility, should also be required as an integral part of the duals implementation proposals. The only change should be further development of 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

[1] Section 81 of Part III at p. 37, CMS Special Terms and Conditions for California Bridge to Reform Demonstration, 11-W-00193/9.

accommodations for a beneficiary's disabilities), since it is now possible to further build on the experience of plans who have participated in the 1115 waiver and administered the physical accessibility surveys.

While the RFS narrative encompasses an element specific to "access" in section 5.2 at pp. 27-28, a plan's provision for ensure accessibility in provider services must be included as part of section 7 and within 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. 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 as they age. Within section 5.2 itself, applicants need to be asked to provide scheduled benchmarks for when specific aspects of accessibility – structural, communication, programmatic modifications in provider offices – will be achieved, as well as plans for how all plan entities and network providers will be trained and educated on accessibility needs.

8. *Monitoring and Evaluation, pages 12 & 30*

DREDF understands the efficiency of a single CMS and DHCS quality assurance and evaluation process. Our cautions on this front are very similar to concerns enunciated above with regard to a uniform appeals process: any integrated evaluation procedures must at minimum retain the highest standards that currently apply to Medicare and Medicaid services. That is, a "watered down" version of quality and evaluation measures that fail to hold plans accountable to existing service delivery standards will be unacceptable. The RFS must explicitly state this, and also require stakeholder input into the development of relevant reporting measures. "Traditional" quality measures and encounter data may not capture factors that deeply impact on the levels of care received on the ground by people with disabilities. For instance, measures that relate to the levels of physical and programmatic accessibility of network provider offices over time are very important to understanding the quality of care that dual eligible with disabilities are receiving in managed care. We also would like to reiterate that reasonable accommodations and modifications require active and ongoing engagement by all entities involved and their staff. As a result, it is also important for quality and evaluation standards to delve into staff training and the reasons *behind* faulty service delivery. For example, was a specialist referral not timely because a primary care provider lacked an adjustable exam table, or because his or her staff was not trained to inquire about the need to schedule the use of an accessible exam room ahead of time?

DREDF also appreciates the efficiency of contracting with a single external evaluator for both Medicare and Medicaid, but similarly recommends that the RFS explicitly specify that the quality and cost impacts on specific vital Medicare and Medicaid services be

measured. In particular, an evaluator should determine the quality and cost impacts of integration on IHSS, HCBS and community-based long term supports and services. Without such specificity, the true financial effect of integration on these crucial services for living independently in the community will be lost in general accounting numbers, and it will be all too easy to re-direct any savings toward other service areas, or even institutional services.

We applaud the reference in Section 8 of the Project Narrative for asking applicants to demonstrate their capacity for reporting beneficiary outcomes according to numerous demographic characteristics, including disability. We anticipate that as far as disability, this will be information that is correlated to functional impairment levels rather than medical diagnosis, and that with regard to ethnicity and race, there will be sufficient granularity to distinguish between, for example, immigrant Hmong and Chinese populations. This would align data gathering in California's eligible demonstration projects with the direction of federal data gathering and disparities evaluation under the Affordable Care Act.

As a final word on monitoring, DREDF would like to reiterate that the state ultimately remains responsible under federal law for ensuring the accessibility of Medicaid services and health care delivery where any federal monies are involved. Applicant certifications and the existence of contractual obligations on paper cannot replace robust state monitoring and evaluation mechanisms to ensure that plans and providers are meeting their obligations under federal and state law, as well as their contract obligations.

7. *Stakeholder Process, pages 13 & 22*

DREDF believes that more granularity is required 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., younger than 45 or 50 years of age) need to be explicitly included in the state's and plans' stakeholder processes. Input from these groups and individuals are a necessary supplement to input from the older Americans who make up much of the dual eligible population.

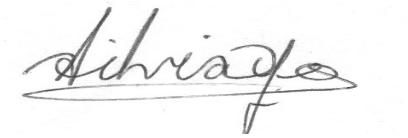
More broadly on the subject of stakeholder engagement, we would like to refer to the letters and comments of our fellow advocates and colleagues concerning the RFS. They have consistently provided positive feedback where warranted, made clear criticisms, and suggested reasonable alternatives. The RFS itself continually stresses the importance of "meaningful" stakeholder involvement. For us, the test of meaningful involvement does not lie simply in the statistics concerning the number of meetings, or the volume of paper or minutes of calls received. Ultimately, meaningful stakeholder involvement lies in the impact of stakeholder input on outcomes. Regrettably, very little of this has been seen so far. This impression has only been confirmed by Governor Brown's recent budget, which has projected a scope and framework for the dual eligible

demonstrations that opposes much of the unified feedback that advocacy and beneficiary groups have provided to this administration.

Despite this, DREDF remains more than willing to discuss any aspect of the comments outlined above. We remain committed to engaging with the administration on behalf of our constituent of dual-eligible individuals with disabilities and functional impairments, and will continue to advocate for a truly meaningful stakeholder process.

Yours truly,

Susan Henderson
Executive Director



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January 10, 2012

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Transmitted to: OMCPRFP9@dhcs.ca.gov

Dear Mr. Douglas,

Disability Rights California appreciates the opportunity to comment on the draft RFS. We have been advocating for an integrated long term care budget for several years, based on civil rights and prudent fiscal policy. We agree with the underlying assumption: the current non-system of acute and long term care is not the best California can do. Public dollars and human resources are wasted, not only by lack of coordination and duplication of efforts, but by sending and keeping people in nursing homes who do not want and do not need to be there. We know there are people who need assistance in finding, keeping and managing services. We want to see fiscal and program policy which gives people with disabilities a true choice in what services to receive, and where and how to receive them.

We have appreciated the opportunities to participate in the stakeholder process, both in the large meetings and at smaller meetings, and the professionalism of the employees and consultants of the state throughout the process.

Any pilot project must be designed with input from those most affected, whose voice has been largely absent from the stakeholder process, despite the representation in the cover letter and the RFS. Any pilot project must build on, and not undermine, the success of the PACE program, the IHSS program, the Public Authorities, the MSSP program.

We have had serious concerns about some aspects of the RFS and the stakeholder process. The state seems to be asking the plans what they want to do, rather than telling them what will be required. Although the plans may respond with good intentions and good ideas, those cannot constitute or substitute for public policy.

Although SB 208 and the RFS were for four pilots, the context has changed with the release of the Governor's Budget and the proposal to increase the pilots to ten and then statewide within three years; with so much at stake, our concerns are even deeper. We would support the idea of a small number of carefully conceived pilot programs, which would meet this definition: "A pilot project is generally a project which is designed as a test or trial to demonstrate the effectiveness of a full program." [1]

Some stakeholders have been asking what was being tested in the 4-county Demonstration, and whether more than one model was to be tested, and what defines a successful or unsuccessful test. If Los Angeles were to be selected among the four sites, the "test" would experiment with the lives of half the seniors and persons with disabilities who are dual eligible in California. Now the scope has very possibly changed to an even bigger number of dual eligibles, with a timetable which precludes any course changes based on any true "test or trial." Successful outcomes are in danger of being sacrificed to a "full speed ahead" devolution of historically public responsibilities to private entities, without input from the people most affected, and without a close examination of the fiscal assumptions (of savings) which are, in part, setting the speed.

California has historic and recent experience mandating managed care for people on Medi-Cal; it is not clear how that experience is informing the current push to make managed care the only care. In 2005, the Robert Wood Johnson Foundation announced the findings of a study of an earlier wave of mandatory managed care in California, with this summary: California's Shift to Medicaid Managed Care Doesn't Save Money or Improve Outcomes.[2]

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1 From the http://www.philanthropywiki.org.au/index.php/Pilot_Project

Over the last year, the state has forced over 200,000 seniors and persons with disabilities who have Medi-Cal only, into managed care. Advocates and consumers fought hard to slow the process down and to build sturdy protections and readiness standards, to prevent disruptions to the health and well-being of the population. Advocates, including physicians, have documented widespread problems including disruptions of crucial care, including cancer and AIDS treatment, surgeries and dialysis. At the joint Senate and Assembly Health Committee hearing on December 7, 2011, legal services attorney Katie Murphy testified that "These problems exist because of uneven and incomplete implementation by DHCS, and often a refusal to fix problems as systemic and a focus only on individual circumstances, dismissed as aberrations."

Among the concerns of DRC and other advocates was that managed care plans were not familiar with the medical needs of people with disabilities, much less with their access and accommodations needs, and were unlikely to be in compliance with the state and federal laws which guarantee the rights of people with disabilities to accessible programs, buildings and services. Despite the three decades which have passed since the first federal access laws, managed care providers were not required to demonstrate compliance before they received a monthly influx of tens of thousands of new patients with disabilities.

Now the Governor's Budget proposes to move another population, which is described as having even higher health needs, into managed care, and give managed care providers even more responsibilities and even more control over the medical and social services for beneficiaries.

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2 http://www.rwjf.org/reports/grr/049006.htm. Key findings: Following the shift from fee-for-service to managed care:

- Medicaid spending increased an average of 17 percent, an effect that lasted well after the shift, suggesting that startup costs were not the cause of the increase.
- Counties with only one managed care plan experienced significantly greater spending increases than those with multiple plans, suggesting a benefit to competition.
- Significant improvements in health outcomes did not result.
- Infant health outcomes showed little change.
- Although the study did not produce administrative cost data, anecdotal evidence suggests that the shift to managed care may result in increased state administrative costs.

Our comments on the RFS follow, in order of their appearance in the document:

**Key Attributes:**

On the question of excluding beneficiaries with certain disabilities: We now understand that the motivation was to protect people. This raises two questions:

a) If people with these disabilities need protection from managed care, don't other people with other disabilities? There are people with all sorts of disabilities, some common and some rare, who have the same need for good acute and long term care as those with the named diagnoses. If people are to be exempted because they cannot get the services they need, and do not want to lose their current providers, those people should be able to self-identify and be exempted.
b) If people with these disabilities are in nursing homes, they will be denied an equal chance to return to the community if they are exempted. This raises the specter of disability-based discrimination, even though the exemption idea was well-motivated.
Our response is NO.

On exempting people who have been institutionalized for longer than 90 days.
Now we understand that only the first year of the project was being discussed. If the duals project will have a benefit for people in institutions, and we think it can, that benefit should be available to everyone, regardless of the length of institutionalization.
Our response is NO.

**Enrollment:**

We object to passive enrollment, as interfering with consumer control. If the managed care project is as beneficial as is hoped, people should want to enroll and not be forced to enroll.

We object to the lock-in, which was never discussed at any stakeholder meeting. Locking in consumers is always problematic and the problems are magnified by the newness of this experiment: we don't know if or how the

service goals will be met, or whether, as seems likely, we will see a repetition of the problems in the SPD enrollment.

How will the enrollment of duals work out better than has the enrollment of seniors and persons with disabilities?
Are people who are on Medi-Cal waivers or waiver waiting lists to be exempted from the project?

**Geographic coverage:**

Why must a site be capable of covering the county's entire population of dual eligibles? This is especially worrisome in Los Angeles, whose duals population is probably greater than that of most states.

**Integrated financing:**

The rate and fiscal incentives are crucial, but the RFS provides minimal information. If the rate is based on current baseline spending, where is the funding for the improvements such as case management and transition services and a whole range of services which are not now provided or widely provided?

What is the basis for savings assumptions, and how do they square with the experience of California and other states?

**Benefits:**

General principles

Services should be provided consistent with the federal Balancing Incentive Program. The Balancing Incentive Program requires the state to make the following structural changes:
1. A No Wrong Door–Single Entry Point system (NWD/SEP);
2. Conflict-free case management services; and
3. A core standardized assessment instrument.

Although California is not participating in the Balancing Incentive Program, this program is the direction in which provision of Medicaid services is moving. California should be moving in this direction now rather than later.

**Expanded benefits:**
If the projects are to improve acute and long term care coordination and keep people at home, they cannot be limited to providing existing benefits. Housing, transportation, home modifications, case management, supported employment, habilitation, independent living skills and transition services are among the many services, lack of which are consistently identified as barriers to living at home. Assistance in accessing these services is consistent with the “no wrong door” approach.

Sites must be required to provide or coordinate these, and to contract with community-based providers, such as Public Authorities, independent living centers, MSSP sites and supported living providers, who know how to work with people with disabilities and have track records in delivering services. Again, this is consistent with the “no wrong door” approach.

People who are in nursing homes, with Medi-Cal payment, should be able to use any monthly income to retain their homes in the community rather than paying it towards share of cost in the facility. When housing is retained, people can go home if they so choose and save the state money on their care. When housing is lost, the chances for leaving a facility are greatly diminished.

**IHSS:**

IHSS is regarded as a model of person-centered personal care because it reflects these values: disability is not a medical condition needing a cure, people with disabilities are not patients, people with disabilities have the same rights over their bodies and lives as anyone without a disability, the medical world does not know more than people with disabilities about disability. In IHSS, “consumer choice” is not just a slogan – it is fully realized. In IHSS, “assessment” does not mean a blood pressure reading or a diagnosis – it means looking at the functions and needs of a person with a disability, including a senior, and how those needs can be met with the assistance of non-medical personal care attendants. This is the social model. It is largely unknown to the medical community, which providers readily admit.
IHSS should be coordinated with other services, but the social model together with consumer self-direction and control should be maintained. The

Public Authorities for IHSS have played and should continue to play a crucial role as an organized voice for IHSS consumers, including dual eligibles. Their advisory boards, statutorily required to be consumer-dominated, are a model worth retaining and replicating.

Any core standardized assessment instrument should be one that the counties can use to make IHSS needs assessments in accordance with current uniform, statewide needs assessment standards.
Counties should continue to perform needs assessments for IHSS. This will help to insure "conflict free" case management services.

**Care coordination:** while all enrollees must be offered this service, any enrollee must be able to refuse this – and any other – service or treatment. Enrollees must be free to make the same mistakes as anyone else, and to make decisions based on whatever information they request, delivered in whatever format they need.

**Supplementary benefits:** We appreciate the encouragement to Sites to provide supplementary benefits. If the Sites do not provide the listed supplementary benefits, it must be clear to Sites that the Sites are required to coordinate benefits. This will help to insure that beneficiaries actually receive the benefits. In addition, it must be made clear to Sites the Sites have an obligation to arrange for non-medical transportation, even if the Sites are not required to provide it.

**Beneficiary notification:** We appreciate the Department's requirements.

**Appeals:** We understand that appeals will be covered by another document. We urge the Department to use the Medi-Cal appeals process so that there will be a seamless appeals process for all of Medi-Cal managed care as well as Medi-Cal LTSS.

**Monitoring and evaluation:** There is no role mentioned for beneficiaries or other stakeholders in the design or implementation of monitoring or evaluation, nor any information about what constitutes quality. Will it include personal interviews with beneficiaries, and assessments of how many people were diverted from or were assisted to leave institutions?

Monitoring and evaluation must start before the first person is enrolled, and must include quick course correction when problems are spotted.

Will plans be required to show compliance with state and federal disability laws? We would be happy to see DHCS accept responsibility for oversight on this.

**Medical loss ratio:**

There should be a medical loss ratio consistent with the federal Affordable Care Act.

**Ongoing stakeholder involvement:**

Beneficiaries and other stakeholders must have a designated and substantive role in the design, operation, oversight and evaluation of programs. They must not be brought in after decisions are already made, and must be equal members of decision-making bodies.

For the Timeline and subsequent sections of the RFS, we fully support the comments and recommendations of the National Senior Citizens Law Center.

Again, thank you for the opportunity to comment on the RFS. We look forward to continuing to work with you and your team.

Sincerely,

Deborah Doctor
Legislative Advocate
Disability Rights California

**Dear California Duals Demonstration:**

**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.**

**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?**

From Medi-Cal website:

*"A permanent injunction (Charpentier v. Belshé [Coye/Kizer]) filed December 29, 1994, allows providers to rebill Medi-Cal for supplemental payment for Medicare/Medi-Cal Part B services, excluding physician and laboratory services. This supplemental payment applies to crossover claims when Medi-Cal's allowed rates or quantity limitations exceed the Medicare allowed amount. The following definitions apply to Charpentier rebills:*

- *Rates – The Medi-Cal allowed amount for the item or service exceeds the Medicare allowed amount.*
- *Benefit Limitation – The quantity of the item or service is cut back by Medicare due to a benefit limitation.*

- *Both Rates and Benefit Limitation – Both the Medi-Cal allowed amount for the item or service exceeds the Medicare allowed amount and the quantity of the item or service is cut back by Medicare due to a benefit limitation.*

*Providers should obtain authorization for DME items before dispensing the item and billing Medicare. A Treatment Authorization Request (TAR, 50-1) for electronic TAR (eTAR) shall be completed and submitted to the appropriate Medi-Cal field office using the Medi-Cal DME code(s) that most accurately describe the item provided. The TAR must include all medical justification and documentation that would normally accompany a Medi-Cal-only TAR and include the message "Medi/Medi: Charpentier/Rates," "Medi/Medi: Charpentier/Benefit Limitation," or "Medi/Medi: Charpentier/Both Rates and Benefit Limitation" in the Medical Justification area. The Medi-Cal field office will process the TAR and return an Adjudication Response (AR) to the provider."*

Best Regards,

Serina Breen

**Freedom Mobility Center**

## Solicitation Questions

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Demonstration Model Summary > Key Attributes > Demonstration Population | 7 | 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.)<br>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.<br>DHCS is seeking comments on this entire document and in particular on whether the Demonstration should exclude beneficiaries:<br>• With any of the following conditions: HIV/AIDS, End-Stage Renal Disease (ESRD) and Amyotrophic Lateral Sclerosis (ALS); or<br>• 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.<br><br>Our recommendation is that the Demonstration population excludes beneficiaries under age 21.<br><br>Please include any additional detailed information about the conditions and other subcategories of the Duals population. |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Demonstration Model Summary > Key Attributes > Enrollment | 7 | 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.<br><br>We would like to work with DHCS to accomplish their goals by seeking additional mechanisms to help beneficiaries find value in Managed Care. |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Demonstration Model Summary > Key Attributes > Enrollment | 7, 8 | 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 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.<br><br>More specifically, it is anticipate that Demonstration sites that choose a passive enrollment process would phase-in enrollment during 2013. The Demonstration may apply an 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. | 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:<br>▪ What options are available to them in OEP for the portion of 2013 that they would remain in the current model<br>▪ What options and benefits will be available to them under the Duals Demonstration when they matriculate<br><br>We suggest enrollment be phased-in based on the birth months of the beneficiaries, similar to the SPD transition.<br><br>Will the file feed standards follow those of Medicare or Medi-Cal? |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Demonstration Model Summary > Key Attributes > Integrated Financing | 8 | 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.<br><br>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.<br><br>Will the current Medicare HCC age/risk factors apply? For Medi-Cal, which risk adjustment factors, including the risk of institutionalization, will be applied? |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Demonstration Model Summary > Key Attributes > Pharmacy Benefits | 9 | 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.<br><br>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. |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Demonstration Model Summary > Key Attributes > Quality Incentives | 10 | 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.<br><br>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.<br><br>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. |
| Timeline | 12 | 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. |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Application and Submission Information > Application Submission<br><br>and<br><br>Selection of Demonstration Sites > Qualification Requirements | 14-15<br><br>and<br><br>17-21 | N/A<br><br>Applications will be evaluated by the state using a four-stage process.<br>1. Qualification Requirements. Applicants must certify they meet the Qualification<br>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:<br>Part 1: Qualification Requirements<br>Part 2: Project Narrative<br>Part 2: Project Narrative: Supporting Attachments |
| Application and Submission Information > Application Submission | 14-15 | 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.<br>• Use 8.5" x 11" letter-size pages with 1" margins<br>• Font size must be no smaller than 12-point.<br>• The Project Narrative must be double-spaced.<br>• 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.<br>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.<br><br>We request that the limit for the Executive Summary be increased and that it be excluded from the overall page limit.<br><br>We recommend eliminating page number and font restrictions to the supportive documents so that responders can fully comply with what is being requested. |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Selection of Demonstration Sites > Qualification Requirements ><br><br>Current Medicare Advantage D-SNP Plan<br><br>***and***<br><br>Current Medi-Cal Managed Care Plan | 18 | 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).<br>a. 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.<br><br>***and***<br><br>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.<br>a. 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 experience of any related parent or subsidiary entity. |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Selection of Demonstration Sites > Qualification Requirements > High Quality | 19 | 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:<br>a. DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements.<br>b. MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements. | Please define what quality measurements are required.<br><br>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. |
| Selection of Demonstration Sites > Qualification Requirements > Conflict of Interest | 21 | Applicants must certify that no prohibited conflict of interest exists. DHCS reserves the right not to award a commercial health plan contract to a 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. | Please clarify what this language means in the context of the Duals Demonstration. |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Project Narrative > Section 4: Care Coordination | 25 | The Applicant must:<br>▪ 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.<br>▪ 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. |
| Selection of Demonstration Sites > Project Narrative > Section 5: Consumer Protections > Section 5.5 Enrollment Process | 26 | The Applicant must:<br>▪ Explain how you envision enrollment starting in 2013 and being phased in over the course of the year.<br>o If you are seeking a passive enrollment approach with a voluntary opt-out, describe that process.<br>o If you are seeking an enrollment lock-in for as long as six months (requiring special Federal approval), then describe that process.<br>▪ Describe what your organization needs to know from DHCS about administrative and network issues that will need to be addressed before the pilot programs begin enrollment. | 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?<br><br>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. |

| Section | Page Number | Relevant Text | Question / Comment |
|---|---|---|---|
| Selection of Demonstration Sites > Project Narrative > Section 5: Consumer Protections > Section 5.7 Appeals and Grievance | 27 | Section 5.7: Appeals and Grievances<br>Applicants must:<br>▪ 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.<br><br>Please standardize the processes which are currently different for the Medicare and Medi-Cal programs.<br><br>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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healthy is for everyone
www.hpsm.org

January 9, 2012

**SENT VIA ELECTRONIC EMAIL TO: OMCPRFP9@dhcs.ca.gov**

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

RE: Comments on Draft Request for Solutions (RFS) for California's Duals Demonstration

On behalf of the Health Plan of San Mateo (HPSM), I would like to take this opportunity to comment on the draft RFS released December 22, 2011. My questions and comments that begin of page 2 of this letter follows the order and structure of the draft RFS.

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

I appreciate the multiple opportunities for stakeholders to give feedback and dialogue about ways to develop this important demonstration. We look forward to our continued involvement in this stakeholder process. I can be reached at maya.altman@hpsm.org or (650) 616-2145.

Sincerely,

Maya Altman,
Chief Executive Officer

**Demonstration Population (p. 9)**

- 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 HPSM 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 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. **In HPSM's 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.

**Enrollment (p. 9-10)**

- 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.

**Integrated Financing (p. 10)**

- 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:

| Outcome Measure | Before CC | After CC | % Decrease |
|---|---|---|---|
| % of at least one non-psychiatric hospital admission | 30.5 % | 16.9 % | - 45 % |
| Average length of stay | 8.2 | 7.3 | - 11 |
| % of at least one ER visit | 42.9 | 29.8 | - 31 |
| # of ER visits per member | 1.2 | 0.7 | - 42 |

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 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 HPSM 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.

**Benefits (p. 10)**

- Other HCBS Services. It is not clear whether pilot sites will be responsible for HCBS services available through specific waiver programs – such as the Assisted Living Waiver or the IHO Waiver. The RFS states LTSS to include IHSS, CBAS, MSSP and long-term custodial care in nursing facilities. We support and recommend explicit acknowledgement that pilot sites will be responsible for all LTSS services, including all available HCBS waiver programs. As noted earlier, it is critical for a single entity to be responsible and accountable for all LTSS in order to deliver integrated services and a seamless experience.
- Alternative, In-Lieu of Services. Will pilot sites have the flexibility to provide alternative or in-lieu services if pilot sites believe such services would enable a beneficiary to remain in their home/ community and prevent unnecessary nursing home placement? For example,
    - Currently, placement options covered under Medi-Cal are limited to a person's home through IHSS or in a nursing facility. Would pilot sites have the flexibility to offer services in board-and-care facilities if such placement is appropriate and is the least restrictive option for beneficiaries? This flexibility would a) give duals more choice and b) give pilot sites more tools to improve quality and contain costs.
    - MSSP is restricted to those 65 and over. However, MSSP covers a number of important services such as home modifications that may be appropriate for pilot beneficiaries who are under 65. Would pilot sites have the flexibility to make home modifications (MSSP benefit)

available to all pilot beneficiaries, including those that do not meet all MSSP eligibility criteria?

**Pharmacy Benefits (p. 11)**

- 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.

**IHSS (p. 11)**

- 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.

**Behavioral Health (p. 11)**

- 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.

**Technology (p. 11-12)**

- 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.

**Beneficiary Notification (p. 12)**

- Approval Process. Right now, all HPSM 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. HPSM 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 confuses members.

**Quality Incentives (p. 12)**

- 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 payment rates before submitting an application.

**Selection of Demonstration Sites (p. 18)**

- 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.

**County Support (p. 22)**

- 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.

**Stakeholder Involvement (p. 22)**

- 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.

**Section 1.2: Comprehensive Program Description (bullet 8, p. 25)**

- 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.

**Section 2.1: LTSS Capacity (bullet 3, p. 25)**

- 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.

**Section 2.2: IHSS (page 25-26)**

- 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?

**Section 2.3: Social Support Coordination (bullet 3, p. 26)**

- ADRC. Please clarify whether the San Mateo County Aging and Adult Services agency would qualify as the local ADRC-type model.

**Section 3: Coordination and Integration of Mental Health and Substance Use Services (bullet 2, p. 25)**

- 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.

**Section 5.5: Enrollment Process**

- 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.

**Section 5.6 – NCQA Accreditation (p. 26)**

- NCQA Accreditation Requirement. HPSM does 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.

**Appendix C – SNP Model of Care (p. 38-43)**

- 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. 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.

**Other Issues to Consider**

- 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, HPSM would have to re-enter the SNP market after a three-year absence. The MA marketplace is highly competitive. Without safeguards in place, the Duals Pilot represents the possibility of HPSM 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 HPSM 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, copayments and deductibles as well as additional services that are covered by Medi-Cal that Medicare does not cover.

  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 HPSM's experience as a DE-SNP, these issues create significant barriers to a beneficiary's initial enrollment, continued eligibility, and continuity of care.**

  HPSM would like DHCS to consider critical elements that impact continuous dual eligible status as part of the Duals demonstration:

  **1.** 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 HPSM 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. HPSM 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 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, HPSM extends 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 HPSM 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.

**2.** 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 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.

**3.** 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.

**4.** 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, HPSM has access to the most up-to-date and complete Medi-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 HPSM's 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. HPSM uses 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 HPSM 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 HPSM communicated 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 demonstration.

Continued HPSM access to MEDS must be a condition of participation in the Dual Eligibles Demonstration Project if HPSM is to assure that dual eligibles remain continuously enrolled in the program without breaks due to unnecessary loss of Medicare and/or Medi-Cal status.

Following is feedback for the Draft Request for Solutions for the California's Dual Eligible Demonstration Project.

**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.

**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.

**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.

**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.

**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.

Please let me know if you have any questions and best of luck with this highly valuable and challenging improvement.

David Jacobson – djacobson@healthcaresm.com – 805-844-7684

*Heritage Provider Network*

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January 9, 2012
Email: OMCPRFP9@dhcs.ca.gov

Department of Health Care Services
Procurement Office
P.O. Box 997413
Sacramento, CA 95899-7413

**RE: Comments on draft Request for Solutions (RFS) on dual eligible demonstration pilots**

Thank you for the opportunity to comment on the draft criteria for the dual eligible demonstration pilots. Heritage Provider Network is a limited Knox Keene licensed organization and delivers care to over 700,000 patients statewide through 2,300 primary care physicians, 30,000 specialists, and over 100 hospitals. Our commitment to the coordinated care model was recently recognized through our designation as the nation's largest Pioneer Accountable Care Organization (ACO) with 144,000 Medicare patients.

With over 30 years experience in California's health care delivery system, we believe that our innovative model and licensure capabilities has the potential to provide great benefit to the State's pending dual eligible demonstration pilots. That said, in the Department's RFS, certain criteria preclude us from applying to be part of these pilots. Below is a list of the troubling criteria, and suggested amendments that will enable HPN, and similar entities, to be eligible for application.

Knox-Keene License Qualification Requirement (Page 17)
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 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.

Medicare Advantage Dual Eligible Special Needs Plans (D-SNP) (Page 18)
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.

Current Medi-Cal Managed Care Plan (Page 18)
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.

Please consider these changes to the draft criteria so that entities who have a longstanding history of providing care to dual eligible are, in the very least, qualified to apply for these pilots. California is one of the most evolved delivery systems in the nation, and it is important innovate and progress as we look forward to 2014. Should you have any questions or comments, please feel to contact me.

Sincerely,

Richard Martin
Vice President
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# IEHP's Comments Regarding The Draft RFS Of The Dual Pilot

| Page # | Section | IEHP's Comments |
|---|---|---|
| 7 | Demonstration Population | ▪ The department should clearly define the services provided through DDS to avoid duplication of services provided by managed care plans.<br>▪ IEHP believes that we can provide quality care to all of our members, regardless of their diagnosis. Beneficiaries with HIV/AIDS, ESRD or ALS condition do provide some unique challenges often related to their use of out-of-network providers. There are two key issues – there must be adequate reimbursement; and for beneficiaries who have providers that refuse to work with the managed care plan, there must be an expedite medical exemption process.<br>▪ If the department intends to exclude beneficiaries who have been institutionalized for longer than 90 days, the department should specify in the final RFS that this exclusion occurs at the initial enrollment. |
| 7 | Enrollment | ▪ We support a passive enrollment with an opt-out provision for the beneficiary. We seek further clarification on this opt-out provision:<br>o Can beneficiaries opt-out for their Medicare only? Or can they opt-out for both Medicare and Medi-Cal?<br>o If they can opt-out for Medicare only, what is the department's expectation from managed care plans in coordinating (and financially responsible for) the LTSS services while the professional and hospital services will be provided through FFS Medicare?<br>▪ If the Federal government approves, the 6-month lock-in period seems reasonable as managed care plans will provide extensive care assessment and management in the first couple months of enrollment. If this is the case, the department needs to define whether the 6-month lock-in period means not allowing beneficiaries to switch to FFS and/or other managed care plan in their county.<br>▪ We recommend the department to use one enrollment mechanism in the Pilot counties to avoid consumer confusion. |

| Page # | Section | IEHP's Comments |
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| | | ▪ In addition, we encourage the department to clarify the rule about how often and when beneficiaries can switch their managed care plan.<br>▪ We support the phase-in enrollment approach as the department has conducted for the Medi-Cal SPD since June 2011. |
| 8 | Geographic Coverage | ▪ There are several extremely rural areas in Riverside and San Bernardino counties. Under the current Medi-Cal managed care model in these two counties, some of these rural areas are designated by the department as "voluntary" and some as "excluded" for the Medi-Cal enrollment purpose. We urge the department to use these current designations for the Dual Pilot. |
| 8 | Integrated Financing | ▪ We request the department to share utilization data early with managed care plans and to provide proposed rate at least 6 months prior to implementation for review, discussion and negotiation. It also allows managed care plans to develop structural organization and operations plans accordingly.<br>▪ Do managed care plans need to submit an annual bid to CMS for Medicare Part C? How does the HCC score play a role in this new integrated financing model? |
| 8 | Benefits | ▪ We request the department to clearly define what benefits and services managed care plans will provide and be financially responsible for. |
| 9 | IHSS | ▪ We seek further clarification from the department for Year 1:<br>o Will managed care plans be financially responsible for the benefits? If yes, will the department share all information about program costs, including administration, wages and benefits?<br>o In the Year 1, IHSS benefits will be authorized under the same process used in the current state law. This means managed care plans will be excluded in the service authorization process. It seems reasonable that the state pays the program directly or through managed care plans as a "complete pass through". |

| Page # | Section | IEHP's Comments |
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| | | ▪ We seek further clarification from the department on which roles managed care plans can expand in Year 2 & 3. |
| 9 | Supplemental Benefits | ▪ We agree with the department to allow managed care plans to define what optional benefits should be provided. We seek further clarification on:<br>o Will the optional benefits process be developed similar to the Medicare bid?<br>o Will their associated costs be counted toward medical utilization used for the department's rate setting? |
| 10 | Beneficiary Notification | ▪ We encourage the department and CMS to develop a single set of rules for Medi-Cal, Medicare Part C and Part D (instead of keeping the Part D rules separately). |
| 10 | Appeals, Network Adequacy, Monitoring & Evaluation | ▪ We support a single set of standards from the department and CMS. |
| 10 | Quality Incentives | ▪ We request the department to publish the capitation withhold criteria at least 6 months before implementation.<br>▪ While managed care plans will not be eligible for Medicare star bonuses, we expect that managed care plans will not be subject to the Medicare star rating. We need the department to clarify this issue in the final RFS. |
| 11 | Medical Loss Ratio | ▪ The ACA requires the MA and SNP plans to have the MLR at least 85%. We need the department to clarify this issue in the final RFS. |
| 11 | Ongoing Stakeholder Involvement | ▪ We need the department to define "meaningful involvement of stakeholders". |
| 16 | Section 2(b)(i) – Local Support | ▪ We need the department to define "local support" and which documentation the department is looking for. |
| 16-17 | Section 3(a) D-SNP experience, 3(b) HEDIS performance, 3(d) length of Medi-Cal Contract, and | ▪ Which benchmarks will the department use? |

| Page # | Section | IEHP's Comments |
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| | 3(h) network experience | |
| 17 | Financial Condition | ▪ We suggest the department informs DMHC about these criteria and work with DMHC to issue a timeline and process on how to request this documentation. |
| | | |
| 18 | Current Medi-Cal Managed Care Plan | ▪ We support the department in encouraging collaboration among plans. |
| 19 | Countywide Coverage | ▪ There are several extremely rural areas in Riverside and San Bernardino counties. Under the current Medi-Cal managed care model in these two counties, some of these rural areas are designated by the department as "voluntary" and some as "excluded" for the Medi-Cal enrollment purpose. We urge the department to use these current designations for the Dual Pilot. |
| 19 | Business Integrity | ▪ We request the department to define "unresolved quality assurance issues".<br>▪ We also request the department to define what level of sanctions or penalties will need to be reported. |
| 19 | High Quality | ▪ The department indicates that managed care plans must demonstrate that they meet or exceed minimum quality performance indicators. We encourage the department:<br>o To involve managed care plans in developing these quality performance indicators, and<br>o To inform us which benchmarks the department will use and why. |
| 19 | Encounter Data | ▪ The certification for encounter data submitted from managed care plans should be "the most complete and accurate", instead of "complete". |
| 21 | Work plan and Deliverables Certification | ▪ The department requests that managed care plans must certify that they are willing to comply with all future Demonstration requirements as specified by DHCS and CMS. We request the department to specify that all future requirements will be |

| Page # | Section | IEHP's Comments |
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| | | informed to managed care plans at least 90 days and must be mutually agreed between the department and managed care plans. |
| 23 | Section 2 – Coordination and Integration of LTSS | ▪ As mentioned in our comment in the "Enrollment" section, if beneficiaries can opt-out for their Medicare only, our effort in coordinating and integrating the LTSS services will be very limited as the professional and hospital services will be provided through FFS Medicare. |
| 26 | Section 5.4 – Stakeholder Input | ▪ We request the department to define "meaningful involvement" of external stakeholders in the development and ongoing operation of the program. |
| 26 | Section 5.6 – NCA Accreditation | ▪ We request the department to specify in the final RFS that the NCQA requirement is for Medi-Cal only. |

*Dear Fellow IHSS Consumers and Our Supporters,*

*There are big movements afoot for re-organizing the IHSS program. Read about it at Duals Integration Demonstration (http://www.dhcs.ca.gov/provgovpart/Pages/DualIntegrationDemonstration.aspx). Several organizations in the state: unions of care providers, Public Authorities, County Welfare Directors, health insurance companies, and other organizations have all given comment. Current IHSS consumers, however, those most affected by these changes, were seldom, if ever, consulted in many of the proposals put forth.*

*The formation of the IHSS consumers Union is the answer to a long wished for organization that speaks and advocates for our needs. Current IHSS Consumers' lives are radically affected by changes to the IHSS Program and need to have a say in the program. In response to some of the more difficult points made in some of the proposals, we have put together this list of demands that represent our views on our rights to determine our lives and hard won civil rights. We have also added demands that have always been missing from a true continuum of care.*

*We strongly oppose passive enrollment into any program that would deprive us of our individual providers, be they family members or the providers we have chosen from the community. This is viewed by the IHSS Consumers Union as a bad faith effort to trick us out of our genuine choice of how we receive our most intimate personal choices in in-home supportive services. Many of our people have difficulty responding to mail in time, which is especially egregious because the state no longer allows our providers to open our mail or read it to those who are visually impaired. We view this as a hostile attempt to trick us out of our true choice.*

*The following demands were put together to express what we cherish as our rights to control our own lives. If you agree, please sign on and join us as a Current IHSS Consumer Member (voting) or Supporting Member (nonvoting) whose support and input we value!*

**NOTHING ABOUT US WITHOUT US!!!**

**Alternate Formats Available On Request**

**IHSS Consumers Union**

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

- Creation of a carve-out for the Individual Provider (IP) mode for self-directing IHSS consumer for those who choose it.

- The right to choose the mode of delivery we most prefer.

- The right to use the IP mode, the most cost-efficient, stripped down method of attendant services because the money goes directly to the provider who delivers a service to the IHSS consumer. Some IHSS consumers prefer staying with the method they currently have, while others choose case management.

- Right to Active Enrollment: Passive enrollment into any program that would deprive us of our individual providers is viewed as a hostile attempt to trick us out of our true choice for the IP mode.

- That IHSS remain a person-centered social model rather than a medical model. Paramedical services and scheduling must conform to the IHSS Consumer's life: work, school, personal needs and preferences rather than any medical agency's shifts or procedures.

- Recognizing that there is a wide diversity in the capacities of IHSS consumers and that “One-Size-Does Not-Fit-All.” Self-Directing IHSS Consumers who do not request case management must not be burdened with multiple visits by IHSS workers, case managers, nor required to have a care coordination team.

- IHSS Consumers retain their authority as the employer with the right to hire, fire, supervise, schedule, train and retain any Individual Providers (IPs) including family and community members and not limited to any person listed by a registry.

- Family member or significant other providers should not be made to give up portions of their attendant hours to strangers coming into their home.

- Self-directing IHSS consumers have the right to train their own providers in the personal-care methods they prefer. Stipends should be paid to incoming providers being trained by the consumer.

- Providers wanting additional training to improve their skills and employability may receive that training in educational settings, outside of the self-directing consumer's home.

- IHSS program paramedical services such as suppository, digital stimulation and catheter insertion, routine daily injections of prescribed medications (i.e. insulin), wound, ostomy, and catheter care will continue to be safely administered by a family member provider or attendant of the consumer's choice, as it has in the IHSS program for decades.

- No entities shall interfere in the independent relationship between the consumer and their provider.

- Profits / Administrative costs must never be at the expense of Consumer hours. Administering entities must have diligent oversight by both the State of CA & CMS (federal). Data collecting, tracking, outcomes stats and monitoring must be thorough, transparent & readily available to the public and cap of administrative costs must be upheld.

- As funds become available from reduced E. R., hospital, institutional care and profits, etc, these monies must be directly invested direct service rather than the administration and profits.

- Access to a universal standard of rehabilitation approved by National Institute on Disability and Rehabilitation**,** adequate to give people with newly disabling conditions proficiencies in Activities of Daily Living. Discharge planning must require discharge planners to secure a hospital trained family or community provider and connect the PWD with IHSS, California Community Transition program, Linkages, MSSPs or other ongoing community supports.
- People with newly disabling conditions who cannot return to inaccessible housing should be transferred to step-down, transitional housing until accessible housing can be acquired.

- Access to ancillary services to support community living, (i.e. Section 8 certificates and 24/7 emergency response services.)

- No care team, managed-care entity or individual provider has any standing or authority to monitor, inform on, or determine the self-directing IHSS consumer's decisions. IHSS consumers view this as patronizing and a flagrant violation of our self-determination and civil rights.

Because the IP mode of IHSS requires nothing more than the actual cost of delivering services (i.e. money to the provider to care for the consumer), it is a particular blessing to governments in times of fiscal difficulty.  As the baby boomers age and need these services, its cost efficiency and utility will be undeniable. We, the undersigned current IHSS consumer members and our supporters of the IHSS Consumer's Union, believe there is no place like home for all citizens as they age or acquire a disabling condition. The above-mentioned demands are put forth in order to safeguard the dignity and self-determination of all persons who need In-Home Supportive Services.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Program Offices

January 9, 2012

SENT VIA ELECTRONIC MAIL TO: OMCPRFP9@dhcs.ca.gov

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Ave., Suite 6001, MS: 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Attn: Medi-Cal Procurement Office
Duals Integration Demonstration Project
cc: Harbage Consulting

Re: draft *Request for Comments on California Duals Demonstration Overview*

Dear Mr. Douglas:

Kaiser Permanente offers the following comments in response to the Department of Health Care Services (DHCS) draft of *California's Dual Eligible Demonstration Request for Solution*s (RFS) released by DHCS in conjunction with Harbage Consulting in December 2011.

***Background***. Kaiser Permanente is a major provider of care to California dual eligible members. We have more than 50,000 members enrolled in our Medicare-Medicaid dual eligible Medicare Special Needs Plan (SNP). These members, who have been KP enrollees for an average of 12 years, have complex treatment and care management needs and receive care through our exclusive, integrated, multi-specialty group practices. Kaiser Permanente Medicare Advantage plans in California, including our SNP for dual eligibles, have all been rated with five stars under Centers for Medicare & Medicaid Services (CMS) quality ratings for 2012. Kaiser Permanente is the only health plan in California with a five-star SNP. Our SNP is one example of a model of care that the dual eligible pilot program seeks to replicate and bring to scale.

We remain deeply concerned that DHCS has not provided a clear pathway to prevent the disruption of care and provider relationships for our SNP enrollees.

***Kaiser Permanente RFS Comments***. The following comment addresses the "Demonstration Goals" Section, on page 6 of the RFS:

> Comment 1: Kaiser Permanente has 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. Kaiser Permanente has 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 the Kaiser Permanente SNP and its specialized care model. Ending Kaiser Permanente 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.

The following comments address specific issues contained in the draft RFS "Enrollment" Section on pages 7 and 8 of the RFS:

Comment 2: 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 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.

Comment 3: 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:

- once due to the closure of a SNP;
- again when passively enrolled into a different plan designated as a pilot site;
- a third time if he/she chooses to opt-out of that pilot plan in which enrollment was mandatory; and

- again if the beneficiary chooses to enroll in another managed care plan after opting out of the demonstration.

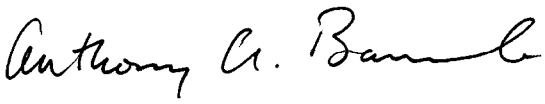
This type of care disruption, which could affect tens of thousands of enrollees, raises major concerns and threatens outcomes that defeat several key demonstration goals. In addition, these potential scenarios include moving more than 50,000 Kaiser Permanente enrollees from Medicare 5-star, coordinated, high-quality health plans, to health plans with below-average or average quality (2.5 stars and 3 stars).

Comment 4. 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?

Thank you for the opportunity to comment on this draft RFS. We offer these comments, including suggested solutions, as alternatives to significant care disruptions that we foresee. We appreciate DHCS's consideration in finalizing the RFS and as the California Dual Eligible Demonstration takes shape.

If you have further questions about our comments, please do not hesitate to contact me at anthony.barrueta@kp.org or 510.271.6835 or paula.ohliger@kp.org or 510.271.2325.

Sincerely,



Anthony Barrueta
Senior Vice President, Government Relations
Kaiser Permanente

January 9, 2012

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

**COMMENTS ON CALIFORNIA'S DUAL ELIGIBLE DEMONSTRATION REQUEST FOR SOLUTIONS (RFS)**

Dear Mr. Douglas:

Thank you for the opportunity to provide comments on California's Dual Eligibles Demonstration Project draft site selection criteria/RFS.

At the outset, we commend the State on this bold policy initiative and its partnership with the Centers for Medicare and Medicaid Services (CMS) to be at the forefront of creating organized delivery options to better serve one of our most vulnerable populations.

L.A. Care supports the State's decision to build upon the existing Medi-Cal managed care models for a myriad of reasons. This makes particular sense for Los Angele County with the recent transition of Seniors and People with Disabilities (SPD) to managed care and the increasing number of SPDs that will become dually eligible.

**Demonstration Population (page 7)**

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.

**Enrollment (pages 7-8)**

L.A. Care requests 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.

**Benefits (page 8)**

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.

**Quality Incentives (page 10)**

L.A. Care urges 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.

**Countywide Coverage (page 19)**

While L.A. Care is 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.

**Nonprofit Organizations (page 21)**

The RFS seeks certification of the applicant's standing as a corporation, LLC, nonprofit, etc. but not as a public entity as described in L.A. Care's enabling legislation (Article 2.81 of the California Welfare and Institutions Code (commencing with Section 14087.96). L.A. Care would like to confirm public entity participation in the RFS and pilot.

**Application Submission (pages 14-15)**

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.

L.A. Care looks forward to working with DHCS on this demonstration project. Please feel free to contact me with any questions at (213) 694-1250 x4102 or hkahn@lacare.org.

Sincerely,

Howard A. Kahn

LEGAL AID SOCIETY
OF SAN MATEO COUNTY


**The Health Consumer Center of San Mateo County**
www.healthconsumer.org

The Legal Aid Society of San Mateo County (LASMCO) appreciates this opportunity to provide comments to DHCS on the RFS for the California Dual Eligibles Demonstration Project. We believe that the inclusion of stakeholder input into the criteria that will be used for site selection is a significant step toward insuring the success of these demonstration sites as a model to better serve the needs of the dual population.

LASCMO is a non-profit law firm that provides free legal services to low-income residents of San Mateo County. We have a longstanding history of working in partnership with local community based organizations and government entities in order to improve the lives of the most vulnerable members of our community through equal access to justice. Among our most innovative projects is a partnership between our Health Consumer Center and the Health Plan of San Mateo that works to improve access to quality health care for San Mateo County residents, particularly the elderly and disabled. Through this partnership we have had the opportunity to work extensively with the dual population and to assist a large number of dual eligibles both individually and through systemic advocacy to overcome some of the barriers that prevent them from fully accessing the health care they need. Our comments on the RFS are based on this experience.

**Demonstration Goals, page 8 of RFS**

LASCMO is pleased to see that one of the goals of the Demonstration Project is to increase the availability of and access to home and community based alternatives. It has been our experience that the current system contains a built-in bias toward institutional care that has been increasingly exacerbated by continuing cuts to the home and community based options available to this population such as In Home Supportive Services (IHSS) and Personal Care Provider Services (PCSP) and Adult Day Health Care (ADHC.) We are hopeful that through the Duals Pilots we will be able to reverse this trend and demonstrate that the provision of services to this population in the least restrictive and most empowering manner possible is not only the best solution from the perspective of the health and well-being of the individuals involved but is also a cost-effective approach to the provision of care.

**Demonstration Model Summary – Demonstration Population, page 9 of RFS**

The RFS as currently configured requires beneficiaries to be "full benefit eligibles." As we understand it from the conference call with DHCS on January 5, 2011, this means that Medi-Cal recipients who have a share of cost will be excluded from the pilot programs even if they have met that share of cost. In contrast, HPSM currently runs a Dual Eligible Special Needs Plan (D-SNP) which enrolls Medi-Cal beneficiaries with a share of cost as long as they meet that share of cost at least once every six months. The current share of cost system in California is one of the greatest

THE NATALIE LANAM JUSTICE CENTER
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barriers to adequate access to health care by the aged and disabled members of our population, as these individuals are forced to spend all but $600 of their monthly income on their health care needs before they can receive any assistance from the Medi-Cal system. The inclusion of those Medi-Cal beneficiaries with a share of cost into the HPSM D-SNP as long as they meet their share of cost once each six months is extremely helpful to at least partially eradicate this barrier, and we would urge a similar provision for the Dual Demonstration Projects.

In addition, in the RFS as it is currently written there is no recognition that the dual population faces significant barriers to maintaining their eligibility for both Medi-Cal and Medicare. 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. It is our suggestion that those plans seeking to become a Dual Demonstration Site 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. It is our further suggestion that DHCS provide the selected demonstration sites with the tools that would enable them to fully assist enrollees to maintain their eligibility status including access to the Medi-Cal Eligibility Data System (Meds), and the flexibility to keep an enrollee in the Pilot where there is information indicating that recertification of eligibility for either Medi-Cal or Medicare is in process.

Finally, LASMCO opposes carve outs of any population from the Dual Pilots. The purpose of the demonstration projects is to improve coordination of care, access to care and quality of care for this population. There is no basis to exclude a segment of the population from the benefits of these pilots based solely on their diagnosis. For each of the suggested carve out populations there is a wide range of needs. Some with HIV/AIDS require less care than those disabled by cancer or diabetes. There is no reason why one group should be eligible for the pilot and another group excluded. Moreover, the exclusion of those already institutionalized more than 90 days will adversely impact the ability of that population to return to a home or community based care situation in violation of the Olmstead decision.

**Demonstration Model Summary – Enrollment, p. 9 of RFS**

LASMCO opposes a passive enrollment process as being inconsistent with the stated goals of the Demonstration Pilots and contrary to what we have learned from the experience enrolling the SPD population into managed care generally. A key goal of the Demonstration Pilots as set forth on page 8 of the RFS is to "preserve and enhance the ability for consumers to self-direct their care and receive high quality care." Passive enrollment into a demonstration project is the antithesis of consumer self-direction. Many duals have long-term relationships with doctors and other care providers who are meeting their needs for coordinated and high quality medical service. To put such individuals in a position where they must actively seek to opt out of care that is meeting their needs is a recipe for failure. The mandatory enrollment of the SPD population into Medi-Cal managed care has been rife with examples of disruption in continuity of care. There is no need for passive enrollment. The plans selected to be demonstration sites should be able to offer benefits to

the dual eligible which will make them attractive and will assure adequate enrollment. Voluntary enrollment will provide the Demonstration Sites with the greatest likelihood of success and is therefore vastly preferable to a system of passive enrollment even with an opt-out provision.

**Demonstration Model Summary – Benefits, IHSS, RFS page 11**

The RFS states that during the first year of the Demonstration, IHSS benefits will be authorized under the same process used under current state law. LASMCO believes that the Demonstration Sites should be given greater flexibility in authorizing IHSS services in order to increase the likelihood of reaching the goal of increasing the availability of and access to home and community based services. As mentioned above, the current budget crisis faced by the state of California has resulted in significant cuts to the availability of IHSS and other home and community based care and increased the long-standing bias toward institutionalization of the disabled and elderly in direct contravention of the Olmstead Act. In order to reverse this trend and fully explore the possibility that care could be provided more effectively, humanely and respectfully in non-institutional settings, Demonstration Sites should have the ability to increase the authorizations of IHSS beyond what is currently authorized under current state law where deemed appropriate to reach the goals of the pilot as set forth on page 8 of the RFS.

**Demonstration Model Summary – Appeals, RFS page 12**

Although LASMCO supports the proposal for a uniform appeals process across Medicare and Medi-Cal for the Demonstration Projects, we would like to see built into this proposal an assurance that the system of appeals will contain all of the consumer protections that currently exist in the Medi-Cal appeals process including the opportunity for timely in-person hearings before an administrative law judge when medical services are denied or delayed.

**Qualification Requirements – County Support, RFS page 22**

As noted above, LASMCO urges DHCS to include a requirement that applicants submit a plan to work cooperatively with the County Department of Social Services agency responsible for determining initial and ongoing beneficiary eligibility for Medi-Cal and for the Medicare Low Income Subsidy Programs such as the QMB, SLMB and QI-1 Programs in order to assure that their enrollees maintain their eligibility for the Demonstration Project and have access to continuity of care once they enroll.

Once again, we thank you for providing us with the opportunity to comment on the RFS. Please contact Tricia Berke Vinson (tvinson@legalaidsmc.org) for more information about these comments.

CA's Dual, "Request for Solutions"

NOTE: LARGE PRINT page numbering is different than the standard printed page numbering

Note: Too much is *not* listed in this draft what the pilots expectations are. The RFS should be comprehensive with details to which commenter can exchange ideas.

The abbreviation, size, scope of the concept in the Draft released December 22, 2011 entitled, "California Dual Eligible Demonstration Request for Solutions" excludes many issues of *great* concern leaving too much room for the state, its contractors and health care plans to design without public knowledge, review, correction; *very* detrimental to beneficiaries! If it walks like a duck, quacks like a duck but doesn't begin to be a duck, I think the expression goes!

Note: A full disclosure, easy to understand silo programs will be exempted, each pilot should be listed on the first page of any/all agreements. If any exempted group/person wants to join the demonstration pilot flexibility should be clear, the person has that freedom to choose participation without limitations or conditions placed on that person.

Note: There should be a carefully designed cultural mandate including services for the deaf community suing sign language which meets the ASL standards NOT and NOT depending on a friend or family member to interpret for the beneficiary. Sign language must be included as one of the many languages. Health Care pilot plans/applicants must be assessed for their ability to communicate NOT with a county health plan contractor. People doing assessments must be fully ready to use common equipment to communicate—not to rely on "Speech-to-Speech telephone operators…or non-certified ASL interpreters. Staffing at all levels of care must have a 24/7 ASL person on duty in critical health care areas such as in the Emergency Room, initial assessment face-to-face, Discharge Planner, Quality Assurance staff, on a locked Psych unit for 5150 admissions, and at least two shifts (7 a.m. – the 3 p.m. to 11 p.m. shifts) with a person who can sign to a patient's needs, surgery, physical rehabilitation services, diagnostic labs, x-ray, financial office, complaint and Ombudsmen, in addition any long term care facility be ready to use certified ASL interpreters in a timely basis.

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.

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.

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."


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 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.

Page 7 of 68
"…what are the specific CMS standards and conditions (not included in this draft?)

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" …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.

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 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.

Page 11, Part D plans beneficiaries are already enrolled in should be continued until a beneficiary

wishes to change their pharmacy benefit. Non-formulary medications have been reviewed and exceptions granted due to reactions to drugs within the formulary. Extreme flexibility must be allowed as a change in a beneficiary's drug usage can have devastating effects. People have many different needs for the use of particular drug use. THAT MUST be mandated when a person is drawn into their new pilot program especially when a person has any kind of pharmacy history.

It is ESSENTIAL that beneficiaries be allowed to choose their own pharmacy with whom they have a history. That history and working relationship with your pharmacist is critical! Contra Costa County suddenly ended their working relationship with major drug stores with a result of a number of deaths of SPDs—not to mention a devastating financial hardship on providers. Beneficiaries could not get to the newly listed pharmacies causing an irreparable lack of quality outcomes.

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.

Page 13, "Supplementary Benefits" ensure that by using services and programs that what ever is used within the community-based services does NOT effect 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!

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 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!

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.

Page 15, Ongoing Stakeholder Involvement, "Meaningful involvement of external stakeholders, including consumers in the development and ongoing operations of the program will be required."

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.

Respectfully submitted:
Maggie Dee-Dowling
426 W. 11th St.
Pittsburg, CA 94565
Tel. 925-427-1219

MOLINA HEALTHCARE

January 9, 2012

Toby Douglas, Director
Department of Health Care Services
c/o Office of Medi-Cal Procurement
MS Code 4200
Post Office Box 997413
Sacramento, California 95899-7413

Dear ~~Mr.~~ Douglas: Toby

Molina Healthcare of California is pleased to provide comments to the draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project. Attached is a chart that indicates the corresponding page, a brief description of the section and our comments. We would be happy to discuss these in greater length if necessary, and will continue to actively participate in the stakeholder meetings that have been taking place across the state.

Thank you again for allowing us to comment on the draft Request for Solutions. If you have any questions, I can be reached at 562-491-7044.

Sincerely,

Lisa Rubino, President
Molina Healthcare of California

**Draft RFS - Dual Eligibles Demonstration**
**Molina Healthcare Comments**

| Page # | Description | Molina Comments |
|---|---|---|
| 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, Molina coordinates 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. |
| 7 | 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. | 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. |
| 7 | Demonstration Population: The Department is seeking comment on whether the Demonstration should exclude beneficiaries with conditions such as HIV/AIDS, End-State Renal Disease (ESRD), Amyotrophic Lateral Sclerosis (ALS) or who have been institutionalized for longer than 90 days. | Molina believes that individuals institutionalized for longer than 90 days should be initially carved out of the Demonstration for the first year. However, Molina 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. Molina believes 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. |

**Draft RFS - Dual Eligibles Demonstration**
**Molina Healthcare Comments**

| Page # | Description | Molina Comments |
|---|---|---|
| 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). | Molina supports 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. Molina believes 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, Molina does 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, Molina suggests 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. |
| 7-8 | 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. | Molina believes 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. Molina believes 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. Molina supports 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. Molina has 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), Molina encourages 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. |

**Draft RFS - Dual Eligibles Demonstration**
**Molina Healthcare Comments**

| Page # | Description | Molina Comments |
|---|---|---|
| 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. Molina 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. |
| 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. | Molina is 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. Molina suggests 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. Molina looks 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. |
| 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. | Molina seeks 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. |

**Draft RFS - Dual Eligibles Demonstration**
**Molina Healthcare Comments**

| Page # | Description | Molina Comments |
|---|---|---|
| 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 Molina assumes that the low-income and co-pay subsidies will also continue for this population, the final RFS should clarify this point. |
| 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. | Molina supports 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. |
| 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. | Molina is committed to providing necessary care for individuals with behavioral health needs. Given the severe access challenges in the county mental health system currently, Molina seeks 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. |
| 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. | Molina suggests 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. |
| 10 | Appeals: There will be a uniform appeals process across Medicare and Medi-Cal. | Molina assumes 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. Molina believes that the first level of appeal for both beneficiaries and providers should be made to the plan. |
| 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. |

**Draft RFS - Dual Eligibles Demonstration**
**Molina Healthcare Comments**

| Page # | Description | Molina Comments |
|---|---|---|
| 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. |
| 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. | Molina supports transparency for purposes of the evaluation, and suggests that administrative costs associated with sub-contracts be examined as part of the pilots. |
| 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. Molina believes 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 CMS, Molina believes 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. |
| 16 | Qualification Requirements: Applications will be based on specific criteria, including that defined by SB 208. | Molina would 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. |
| 16-17 | Criteria for Additional Consideration: Length of experience as D-SNP; 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. | Molina supports 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, Molina 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 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, Molina 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. |

**Draft RFS - Dual Eligibles Demonstration**
**Molina Healthcare Comments**

| Page # | Description | Molina Comments |
|---|---|---|
| 17 | Qualification Requirements/Financial Condition: Plans will be required to show a letter from the Department of Managed Health Care Services demonstrating they are in good financial standing. | Molina 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. |
| 18 | Current Medi-Cal Managed Care Plan: Applicants will be required to have a current contract with the Department to operate a Medi-Cal Managed Care contract in the same county as the proposed dual eligible site. | Molina currently has 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. Molina 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. |
| 18 | Current Medi-Cal Managed Care Plan/Geographic Managed Care: At least two entities with a current Medi-Cal managed care contract must apply for the Application to be considered. | Molina seeks clarification on whether all plans within the GMC model would receive dual eligible enrollments, even if all plans don't apply? Secondly, Molina assumes 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? |
| 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. Molina 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. Molina understands 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. |

**Draft RFS - Dual Eligibles Demonstration**

**Molina Healthcare Comments**

| Page # | Description | Molina Comments |
|---|---|---|
| 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. |
| 19 | High Quality: Plans must demonstrate minimum quality indicators including Department indicators, MA-SNP quality requirements and mandatory HEDIS measurements. | Molina supports 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. |
| 19 | Encounter Data: Applicants must certify they will provide complete encounter data as specified by the Department. | Molina works 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. |
| 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. | Molina has 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 the pilot participants in order to facilitate such agreements and contracts. Molina would suggest a standard agreement or contract for the parties to use in their discussions. |
| 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? |
| 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. Molina is 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. |

**Draft RFS - Dual Eligibles Demonstration**

**Molina Healthcare Comments**

| Page # | Description | Molina Comments |
|---|---|---|
| 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. | Molina uses 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 to supplement existing provider networks in this area? Molina would suggest that plans be allowed to provide this benefit through providers that can meet appropriate care and access standards. |
| 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, Molina supports the continuity of care provisions as 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. |
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| | | |

<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 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 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.

**M**ultipurpose Senior Services Program **S**ite **A**ssociation
1107 9th Street, Suite 701, Sacramento, CA 95814 Phone: 916. 552. 7400 ~ Fax: 866.725.3123

## Response to California's Dual Eligible Demonstration Proposed Request for Solutions

On behalf of California's MSSP Sites and the older adults with disabilities we serve, the following comments are submitted to open a dialogue between DHCS and MSA about this highly impactful and important initiative.

The Request for Solutions document outlines a massive undertaking of a number of initiatives at one time with little details. The lack of specifics and direction regarding expectations, implementation and quality assurance measures, as well as no consumer protections in place are troubling. We acknowledge that changes regarding the delivery of health care in California is needed, however the speed and magnitude of this project may result in unintended consequences that instead of making things better, may actually compound the fragmentation and gaps in care. Trying to force together programs, services and providers that have traditionally operated separately for over 30 years, cannot happen overnight and not without meaningful dialogue with those who have provided these services.

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.

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?

MSA encourages the State to consider a longer phase-in timeline with strategic handoffs and clear communication to the public while bringing key groups to the table to help educate both DHCS and managed care entities regarding potential pitfalls and barriers that are unique to these programs. It is imperative that the work on these transitions be comprehensive to ensure that the frail older adults of California do not fall through the cracks due to changes being fragmented and moving too quickly.

MSSP traditionally fills in where all other services leave off to help this vulnerable population navigate through services and change when no one else can or will. Incorporating the MSSP Site Association into direct conversation can help California determine the best approach and program design. Our unique perspective and over 30 years of success can help to ensure a proven, successful method of care management for California's most frail and vulnerable is maintained to support their desire to remain in the community.

The MSSP Site Association appreciates the opportunity to provide comments on the proposed Request for Solutions and looks forward to working closely with the State in moving forward on health care reform in a bold but sensible manner, ensuring the valuable assets within the system are retained, including MSSP. Please contact Denise Likar, President at 562-637-7138 or Erin Levi of Lehman, Levi, Pappas & Sadler at 916-441-5333 to collaborate on this important initiative.