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

January 9, 2012

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Mall, M.S. 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Delivered via e-mail to: OMCPRFP9@dhcs.ca.gov

Re: Response to Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project 12/22/11

Dear Director Douglas,

Thank you for providing this opportunity to comment on the draft Request for Solutions. The National Senior Citizens Law Center has been an active participant in the Dual Eligible Demonstration stakeholder process. We participated in the 1115 dual eligible technical workgroup, served on the Dual Eligible Technical Assistance Panel and have been involved in numerous meetings and conversations with Department staff and contractors. We support the goals of the Demonstration and have had high hopes that the Department of Health Care Services would use the opportunity presented by the Demonstration to develop innovative, person-centered systems of care.

We believe the draft Request for Solutions falls far short by simply expanding enrollment in existing medical-focused managed care systems. We have serious concerns about the policy decisions reflected in the draft and believe that significant revisions are needed to ensure that the goals of the Demonstrations can be met while including sufficient consumer protections.

We have provided detailed comments on the draft RFS below, but want to note that our comments do not include our views on the proposals outlined in the Governor's budget which would impact significantly the scope, size, timing and substance of the duals Demonstrations and, more broadly, the reform of the Medi-Cal Long Term Services and Supports delivery system.

We have serious concerns about the Governor's proposals including the fact that they were never raised with stakeholders in the myriad meetings held to discuss the duals Demonstration. The decision to propose such drastic changes in the Governor's budget without first discussing them with stakeholders is, we fear, an indication that the stakeholder process to date has not been a meaningful one.

Despite that concern, we continue to be ready and willing to work with the Department to design new models for person-centered care that will improve the delivery of services to dual eligibles.

Sincerely,

Kevin Prindiville
Deputy Director

Georgia Burke
Directing Attorney

Overview

P. 6 Demonstration Goals

We agree with the goals listed for the Demonstration, particular those related to expanding access to home and community based services and preserving and enhancing self-direction. An additional goal should be added related to improving the quality of care provided to dual eligible. For all the goals, the Department needs to explain in this document or others how progress towards each goal will be measured.

Demonstration Model Summary

P. 7 Demonstration Population

The draft seeks comment on whether certain groups of individuals should be excluded from the Demonstration. It is unclear whether the exclusion would be done to protect these individuals from the potential harm of participating or to protect plans from costs associated with these conditions.

Individuals who have been in institutions for 90 days prior to enrollment should be included in the demonstration. If Applicants will be asking for the authority and responsibility to provide long term supports and services, they should be expected to provide these services for all individuals that need them and should be incentivized to work to transition institutionalized individuals into the community as appropriate. We would oppose any policy that would disenroll individuals from plans after they have been enrolled in a plan for 90 days or any other length of time. The potential positive effects of an integrated system – plans working to keep individuals in the community – can only be achieved if plans bear the full risk of institutionalization.

Individuals with HIV/AIDS, ESRD and ALS should have the option to enroll in an integrated model, but should not be passively or mandatorily enrolled or locked-in if they voluntarily enroll. As the question seems to indicate, individuals with these conditions – and others – are likely to have complex health needs that California's Medi-Cal managed care plans and most Dual Eligible Special Needs Plans (D-SNPS) may not be prepared to care for adequately. The potential for disruption in medication and treatment regimes and provider relationships is too great to expose these individuals to a passive or mandatory enrollment process. To the extent that the models offer an improved beneficiary experience and individuals in these groups believe they could benefit by participating, they should be allowed to do so instead of being excluded on the basis of their condition.

We note the inconsistency in the Department's willingness to consider that managed care may not be appropriate for these groups while insisting that it provide benefits to all others, even though many of those have conditions equally or more complex.

The Department has indicated that the Demonstration population is not expected to include full benefit dual eligibles with a Share of Cost. We believe that individuals with a Share of Cost should be eligible to enroll as many of them have significant long term care needs that could be well serviced by an effective, integrated model. We also recommend providing exceptions or modifications to current Share of Cost rules to allow people who need to enter an institution, but intend to return to the community, to maintain their community housing.

Finally, we note that many dual eligibles struggle to attain and maintain Medi-Cal eligibility and Medicare enrollment. The current eligibility system which requires Medi-Cal recipients to renew their eligibility each year and provide full verification of all their assets at the time of renewal presents a major challenge to those individuals who are home-bound, severely disabled and must often rely on others for assistance with their daily living activities. As a result, there are often gaps in eligibility for Medi-Cal for this population. Gaps in Medi-Cal eligibility can also impact eligibility for Medicare as termination from Medi-Cal results in termination of buy-in for the Medicare Low Income Subsidy Programs such as QMB, SLMG and QI-1. Applicants should be required to provide a plan for assisting their enrollees to maintain their status as "full eligible duals" in order to insure continuity of care.

P. 7 Enrollment

We were extremely disappointed to see in the draft plans offered the option of pursuing a lock-in enrollment model. This idea was never discussed in any stakeholder meeting we participated in. The idea of passive enrollment was discussed, but the Department repeatedly assured stakeholders that under such a model individuals would have the right to opt out at anytime.

We oppose a lock-in enrollment as well as a passive enrollment model. We agree with the Department's goal of getting dual eligibles into good systems of care but stress that the Demonstrations are untried. Before we know more about the plans that will be offered and how well they perform, we cannot say for certain that they will represent an improvement over currently available systems.

Offering plans the option to lock-in enrollees for up to six months represents a drastic change to dual eligibles' current enrollment rights in Medicare (where duals can change Part C or Part D plans at any time effective the following month) and Medi-Cal (where in all but COHS counties duals can enroll or disenroll from managed care at any time effective the following month). These rights exist out of recognition that dual eligibles are a particularly vulnerable population with changing health needs that may require a disenrollment from a managed care plan that is not able to meet those needs. The current proposal does not contain new benefits or protections sufficient to justify the loss of these enrollment rights. Adopting a passive or lock-in enrollment policy would leave dual eligibles with fewer rights and options then they have today.

We propose instead an "opt-in" enrollment system that honors the autonomy, independence and choice of the individual by preserving for low-income dual eligibles the same right to provider and delivery system choice that exists for middle and higher income Medicare beneficiaries. Preserving that choice is key to maintaining continued access to specialists and

other providers that may not participate in the integrated model, particularly for those with complex medical conditions.

Voluntary, "opt in" enrollment processes have been used by integration models that are generally regarded as positive, beneficiary-centered programs. For example, the Program for All-Inclusive Care for the Elderly (PACE) is an "opt in" model. Massachusetts' Senior Care Options, Minnesota's Senior Health Options and Wisconsin's Family Care Partnerships all use an "opt in" enrollment model. An "opt-in" enrollment mechanism ensures that participating plans attract and retain enrollees by offering each enrollee a higher quality, more coordinated experience than the one they have in the fee-for-service system. The "opt in" model also ensures that program participants are committed and willing to use the care coordination services that the model is designed to provide.

The right to "opt out" alone is not adequate to protect dual eligibles from harm. A dual eligible who is automatically enrolled into an integrated model may not realize that the model is not a good fit (for example, that current providers are not part of the network) until after the enrollment has taken effect. By that time the individual may have experienced a disruption in care that opting out in the following month comes too late to remedy. Locking the dual eligible into the enrollment would only exacerbate this problem.

The draft RFI does not detail how dual eligibles already enrolled in D-SNPs and Part D plans would be treated. The draft indicates that PACE would remain an option, but fails to recognize the impact an "opt-out" model would have on PACE enrollment. Without an independent assessment and screening tool done in conjunction with enrollment, there is a risk that this proposal could harm California's (and the nation's) most successful model for integration.

Concerns that "opt out" and lock-in policies could address, such as adverse selection and marketing costs, can be addressed in other ways (for example, through appropriate rate setting, strict marketing rules and the use of independent enrollment brokers).

Until we know these models meet the goals of the Demonstration an "opt in" enrollment system provides the best way to ensure that the new models grow into effective, person-centered programs.

We also oppose the timeline described for informing dual eligibles about their enrollment options. Providing information in the Fall about an enrollment that may not take effect until later in the year will only confuse this population. Decisions about the enrollment timing and process should be made by the Department and CMS with input from stakeholders, not the plans.

Finally, we encourage the use of enrollment brokers to process enrollments. There have been serious problems with misleading marketing of Medicare plans to dual eligibles. Use of an independent enrollment broker is preferred. In addition to a broker, the Department and CMS must invest in both training and support for organizations that can provide personalized assistance to individuals contemplating enrollment choices, particularly individuals in hard to

reach groups. Very few organizations currently have the experience with Medi-Cal, Medicare, LTSS and behavioral health that will be necessary to properly advise beneficiaries.

P. 8 Integrated Financing

We are extremely concerned by the lack of information about how Demonstration plans will be financed. It is critical that the rates be sufficient to fund the benefits and administration without risking the quality of care and services provided under the Demonstration. We urge that the state be more transparent about the assumptions in the model generating the rates and the rationale for those assumptions than they are in this draft. It is important that stakeholders know the expectations concerning the cost and utilization of the various services in order to both understand what is expected under the Demonstrations and to assess the results against those expectations.

The indication in the RFS that rates will provide less than is currently being expended on this population prior to any analysis of the experience under these new, untried, yet-to-be-designed models is of concern. Providing quality care to this very vulnerable population should be ensured before taking money out of the system. Because lower rates will make it difficult to even maintain existing services, we do not understand how supplemental services, which have been promoted as among the central benefits to the Demonstration, can be added in any meaningful way if rates are lowered.

In its call on January 5, when asked by a plan representative whether plans would be bound by their responses to the RFS in light of the fact that rates have not yet been established, the response was that neither plans nor the Department would be bound until final contracts were negotiated and signed. The lack of guidance on rates, other than that they will be lower than current spending, makes it extremely difficult for plans to realistically propose what services they could offer and even more difficult for stakeholders and the Department to compare proposals since there is no guarantee that responses to the RFS will in any way correspond with the final package of services that any Applicant can or is willing to offer.

This section indicates that no Part C or D premiums will be charged to enrollees, but does not address co-pays. Dual eligibles enrolled in these models should not be charged co-pays for any Medi-Cal or Medicare Part A or B services (except for duals with a share of cost) and co-pay liabilities for prescription drugs should be no higher than those set by the Part D Low-Income Subsidy level for full-benefit duals. Plans should be encouraged to reduce the Part D co-pay liability of duals. Further, the Part D exemption from Part D co-payment liability for duals receiving HCBS or institutional care should apply.

The draft does not directly discuss provider rates and reimbursements. In order to have an adequate network of providers for consumers, it is critical that the reimbursement from the integrating entity be adequate to provide quality care and services and to ensure an adequate provider network. Access to providers is a current problem for dual eligibles because Medi-Cal does not generally reimburse providers for Medicare cost-sharing amounts. The RFS should include language limiting Applicants' ability to achieve savings by reducing provider

reimbursement levels and should require that plans reimburse providers up to full Medicare rates to improve access.

Finally, we suggest that the Department consider adding standards, incentives and/or penalties to ensure that the goal of increasing access to home and community based services is achieved. If the Department expects integration to achieve savings through increased coordination and resulting reduced hospitalizations and nursing home admissions, the financial structure should explicitly reward these savings and prohibit measures that award reduced access. For example, financial arrangements could include rewards for transitioning individuals out of institutions and minimum standards for amount or percentage of funds spent on home and community based services that would reference current levels. At a minimum, the rate should include funding to support relocation of members from institutional settings into the most integrated community setting.

P. 8 Benefits

If the Demonstration models are intended to provide a completely integrated seamless system to enrollees, then they must provide enrollees access to the full range of Medi-Cal and Medicare services. It is unclear from the draft whether waiver services are included in the benefits package to be offered by Demonstration models. The draft is also unclear regarding the intent for behavioral health integration and/or coordination. The draft should make explicit that coverage rules and medical necessity standards under Medi-Cal and Medicare will not be restricted, ensuring that individuals will have access to any benefits they would have had access to outside of the Demonstration.

P. 9 Pharmacy Benefits

The draft indicates how Demonstration sites will be paid for pharmacy benefits, but fails to discuss the benefits they will be required to provide. Sites should be responsible for providing Part D drug coverage and should be encouraged to limit or completely eliminate co-pays. To the extent passive or lock-in enrollment options are pursued, plans must offer robust formularies to ensure that duals that are forced into plans can get the drugs they need (since enrolling in an alternative plan better suited to their needs would not be an option under a lock-in scenario). The draft should also be explicit that the sites will be responsible for covering non-Part D drugs that are covered by Medi-Cal.

If most of the Demonstration sites will be operating as D-SNPs (per p. 18), we do not understand the exemption from submitting a Part D bid to CMS. If they are not submitting a bid, who will review their formularies, utilization management rules, networks and more to ensure that they are complying with Part D rules and regulations. For models that do not formally become D-SNPs, it is unclear how they will provide pharmacy benefits to dual eligibles. We are concerned about these ambiguities in the draft concerning responsibility for oversight of prescription drug requirements for sites. Currently, CMS addresses formulary issues, beneficiary protections, call center requirements and multiple other issues through extensive regulatory and subregulatory guidance. CMS oversight of Part D plans is continuous and has become

increasingly intensive in response to issues that have arisen since the inception of the program, for example, CMS oversees plan P&T committees; plans must get CMS approval for changes in formularies; CMS monitors call center wait times; CMS requires reporting of drug denials at the pharmacy during transition periods, etc. The draft does not indicate whether CMS oversight will continue at the same level and how that oversight will work in light of the fact that plans are not required to submit Part D bids.

For sites that are not operating D-SNPs, but are meeting D-SNP requirements (per p. 18) it is unclear how enrollees will access Medicare prescription drug benefits.

P. 9 IHSS

We appreciate the proposal to leave IHSS essentially untouched in the first year of the Demonstration, but believe more direction is needed regarding years two and three. It is essential that the Demonstrations not become a vehicle for cutting IHSS hours or limiting consumer choice. Protections must be in place to ensure that enrollees maintain access to services at, at least, current levels and that key components of the program like consumer direction are maintained.

It is disappointing that the draft does not discuss "(1) consumer protections for acute, long term care, and home and community based services within managed care; (2) development of a uniform assessment tool for home and community based services; and (3) consumer choice and protection when selecting their IHSS provider." These are all key issues identified in the Governor's budget which must be part of any model integrating IHSS and other LTSS.

P. 9 Care Coordination

Person-centered care coordination will be the key to a successfully providing integrated care that fulfills that stated goals of this project. It is disappointing to see the draft provide so little detail and information about what will be expected from plans in regards to care coordination. The draft even fails to use the phrase, 'person-centered' in this section. In the absence of clear instructions to plans on what they must offer, it is likely they will continue to rely on existing care coordination strategies and practices offering no new benefit or protection to dual eligibles enrolling in plans. See more comments below on the care coordination section of the project narrative requirements.

P. 9 Supplementary Benefits

Many stakeholders, including NSCLC, were brought to this conversation on the promise that integrated care would create opportunities for duals to receive benefits they currently do not receive from Medicare or Medi-Cal including benefits recently lost due to state budget cuts (dental, vision, etc.) and enhanced or alternative services designed to help beneficiaries remain in their homes and communities. Applicants should be required, not just encouraged, to provide supplemental and alternative services to enrollees. The Department should set clear standards

for when and how these services must be provided. Contracts for Wisconsin's integrated programs provide examples for how to do this.

P. 9 Technology

Technology should be not be relied on at the expense of in-person, one-on-one visits and observation that are core elements of a person-centered care coordination program.

P. 10 Beneficiary Notification

It takes considerable time and resources to develop effective beneficiary notification materials, processes and rules. The Department has not begun to have any serious conversations with stakeholders about these issues and we are skeptical that they will be generated within the compressed timeframe laid out in the draft. We believe that individuals need to receive information about any upcoming enrollment options or changes 90 days in advance.

The task of developing enrollee materials should not be left to plans. The Department should work with CMS to develop model materials that plans are required to use as is currently done in the Medicare program. Stakeholders should be involved in the development of these materials. As models are developed, the Part D and Medicare Advantage rules should be integrated with California laws and regulations adopting these standards from each program that provide the most protection to individuals. For example, in the area of language access, the RFS should be clear that both Title VI and translation and interpretation requirements under Dymally-Alatori apply.

Finally, we question in the draft the discussion of marketing materials. One argument we have heard put forward by plans in favor of passive enrollment is that it would save everyone the expense of marketing. If a passive enrollment system is employed, we suggest limiting the marketing that plans are allowed to do and relying on independent enrollment brokers as the primary source of information for individuals forced to join a plan. Alternatively, if the Department opted for a voluntary enrollment system, it may be appropriate to consider relaxing some Medicare marketing requirements, such as the prohibition on contacting current Medi-Cal managed care enrollees with information about a Medicare D-SNP offered by the same organization.

P. 10 Appeals

We support the intention to create a uniform appeals process. The process should be set by CMS and the Department and should integrate the strongest protections from each program into a single process that is easy for beneficiaries to navigate. As with the beneficiary notification section, however, we are concerned that, given the lack of discussion and progress on this item to date, the Department does not have the time and resources to create and implement an integrated appeals system prior to the enrollment of individuals into plans. We worry that this is an area of promise that will not be fulfilled.

P. 10 Network Adequacy

The approach to network adequacy is an example of a larger problem with the approach laid out in the draft RFS as it does not represent an improvement over current programs available to dual eligibles. Instead of describing new person-centered models which would build network requirements around the needs, preferences and existing relationships of the people in the plan, the adequacy standards outlined rely on existing, oftentimes inadequate, standards which define networks by the business relationships between the plan and providers. In a person-centered model, plans should be required to offer open networks.

We do not understand the reference to allowing plans to utilize an exceptions process to current Medicare standards. We oppose any exception which would decrease requirements plans currently need to meet.

See more comments below in the network adequacy section of the project narrative requirements.

P. 10 Monitoring and Evaluation

This is another area where the lack of specificity raises serious concerns. Monitoring and evaluation are key components of the framework of consumer protections that will be necessary to protect enrollees in these plans. A recent report from the State Auditor indicated that the Department has not been monitoring adequately Medi-Cal managed care plans. Significant work needs to be done to ensure that as plans become responsible for providing more benefits, the monitoring capacity at the Department is improved.

In addition to needing to further define what will be monitored and evaluated and by whom within CMS and the Department (or other parts of California's government), the RFS should be explicit that monitoring and evaluation will be done in a transparent way including the public release of all reporting measures submitted by plans. In addition, contracts with plans should be clear that plans are covered by the California Public Records Act.

While perhaps not appropriate for including in the RFS, we also strongly recommend that an ombudsman (more likely an organization) be identified to assist in monitoring and evaluating the performance of these plans. This was a need identified as a core principle by the 1115 Dual Eligibles Technical Workgroup. The ombudsman would have the capacity, authority and responsibility to assist individuals with making enrollment decisions, appealing plan denials and services and navigating, generally, problems that arise in plans. The ombudsman would also collect data and identify systemic problems to report to the Department and CMS as they arise. The ombudsman should be specific to dual eligibles and others receiving LTSS from plans and should have expertise in the health systems duals rely on – Medi-Cal, Medicare and LTSS. The ombudsman could be funded by the legislature or by an assessment on plans. In Wisconsin, both stakeholders and the state report great satisfaction with the role Disability Rights Wisconsin plays as ombudsman to the state's integrated care model. We recommend a similar approach in California.

P. 11 Medical Loss Ratio

We understand that the intent of this provision is to ensure that plans are not prohibited from investing in care coordination activities that may be reported as administrative expenses in a medical loss ratio (MLR) calculation, but we worry that not setting a minimum MLR (and excluding these plans from existing MLR requirements) lessens accountability. The state auditor report referenced above indicating concerns about plan reserve and executive compensation levels. A minimum MLR is one way to ensure that the state's money is spent on providing care to low-income dual eligibles and not the enrichment of plan employees or investors. We recommend that a standard be adopted that is at least as stringent as the 85% MLR that applies to Medicare Advantage plans.

Whether or not a minimum MLR is adopted, cost data must, as indicated in the draft, be reported. The RFS should explicitly indicate that the data will be shared publicly.

P. 11 Learning and Diffusion and Ongoing Stakeholder Involvement

These activities will only be meaningful if the recommendations above regarding transparent release of plan data on costs and quality and the identification of an independent ombudsman are adopted.

Timeline

The timeline for selecting sites and drafting the state's proposal is very aggressive especially given the Department's limited resources and many important policy initiatives underway. This is an ambitious project tackling many complex issues and we are concerned that rushing through the design and site selection process will negatively impact all stakeholders as the process continues. We are also concerned that even if the timeline is met, there will be very little time to prepare for a January 2013 enrollment. Very little progress has been made on important policy issues like rates, networks, LTSS integration, appeals processes, assessment tools, consumer protections and more. Once those policy decisions are made, there will be even less time to translate those decisions into contract requirements and beneficiary notices. This process should be driven by a desire to 'get it right' not be artificial deadlines and budget projections.

Application and Submission Information

We appreciate the note that responses will be public and suggest that they be made available on the Department's Web site within a reasonable time. The RFS should include more information about the criteria to be used to define which information is proprietary. Models of care should not be kept confidential.

We also support the discussion of subcontracted entities. In particular, we support the statement that incentive arrangements not induce subcontractors to withhold, limit or reduce

medically necessary services. We would like the Department to ensure that this is also true of incentive arrangements with capitated managed care plans.

We also have more global concerns about the entire approach of the Request for Solutions in light of the Governor's budget proposal. One question we have in relation to the Governor's budget is whether, given the goal to mandatorily enroll dual eligibles into Medi-Cal managed care and to integrate LTSS benefits into Medi-Cal managed care in 2013, a Request for Solutions is an appropriate vehicle for moving forward. The RFS is designed to solicit input from plans indicating a willingness to participate in a pilot or development of a new system. But if all current plans will be expected to participate in the Medi-Cal enrollment and LTSS integration pieces of the Governor's proposal, a RFS does not seem appropriate. Instead of waiting for plans to indicate what they would like to do, the Department will need to set clear standards and requirements plans must meet.

Further, we oppose an approach that requires all current plans to become integrated plans. The Demonstration should begin with plans that indicate a willingness to take on this difficult task and can demonstrate steps they have already taken to prepare. We favor limiting the Demonstration to four pilot counties and limiting the total number of impacted beneficiaries until new models are tested and proven to improve access and quality. We do not favor an approach that would include all dual eligibles in a large county like Los Angeles.

Selection of Demonstration Sites; Criteria for Additional Consideration

P. 16 Criteria for Additional Consideration

We recommend amending criteria (a) as follows:

- Record providing Medicare benefits to dual eligibles; with longer experience offering a D-SNP or Part D plan without significant sanction or corrective action plans considered beneficial. Evidence of Medicare sanctions and corrective action plans will be viewed negatively.

We recommend amending criteria (e) as follows and making it a requirement for all Applicants per our comments regarding Supplemental Benefits above.

- Inclusion of *enhanced and alternative* benefits beyond the minimum Medicare and Medi-Cal benefits will be *required*, for example: dental, vision, substance abuse, *housing assistance, home modification and other services likely to assist an individual to remain in the community, but not currently covered by either Medicare or Medi-Cal*.

P. 18 Current Medicare Advantage Dual Eligible Special Needs Plan and Current Medi-Cal Managed Care Plans

If the Department is only exploring risk-based capitated managed care plans as vehicles for integration, we believe that all Applicants should be required to be D-SNPs. Experience as a D-

SNP and compliance with accompanying regulations and rules guarantees a minimum level of quality and protection that we expect the Department and CMS to improve upon. Experience as a Medicare Advantage plan alone should not be enough. We also recommend that Applicants be required to demonstrate experience operating D-SNPs in the same county as the proposed dual eligible site (just as they are required to under section 4).

We encourage the Department to adopt a requirement that all Applicants operate D-SNPs, not simply certify that they will work in good faith to meet all D-SNP requirements by 2013. CMS has developed a thorough and extensive process to determine whether a plan meets all D-SNP requirements. That process should not be cut short in the interest of an earlier implementation date.

If the enrollment process for dual eligibles remains voluntary, we would support an approach that would only require one plan in a county to offer an integrated benefit. If the enrollment rights of dual eligibles are limited in any way, there must be a choice of integrated plans in non-COHS counties. Counties that do not have two plans that currently operate a D-SNP and a Medi-Cal managed care plan would be excluded in that scenario.

We have a question on the definition of 'good standing.' A Medicare plan in good standing should have no current, open corrective action plans and should not have been subject to sanctions at anytime during the previous three years. We also ask the Department to indicate how it will handle a situation in which a plan that has been approved as a Demonstration site is placed under sanction by CMS.

P. 19 Countywide Coverage

We would like clarification from the Department on the suggestion that Applicants could enter into 'partnerships of agreed upon geographic divisions.' We oppose the idea that individuals in one part of a county would have a different set of plans to choose from than those in another part of the county.

p. 19 Business integrity

We believe that this is an extremely important element of the RFS. The Department and CMS should only be allowing plans with a strong record serving dual eligibles to take on this new responsibility and to be rewarded with the new financial flexibility proposed. Plans that have a history of sanctions under Medicare or Med-Cal should be excluded from participating.

In addition to the items listed, plans should be required to list all corrective action plans issued by Medicare over the last five years including information about the reason for the corrective action plan and the resolution.

P. 19 ADA and Alternate Format

We are pleased to see the RFS include a requirement regarding ADA compliance. We recommend adding a similar section to indicate compliance with all state and federal civil rights laws, particular those related to language access.

P. 20 Stakeholder Involvement.

We appreciate the inclusion of this requirement. Of the specific items listed, we believe items two through five should all be required. Items three through five are essential to demonstrating stakeholder input into the development of the application and item two is the most effective way to encourage ongoing stakeholder input into plans as they are implemented. Advisory boards set up under item two should include advocates like local legal services programs who can help dual eligibles present concerns and push for resolution of problems.

Project Narrative

P. 22 Section 1.1 Program Design

In addition to generally describing experience serving duals in Medi-Cal and Medicare Special Needs Plans, the Applicants should be required to specifically describe their experience in delivering long term supports and services.

P. 23 Section 1.2 Comprehensive Program Description

This section is so broad and general in its requests that it is difficult to imagine responses that will be specific and meaningful. For example, a question asking "Explain how the program will affect the duals population," seems to call for general claims that the population will be better served but does not elicit specific information that would assist in evaluating responses.

P. 23 Section 2.2 IHSS

While this section sets parameters for the first year, it does not explicitly carry over the consumer protections in Year 1, including especially the consumer rights in the first bullet on p. 24, into subsequent years.

Further, the Department has provided no LTSS framework (in its Jan. 5 call, the agency stated that the reference to an Exh. E was in error). It is critical that the Department set minimum requirements so that the core protections in IHSS (consumer choice of providers, including family members, consumer right to hire fire, supervise, assign tasks, etc.) are maintained. Other protections such as the consumer's right to determine the extent to which the IHSS worker is involved in the care plan, need to be spelled out. Further the issue of how IHSS assessments and care coordination will be integrated with other LTSS needs to be addressed. Applicants need to be required to lay out how IHSS and other long term supports will be coordinated.

Suggest changing the last bullet to: "Describe your transition plan for moving individuals out of inappropriate, unnecessary or unwanted institutional care settings. What processes, assurances do you have in place to ensure proper care and respect individual preferences?"

P. 25 Section 4 Care coordination

This section asks Applicants to complete and attach the model of care coordination as outlined per current D-SNP requirements. This requirement is emblematic of the core problem with the RFS, which is that it does not propose genuine innovation to provider person-centered, integrated care, but instead relies entirely on a medical model.

The SNP model of care is only about Medicare services and excludes entirely LTSS that allow individuals to live where they wish with maximum independence. This goal of this Demonstration to be make it easier for individuals to seamlessly access the full range of Medicare and Medicaid services that they need. The design of a model of care needs to be built around those goals, not around Medicare SNP obligations. (Note, for example the SNP model of care reference (p. 37) to the need for a "gatekeeper," a concept that is contrary to the vision of facilitating, not limiting, access to appropriate care and the provision allowing phone interviews for assessments (p. 39), a practice that the SPD enrollment process has shown to be inadequate for this population).

Significant alterations and additions to this model will be necessary to make it person-centered. The Department must engage with stakeholders to develop a new model with sufficient protections for LTSS consumers to protect against incentives the plan will have to use care coordination programs to deny or limit necessary care.

Preliminary adjustments can be made to the attachment. For example, the model should specifically require Applicants to spell out how consumer choice will be integrated into care coordination. The Department should require protections that allow individuals to determine their care, where they receive that care, and from whom. Applicants should be required to describe how they will implement those protections. Further, Applicants should be required to be much more specific about how care will be coordinated, where care coordination will be centered, who will be responsible and how care coordination will differ depending on health condition.

The Department also needs to continue to engage with stakeholders on the assessment process and its relationship to care coordination. The lack of discussion of assessments in the draft was striking.

We appreciate that this section asks Applicants to specifically address care coordination for individuals with cognitive impairments. There is significant expertise in the stakeholder community around Alzheimer's disease and dementia that both the state and the Applicants should draw on to better serve these individuals. We also note that there are many other subgroups within the dual eligible community that will also need specialized approaches and

that stakeholders, including consumers, have much to contribute in designing appropriate approaches.

We also note that there are no requirements in this section or anywhere else in the project narrative where plans are required to describe the extent to which providers in their network currently participate in care coordination and what steps they will take to train/incentivize/monitor providers who are not experienced in participating in care teams and care coordination. Applicants should be asked to specifically address both issues.

P. 25 Section 5 Consumer Protections

The fact that the Department is not further along in developing specific consumer protections is very concerning. Consumer protections need to be woven into every aspect of the Demonstrations.

P. 25 Section 5.1 Consumer Choice

As discussed above, consumer choice begins with choice to participate in the Demonstration. Demonstrations are by their nature experiments. Dual eligibles should have the right to make an affirmative determination that they choose to participate in such an experiment.

P. 26 Section 5.2 Access

This question includes no specific reference to language access.

More globally, the Department should be setting rigorous standards for accessibility and require Applicants to at least meet those standards and describe how they will do so. Accessibility is a basic consumer right established by law (Title VI, Olmstead, Dymally-Allatorre, etc.) and cannot be an item to be defined by Applicants.

P. 26 Section 5.3 Education and Outreach

While the general questions here are useful, the Department will need to develop much more specific requirements around all aspects of communications with beneficiaries including Web sites and customer service centers.

P. 26 Section 5.4 Stakeholder Input

An important element of stakeholder input is transparency. Stakeholders cannot have meaningful input if they do not have access to information on all aspects of plan performance, costs, etc. We repeat our request that the Department require that Applicants agree that information submitted to the Department and CMS also be publically available.

We also reiterate our comment in Section 4 that consumers and other stakeholders have much to offer in terms of specific knowledge and recommendations, particularly about the needs of

diverse subgroups of duals. Besides having more general stakeholder involvement at the macro level, Applicants and the Department should set up processes to tap into this specialized knowledge on a continuing basis.

P. 26 Section 5.5. Enrollment process

Applicants should not be designing the enrollment process. The state has extensive experience with enrollment brokers for enrollment in Medi-Cal managed care. For any enrollment system, especially if it has opt-out elements, it is critical that individuals have impartial information in order to make an informed decision at the beginning of the process and not experience disruption in care because they have to bounce in and out of a plan. As discussed above (p. 4), independent enrollment brokers should be used to process enrollments and investments should be made in HICAPs and CBOs to enable them to assist individuals in making enrollment choices. The creation of an independent ombudsman would also be useful for ensuring an effective enrollment process.

Any opt-out system, particularly one with a lock-in, should explicitly permit opting out prior to the date of opt-out enrollment. Individuals who do not want to participate or who would not be appropriately served by the Demonstration need to have that choice from the start and not be subjected to care disruption. Further, individuals already enrolled in PACE, although they should be permitted to join the Demonstration, but should not be included in any automatic opt-out enrollment. They should only be enrolled in an opt-in manner.

P. 27 Section 5.7 Appeals and Grievances

We appreciate that Applicants will be required to comply with a uniform appeals and grievance procedure. As noted above, we have serious concerns that no specific work on design of an appeals system has begun, or at least has been shared with stakeholders. Designing a process that is both easy to navigate and incorporates all needed protections is a difficult and time-consuming task.

P. 27 Section 6.1 Operational Plan

We ask for a requirement that the monthly reports of the Applicants be publically available so that there is accountability to all stakeholders. More broadly, as noted above, we have serious concerns about the timelines currently proposed by the Department in light of the many critical details that have not been worked out.

P. 27 Section 7 Network Adequacy

As noted above, we do not believe that Medicare standards for network adequacy are sufficient to meet the requirements of this high needs population. Provider networks in person-centered integrated models must be built around the needs of the enrollees, working to ensure access to existing providers. Plans should be required to offer open networks that allow access to all Medicare providers in the area. Applicants should also be asked how they will ensure that the

network is adequate for the specific enrollees they have. What will they do to bring in existing providers for their members?

With respect to Part D data, we do not understand to whom the formularies and drug event data will be submitted. Will CMS continue to review formularies? What about drugs covered by Medi-Cal and not Medicare?

We also note that provider payment rates and terms have much to do with network adequacy. Although we recognize that specific rates cannot be set yet, Applicants should be required to describe the methodologies they plan to use (capitation, Medicare rates, extra payments for care coordination, etc.) to pay providers.

P. 28 Section 7.1 Transition and Discharge Planning

The Department and CMS should set rules plans must follow to ensure smooth transitions into plans by maintaining access to current providers and services, treatments and drug regimes. These protections should not exclude any types of providers; we have seen in the SPD enrollment transition, for example, that the exclusion of transition rights related to DME providers has caused hardship and disruption for beneficiaries.

If a plan decides to terminate or reduce a service that was being provided to the individual prior to enrollment in the plan, the individual must retain the right to continue to receive those services during an appeal.

P. 28 Section 9 Budget

Examples of infrastructure support should also include capital investments and training to increase accessibility of network providers.

We appreciate the opportunity to provide these comments.

ON LOK
Lifeways
all-inclusive care for seniors

1333 Bush Street, San Francisco, CA 94109-5611
p: 415-292-8888 f: 415 292 8745 www.onlok.org

January 9, 2012

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

RE: Comments on Draft Request for Solutions for Dual Eligible Demonstration Project

Dear Toby,

Thank you for the opportunity to comment on the California Dual Eligible Demonstration Project Request for Solutions (RFS). On behalf of On Lok, I am pleased to submit the following comments.

California's dual eligible demonstration is a very important project designed to develop better coordinated delivery models for dual eligible beneficiaries for the benefit of beneficiaries and payers. As you know, On Lok has almost thirty years of experience in developing and operating the PACE (Program of All-inclusive Care for the Elderly) model of integrated financing and care for vulnerable individuals who meet Medi-Cal's criteria for nursing home eligibility. PACE is a person-centered care model that integrates all Medicare and Medi-Cal covered benefits and is fully accountable for the financing and delivery of care. By aligning incentives between participants, payers and the PACE organization, PACE maximizes participants' ability to remain in their homes and communities through better management of chronic conditions and timely access to a full range of home and community-based services. PACE already achieves the demonstration goals outlined on page 6 of the draft RFS for a sub-group of the dual eligible population.

On Page 8, the draft RFS states: "In the Demonstration areas where the Program of All-inclusive Care for the Elderly (PACE) is available, PACE will remain a separate program, and dual eligible meeting the eligibility requirements for PACE will be able to select PACE, the Demonstration plan or may opt-out of both." While we appreciate this confirmation that PACE will continue to be an option for eligible beneficiaries as stated in SB 208, we believe the RFS must go further in ensuring PACE eligible individuals are informed of their ability to select a PACE plan. Whether the Demonstration plan adopts an opt-in or opt-out enrollment process, it is critical that potential eligible dual eligible beneficiaries are informed of their ability to select PACE plan not just at initial enrollment but at reassessment and when changes in health condition occur after enrollment in a Demonstration plan. Specifically:

beneficiaries and payers. As you know, On Lok has almost thirty years of experience in

- Enrollment materials must include a description of PACE and list PACE as an option for dual eligible beneficiaries to select in the demonstration counties where PACE is available. PACE plans need to be treated equally with other plans serving dual eligible beneficiaries.

- Before dual eligible beneficiaries opt-out of the Demonstration plans, individuals potentially eligible for PACE should be informed of their ability to select a PACE plan in areas where one is available.

- Dual eligible beneficiaries enrolled in Demonstration plans should be informed of their ability to select a PACE plan when beneficiaries meet the Medi-Cal nursing home criteria at reassessment and when changes in their health status occur. Demonstration plans should be required to coordinate with PACE plans to ensure a "warm hand-off" for individuals into the PACE plan similar to the process described in Section 3, page 26, for Mental Health and Substance Use Services. This notification should occur when an individual becomes nursing home eligible but still living in the community rather than waiting until nursing home placement occurs.

Furthermore, we urge DHCS to include a requirement for Demonstration plans explain in their application how PACE eligible individuals will be informed of their ability to select a PACE plan and how the plan will work with the PACE plan to coordinate disenrollment from the Demonstration plan to enroll in PACE for individuals choosing PACE in counties where PACE is available.

We have the following additional comments on the draft RFS:

- We support starting the Demonstration in four counties as described in the draft RFS prior to expanding to additional counties. Given the experience of the mandatory enrollment of seniors and people with disabilities in Medi-Cal managed care, the enrollment of dual eligible beneficiaries in managed care plans that have not been responsible for the full range of Medicare and Medi-Cal benefits will be challenging. It will be critical to learn from these initial four pilots prior to expanding to additional counties.

- We strongly support an aggressive education and outreach period to enable beneficiaries to make an informed choice in selecting a plan that best meets their needs. Demonstration plans proposing a passive enrollment approach with voluntary opt-out must be required to meet a high standard for ensuring lower default rates rather than the high rates experienced in the mandatory enrollment of seniors and people with disabilities.

- We support the creation of a uniform assessment instrument and single point of entry system in the Demonstration counties to ensure dual eligible beneficiaries are informed of the options available. We would be happy to work with DHCS and other stakeholders on the development of such an instrument and system.

- We do not support DHCS allowing Demonstration plans to lock-in beneficiaries for as long as six months as stated on page 28. We believe that the special election period for Medicare Advantage plans that allows dual eligible and PACE eligible individuals to enroll or disenroll on a monthly basis is an important quality control mechanism.

Thank you for the opportunity to provide these comments. Please contact me at (415) 292-1161 or redmondson@onlok.org or Eileen Kunz at (415) 292-8722 or ekunz@onlok.org if you have any questions.

Sincerely,

Robert Edmondson
Chief Executive Officer

Clement Cypra
Deputy Vice President
State Advocacy

PhRMA

January 9, 2012

VIA ELECTRONIC SUBMISSION

Toby Douglas, Director
State of California – Health and Human Services Agency
Department of Health Care Services
1501 Capitol Avenue, MS 0000, P.O. Box 997413
Sacramento, CA 95899-7413

Re: Draft Request for Solutions for California's Dual Eligibles Demonstration Project

Dear Mr. Douglas:

The Pharmaceutical Research and Manufacturers of America ("PhRMA") is pleased to submit comments regarding the draft Request for Solutions (RFS) for California's Dual Eligible Demonstration Project.[1] PhRMA is a voluntary nonprofit organization representing the country's leading research-based pharmaceutical and biotechnology companies, which are devoted to inventing medicines that allow patients to lead longer, healthier, and more productive lives. PhRMA companies are leading the way in the search for cures.

PhRMA supports many aspects of the draft proposal to improve care coordination for dual eligible beneficiaries. The California initiative provides a significant opportunity to improve the coordination of care for these vulnerable individuals. This increased coordination offers the potential to both achieve higher quality of care and to realize savings. PhRMA also believes that California's efforts to incorporate elements of the Medicare Part D benefit into the Demonstration are critical to ensuring that California residents continue to have access to the full range of benefits and protections currently available to them through the Medicare Part D program. In addition, we strongly support California's commitment to include important consumer protections in the Demonstration and urge the State to ensure that the protections of Part D, the Knox-Keene Act, and Medi-Cal continue to apply.

We are concerned, however, by the lack of information provided with respect to the financial methodology for this program at this early stage of its development. Some of the statements could be read as creating unintended consequences both for the Demonstration sites and for non-dual Medicare beneficiaries in California. We would also suggest that California consider using an "opt-in" mechanism for purposes of enrollment, at least in the initial months or in those counties where the Demonstration sites have less experience in dealing with the special needs of this population.

[1] State of California—Health and Human Services Agency, Department of Health Care Services, Draft Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project (Dec. 22, 2011) (hereinafter "Draft RFS").

Part D Is an Established and Effective Method of Prescription Drug Delivery

The medical needs of dual eligible beneficiaries are significant, which means that they justifiably account for a significant share of Medicare and Medicaid spending. Nonetheless, PhRMA agrees that the use of "organized systems of care that are responsive to beneficiaries' needs and overcome existing fragmentation and inefficiencies created by current categorical funding and service structures"[2] has the potential to improve care coordination and quality while reducing costs. PhRMA further believes that the integration of important Medicare Part D requirements into the Demonstration, including the SNP requirements, is an important step in ensuring that dual eligibles continue to receive prescription drug coverage in a tested and effective manner. We urge California to adhere to these principles and requirements as the program draft develops to ensure that the creation of this new program does not unduly disrupt continuity of care for the state's dual eligible population.

The Medicare Part D benefit effectively provides access to robust prescription drug coverage for all Medicare beneficiaries in California, including dual eligible beneficiaries. It has tested procedures for protecting patient access. Furthermore, the Part D benefit has resulted in substantial savings for other parts of the Medicare program. Indeed, a recent study by the Journal of the American Medical Association ("JAMA") found annual savings of $1,200 on other Medicare costs for seniors who previously had no drug coverage or limited drug coverage prior to the creation of Medicare Part D.[3] The potential for Part D plans to achieve savings with respect to the dual eligible population will be magnified by the improved coordination of all of a patient's care in this dual eligible demonstration program. Dual eligibles have varied and complex healthcare needs, including the management of multiple prescription drug medications, and changing a prescription for a patient without considering other conditions and prescriptions has the potential to exacerbate the patient's problems. PhRMA believes that incorporating Part D requirements into the Demonstration will enable the state, the federal government, and the newly formed Demonstration sites to capitalize on the successes and efficiencies of the current Medicare Part D program in providing care to California's dual eligible population.

Because some of the Demonstration sites will be coming into compliance with the Part D standards over the first year of program operation, to protect these patients it will be important for California to establish procedures for ensuring that the standards are brought on line promptly.

The Consumer Protections of Medicare Part D and Medi-Cal Should Continue to Apply

Throughout the process of designing the dual eligible Demonstration project, California has shown a strong commitment to consumer protection. In fact, one of the first documents prepared by the state with respect to the Demonstration was a "Framework for Understanding Consumer Protections," which appears on page 42 of the draft RFS. According to this

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[2] Id. at 5.
[3] J.M. McWilliams, "Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage," Journal of the American Medical Association, July 27, 2011.

"Framework," the concepts to "set the stage for a conversation about consumer protections" include:

- Beneficiary control and choice;
- Beneficiary-centered models;
- Comprehensive benefit design;
- Responsive appeals process;
- Transition rights to avoid care disruptions;
- Meaningful notice;
- Oversight and monitoring;
- Appropriate and accessible; and
- A phased approach.

PhRMA strongly supports the inclusion of these and other consumer protections in the Demonstration and urges California to ensure that the protections of both Medicare (including Part D) and Medi-Cal continue to apply to the dual eligible population enrolled in the Demonstration. For example, in defining the uniform appeals process in the forthcoming Demonstration Proposal and MOU, PhRMA urges California to rely on the most protective aspects of the appeals processes under the Medicare and Medi-Cal programs.

Related to the issue of consumer protections, PhRMA strongly supports the proposed requirement that Demonstration sites have a current unrestricted Knox-Keene License. The Knox-Keene Health Care Service Plan Act of 1975 requires health plans to provide certain important consumer protections and will further ensure that participating Demonstration sites adopt consumer protections, including those outlined above.[4]

California Should Consider Unintended Consequences of Its Payment Methodology

The draft RFS proposes that "Demonstration Sites will be paid according to the regular Part D payment rules, with the exception that they will not have to submit a bid. The direct subsidy will be based on a standardized national Part D average bid amount. This national average will be risk adjusted according to the same rules that apply for all other Part D plans. CMS will provide additional guidance for plans in the Draft and Final Call Letters for the contract year (CY) 2013 in February and April 2012, respectively."[5]

This methodology may work effectively; however, we note that today, Part D plans bids are based on the entire Medicare population including dual eligibles. Because dual eligibles prescription drug needs tend to be higher than the rest of the Medicare population, removing them en masse from the pool on which the plans submit their bids could cause the plans' bids for the non-dual population to be lower than they otherwise would have been. This would place considerable pressure on the risk adjustment methodology in order to prevent the Demonstration sites from experiencing financial problems that could translate into access restrictions that undermine the quality of care.

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[4] See Cal. Health & Safety Code § 1340, et seq.
[5] Id. at 9.

California Should Consider Use of an Opt-In Enrollment Mechanism

Given the size of the population that will be transitioning to this new program and the relative inexperience of at least some of the plans, PhRMA urges California to consider that it might be better in the long run if patients are given the choice of whether to enroll in the Demonstration – following sufficient education – rather than allowing Demonstration sites to automatically remove beneficiaries from their current care system.[6] It is important for these fragile patients and their caregivers to trust and have confidence in the new program, lest everyone exercise the opt-out right and undermine its efficacy. A slower transition to operation may help improve confidence as well as minimizing the disruptions that necessarily will attend the migration of such a large population of patients. Considering that California intends to enroll approximately 150,000 beneficiaries initially (and up to 1.1 million beneficiaries by 2015), over one-third of whom are severely mentally ill, PhRMA believes that patient choice could prove to be an important mechanism for building public confidence in the demonstration.

* * * *

We thank you for your consideration of these comments on the California Dual Eligible Demonstration RFS. We urge the state of California to finalize this proposal in a manner that enhances coordinated care without unnecessarily disrupting care for some of the state's most vulnerable beneficiaries. We look forward to the opportunity to continue working with the state as it develops the Demonstration. Please contact me, if you have any questions regarding these comments. Thank you for your attention to these important issues.

Respectfully Submitted,

Clement Gypra
Deputy Vice President, State Advocacy
PhRMA

[6] Id. at 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.").

SCAN Comments on the December 22, 2012 California Dual Eligible Demonstration Request for Solutions

1-9-12

Introductory Statement

SCAN Health Plan (SCAN) appreciates the opportunity to provide comments on the State's draft Request for Solutions (RFS) document. SCAN strongly believes, and our experience demonstrates, that the availability of integrated, coordinated care to vulnerable populations results in improved health outcomes and lower costs of care. We applaud the Department's dedication to placing the individual at the center of care. SCAN's longstanding experience in providing primary, acute, behavioral health, and long term care services to dual eligibles has shown that holistic, patient-centered care is necessary to effectively manage the complex conditions with which this population lives.

We especially want to highlight three areas critical to the program's success:

1) The state should expand the number of qualifying plans, especially in single and two-plan counties. This is key, given the Governor's expressed intent to rapidly double the size of the pilot and move all dual eligibles into integrated care settings on a permanent basis within three years. Greater plan participation, with increased numbers of providers, will allow improved patient access and choice. Further, it will avert the negative impact that an influx of duals may have on services to other populations (commercial, Medicare FFS, Medicare Advantage, MediCal, CalPERS).
2) In keeping with the stated intention of insuring quality performance, the state should look to additional measures beyond NCQA accreditation to guarantee a plan's quality performance. One such measure could be a Medicare Advantage plan's CMS star rating. We suggest that a score of four stars or more should qualify an MA plan for participation.
3) The State should stand firm in its resolve to require that a plan have both a history and a current capacity to provide home and community based services to participate in this program. This is the only way to assure that dual eligible patients with chronic conditions will receive the attention they deserve to avoid institutionalization.

Demonstration Goals

SB 208 Goals

1. *Coordinating benefits and access to care, improving continuity of care and services.*
2. *Maximizing the ability of dual eligibles to remain in their homes and communities with appropriate services and supports in lieu of institutional care.*
3. *Increasing availability and access to home- and community-based alternatives.*

SCAN supports the Demonstration's goals as articulated in SB 208. These objectives reflect SCAN's guiding mission since our founding over 30 years ago to provide the care and supports necessary to enable our members to continue to live independently and within the community as long as possible.

Other DHCS Suggested Demonstration Goals

1. *Preserve and enhance the ability for consumers to self-direct their care and receive high quality care.*
2. *Improve health processes and satisfaction with care.*
3. *Improve coordination of care.*
4. *Improve timely access to care.*
5. *Optimize the use of Medicare, Medi-Cal and other State/County resources.*

SCAN agrees with these additional Demonstration goals, with the following clarification: while self-direction is effective and appropriate for the vast majority of dual eligibles, individuals who lack the capacity to manage their care must have the ability to delegate that responsibility to a care management team or to an appropriate surrogate. Whether or not an enrollee is capable of self-direction, he or she is entitled to coordinated, high-quality care. It is important that the State establish evidence-based definitions and measurements to ensure the delivery of this high quality care. All too frequently, anecdotal information becomes a surrogate for quality care expectations and the impact can be detrimental to this vulnerable population.

Demonstration Population

Allowing for Potential Carve Outs of Specified Services

SCAN believes that all chronic care patients can benefit significantly from patient-centered care management. Carve-outs for particular disease states should be limited The RFS draft asks specifically for comments about excluding the following groups from the Demonstration: End-Stage Renal Disease, HIV / AIDS, dual eligibles institutionalized for over 90 days, and developmental services. While these are more discreet and intense conditions which require specialized attention, SCAN's experience is that they can benefit from integrated and coordinated care services.

End-Stage Renal Disease (ESRD) Carve Out

SCAN has operated a successful ESRD Medicare managed care demonstration for five years, providing coordinated, integrated services (including intensive case management) to about 600 beneficiaries with ESRD. (Approximately 80% are dually eligible.) SCAN's ESRD Program has consistently achieved a high level of member satisfaction, and has exceeded quality metrics set at FFS benchmarks. Members receive specialized treatment and monitoring, and their health status has proven to benefit greatly from the specialized care coordination and integration of the medical services.

Developmental Services carve out

SCAN believes that it is appropriate to carve out the care centers initially. As with the other suggested carve out services on this list, specialized managed care plans should be developed to eventually eliminate the carve out of the Regional Centers and allow for more fully integrated care delivery to dually eligible developmentally disabled beneficiaries.

Carve Out of Dually Eligible Beneficiaries Institutionalized for Over 90 Days

SCAN's experience managing the care of dual eligibles suggests that those duals who have been institutionalized for longer than 90 days will still benefit from the patient-centered care management model created through the Demonstration. Certain of these individuals, many of whom have complex physical and functional needs, may be able to transition into the community with the right supports. This will not only fulfill their personal preferences, but also curb the State's costs to provide support. This recommendation also aligns with the Olmstead decision, which

requires states to have in place a working plan to provide opportunities that allow individuals to live in the least restrictive setting.

Enrollment

Enrollment Phase in and readiness for October 1, 2012 Annual Enrollment

SCAN supports the Department's proposal to phase in enrollment of dual eligible beneficiaries over the first year of the Demonstration, on the basis of the beneficiary's birth month. However, SCAN recommends that the timing for the initial introduction of an annual enrollment period be delayed until October 2013 to ensure that plans will be able to dedicate the resources necessary to properly develop explanatory materials for this complex new product and to design the new product in a manner that effectively integrates with the plans' current Medicare products. A critical part of success will be the education and acceptance of the program by the beneficiaries and their caregivers. This includes understanding all options, including how they can transition to the new model with minimal disruption and maximum continuation of their primary providers.

PACE and Other Current Fully Integrated D-SNPs

The PACE program has extensive experience offering a full continuum of medical, behavioral, social, and long-term care services on a capitated, full-risk basis to dual eligibles approved for a nursing facility level of care. SCAN's fully integrated D-SNP also offers this full continuum of services but does so on a non-facility based, county-wide network basis, as envisioned by the Department's proposal.

Any fully integrated D-SNP or PACE currently operating in California should be allowed to continue to provide these important services to beneficiaries, independent of the Demonstration. These plans (including SCAN) could serve as a benchmark against which the State can evaluate the efficacy of dual demonstration sites in the areas of cost, quality, and member satisfaction. Currently, SCAN has over 8000 dual eligible members in its D-SNPs and the PACE programs have only 2,200 in multiple CA locations. These successful programs should be allowed to continue and grow, as an alternative to the Demonstration, to the benefit of both models.

Integrated Financing

Risk Adjustment of Payment

To avoid problems relating to adverse selection and risk avoidance, CMS currently adjusts its payments to Medicare Advantage (MA) plans and D-SNPs based on the level of risk borne by each plan in relation to its enrolled population. This structure of plan payment should be replicated within the pilot demonstration. Incenting plans to accept and to manage the care of high-cost individuals with complex health conditions is paramount to plans' ability to deliver patient-centered, high-quality care to this population.

SCAN currently accepts risk for providing care to medically fragile populations in California, and would require an appropriate capitated rate to provide a comprehensive set of services for this medically complex population. Providing appropriate care and access to services requires that the reimbursement rate reflect the intensity and quality of services for individuals with extensive medical conditions. The rates developed for the pilots must be transparent and accurately reflect

the historical cost of institutional and non-institutional care required by the dual population. They should be actuarially sound, and each participating plan/pilot must have adequate time to review the rates and if necessary, request modifications. The successful contracting entities, with an adequate capitated rate, should be expected to align incentives with contracting providers and make value-based purchasing decisions that improve the quality of care for the dual eligible population.

Supplementary Benefits

The RFS cites the importance of supplementary benefits within the context of the demonstration plan model. SCAN has a long and successful history of offering supplementary benefits through community vendors to our most vulnerable members. These services include home delivered meals, transportation, and home safety improvements. SCAN's experience has shown that providing these benefits enables our most at-risk members to continue to live safely in their homes, avoiding institutionalization and unnecessary hospital admissions.

SCAN's fully integrated D-SNP offers a comprehensive benefit package that encompasses primary, acute, behavioral health, and long term services and supports. In addition, comprehensive home and community-based services (HCBS) enable individuals to remain or return to their homes or setting of choice safely. Such benefits support independence, but also help prevent declines in health status and hospitalizations. They also play an important role in avoiding nursing home stays that can easily become much more costly than the provision of the HCBS themselves.

The long-term supports and services must address the needs of beneficiaries across the continuum of care and emphasize patient-centeredness, hands-on care coordination, linkages between primary care and other clinical, behavioral, and supportive services with an emphasis on home and community-based services rather than institutional care. To allow for the greatest degree of patient independence, these services must include, at a minimum:

- Attendant care
- Home-delivered meals
- Home health services
- Home/domestic assistance
- Personal care
- Respite care
- Home modifications
- Support in navigating health care and community resources (e.g., assistance with scheduling appointments, arranging for prescriptions, transportation, or durable medical equipment)

SCAN applauds the flexibility granted by the State to plans within the Demonstration to offer supplementary benefits. Historically, it hasn't always been clear that plans had the flexibility to provide all the benefits necessary to accomplish the desired objective of maximizing patient independence.

SCAN and any other plans' ability to offer these supplementary benefits depend upon a known and predictable funding stream for the most at-risk members. To continue to make these benefits available to the beneficiaries who need them, SCAN and other potential Demonstration participants would require the necessary funding information in advance of the 2013 plan development process. There is currently no mention in the timelines or the RFS indicating when the rate information will be available to plans. This should be clarified as soon as possible, and in any event before the RFS is finalized.

Need for earlier plan payment information than in the draft RFS

The draft RFS does not include in its timeline when plan rate information will become available this year. State representatives at stakeholder meetings have indicated that rate information will be revealed very late in the Dual Demonstration Development process. Currently, Dual Special Needs Plans develop their plan benefits using current rates from Medicare and Medicaid as a proxy for the following year's rate and adjust if necessary when the final rates are announced in June. However, the Draft RFS indicates that the payment scheme will be completely different from the Medicare Advantage calculation. To the extent that the new payment model significantly differs from that historically used by D-SNPs, it is likely that plans will be required to enter into new contracts with physicians, hospitals, nursing facilities, and other providers within their existing network.

SCAN is concerned that the timeline contemplated by the draft RFS will not allow plans adequate time to develop benefit packages and publish the beneficiary notice material that must be reviewed and approved by CMS prior to the October 1, 2012 publishing date.

To enable plans to make benefit determinations in a timely manner, site payment arrangements should be clearly determined and articulated to Demonstration participants as early in the application process as possible. This is especially important in the context of enhanced benefits that plans seek to offer to individuals at risk of institutionalization. Many of these benefits are non-mandated and must be financed out of available capitation funds. Development of and commitment to these ancillary benefits by Demonstration participants will require a predictable level of funding.

Quality Incentives

To encourage continuous improvements in quality within MA plans and D-SNPs, CMS provides enhanced payments to plans that reach established quality benchmarks via its Star Rating System. In SCAN's experience, aligned incentives shared with provider groups provide a higher level of quality of care for beneficiaries. Structuring provider payment for patient care on a performance-based reimbursement system such as CMS' Star Rating System aligns financial incentives with quality improvement. SCAN encourages the Department to include a similar system within the pilot demonstration. The Demonstration should include innovative rate structures that provide incentives for quality outcomes and cost efficiency. These could include, but would not necessarily have to be limited to, bonuses for reaching specific quality benchmarks or certain levels of savings.

Selection of Demonstration Sites

Qualification Requirements

- SCAN would maintain that any pilot program require a contracting entity to include at least the following types of providers in their network:
    - Hospitals
    - University Medical Centers
    - Pharmacies
    - Durable medical equipment and other ancillary providers and services
    - Home and community-based care providers and services
    - Skilled nursing facilities and other long-term care providers and services
    - End-of-Life, palliative care and hospice services
    - Home Health Agencies

    - Regional Centers (for services for the developmentally disabled)
- In light of the Governor's budget, SCAN applauds the intent to move all dual eligibles to managed care models but cautions that attention be paid to network capacity and impact on the other populations (commercial, Medicare Advantage, Medicare FFS, MediCal, CalPERS) served by the current network. SCAN recommends expanding to additional plans, and by extention, many additional providers, in the counties selected for the pilot to absorb this additional population. This will also insure greater patient access and choice.
- Also, importantly, given the prevalence of mental/cognitive diseases and conditions among dual eligibles, contractors participating in the pilot program should also demonstrate how they will manage these conditions in a medical home environment. Providers must recognize that behavioral health services can vary greatly depending on the age and diagnosis of the individual and must not have a one sise fits all model. This will require additional behavioral health services that coordinate with the patient's primary care medical home and serve as an active participant of the multi-disciplinary team. The behavioral health interdisciplinary team should be comprised of a pharmacist, licensed behavioral health providers such as Licensed Clinical Social Workers (LCSW), Marriage/Family Therapists (MFT) or psychologists, registered nurses, social workers and care coordinators. For behavioral health services that are not delivered at the patient's primary care location, alternative treatment sites must meet the beneficiary's medical, psychological and functional status needs and preferences and may include a medical office where medical and psychiatric care are co-located, or in the member's home (includes a nursing home, assisted living facility, private residence or telephonically).
- The pilots should provide a range of culturally- and linguistically-appropriate management programs specifically designed to enhance the beneficiary's behavior and appropriate use of services using:
    - Care management programs that include behavioral health care coordination, dementia case management, in-person and/or telephonic case management services, medication therapy management, skilled nursing facility case management and inpatient complex care management.
    - Collaboration with other community and state agencies such as state Regional Centers for the care of individuals with developmental disabilities to avoid duplication of case coordination activity, coordinate benefits and ensure access in a timely manner.
    - Care transitions including reconciliation of medication regimens across care settings, physician follow-up after hospital discharge, and teaching home caregivers about warning signs and care plans.
    - Disease management programs specific to the needs of the individual patient such as diabetes, behavioral health, congestive heart failure and chronic obstructive pulmonary disease.
        - Whenever possible, a disease management program should provide an educational pathway or protocol focused on the disease state, including disease process and management, recognizing disease-specific symptoms and actions to take, when to call the doctor or seek urgent/emergent care, medication management, nutrition, self-management and healthy behaviors.
    - Consumer and caregiver engagement

Care Coordination and Risk identification

SCAN recommends that all members be evaluated using a risk identification process and that individualized required care plans and follow-up be developed based on the results of that process.

Requiring that all members have intensive care plans and care management will create unnecessary expense and interference in the beneficiaries' lives. Many dual eligible seniors are actually quite healthy and live a long and normal life with no need for these services. The plan needs to ensure that beneficiaries have a process in place to identify when a care plan is needed or to respond to the member as and when the member feels the need for such intervention/services.

NCQA Accreditation

SCAN applauds the states position that requires plans to have outside quality certifications. NCQA does separate requirements for commercial, Medicaid and Medicare plans. The most significant standards of quality for duals are around the Medicare process and it should not be assumed that commercial or Medicaid accreditation means that quality standards will be met on the duals population. It can easily take 3 years or more for a plan to change the processes and measurement to reach accreditation, so the requirement should be extended. The NCQA certification for the SNP MOC, however, can be reached in 1 year and should be required at the end of the first year of the pilot.

Frameworks

SCAN commented extensively, and positively, in October regarding the three frameworks on consumer protections, long-term care coordination, and mental health and substance use. We attach those comments as an appendix.

SEIU California
Stronger Together

1007 7th Street
4th Floor
Sacramento, CA 95814
916.442.3838
Fax: 916.442.0976

3055 Wilshire Blvd.
Suite 1050
Los Angeles, CA 90010
213.368.7400
Fax: 213.381.7348

7677 Oakport Street
Suite 725
Oakland, CA 94621
510.568.2500
Fax: 510.568.3652

www.seiuca.org

January 9, 2012

Office of Medi-Cal Procurement
California Department of Health Care Services
Sacramento, California 95899
VIA ELECTRONIC MAIL: OMCPRFP9@dhcs.ca.gov

Re: California's Dual Eligibles Demonstration Project Draft Request for Solutions

For SEIU California and its Locals ULTCW, UHW, and 521, and CUHW, and on behalf of its nearly 300,000 IHSS member providers we would like to submit the following comments regarding the Dual Eligibles Demonstration Project (Demonstration) draft Request for Solutions on demonstration site criteria for the Department of Health Care Services (DHCS). Comments are based off of the Draft Request for Solutions – Regular Font document.

Demonstration Model Summary

Demonstration Population (p. 9)
Beneficiaries who have been institutionalized for longer than 90 days and those with HIV/AIDS, End-Stage Renal Disease (ESRD), and Amyotrophic Lateral Sclerosis (ALS) should not be excluded from the Demonstration. Managed care incentives should result in the right care at the right time in the right setting for all beneficiaries. This means not only a focus on prevention and wellness, but also the management of serious, chronic conditions. Integrating all long-term supports services (LTSS), including fully integrating nursing homes, into the Demonstration will provide incentives to use the more cost effective and consumer-preferred use of services.

Not all plans will be able to immediately take on the full risk of integrating LTSS and nursing home care. DHCS should develop a portfolio of risk options that plans may assume with specific criteria, starting with pass-through payments and ranging up to and including full risk. A phased-in approach would let plans elect an appropriate level of risk the first year and add more risk over a period of up to three years, with the goal of all Managed Care plans assuming full risk at the end of the three year demonstration period. DHCS must approve the plan option selected, based on objective criteria, plus elections for additional risk at each phase.

This will protect consumers as well as program longevity. Too much risk too soon carries the possibility of under-treatment, consumer access issues and potential solvency problems.

Enrollment (p. 9-10)
With careful attention to continuity of care issues, passive enrollment with opt-out will ensure a reasonable balance between the needs of the plan and the success of the Demonstration with consumer choice and protection.

The option for applicants to pursue up to a six month enrollment lock-in unnecessarily curtails consumer choice and infringes on the protection opting-out gives beneficiaries in deciding where and how they receive their care.

Additionally, the Program of All-Inclusive Care for the Elderly (PACE) should be a benefit under the demonstration, not an alternative option. PACE should also be given the ability to contract for IHSS services from the public authority.

Beneficiary Notification (p. 12)
Passive enrollment is essential to the viability of the Demonstration. However, learning from the experience of seniors and persons with disabilities (SPDs) enrolled in Medi-Cal managed care, default enrollment must be coupled with superior advance notification and continuity of care protocols, including clear accountability for the Demonstration sites. These provisions should be written into the Demonstration model. Further, some of the projected cost savings from the program should be budgeted to strengthen these processes.

Network Adequacy and Monitoring and Evaluation (p.12)
From written materials to office equipment, Medi-Cal SPD consumers have faced accessibility issues as they have transitioned from their old providers to managed care. Currently, the only leverage that plans have with providers in their network is to cancel the contract, which may be difficult due to network adequacy requirements. DHCS should be empowered to directly enforce demonstration standards at the provider level to ensure the highest consumer protections including appropriate accessibility. We believe this principle should be written into the demonstration model.

Further, SB 208 states that the Demonstration must monitor how IHSS is used both before and during integration with the sites. The Demonstration should go beyond this initial data collection and evaluate how the integration of IHSS/LTSS has impacted, amongst other measures, health outcomes, consumer and IHSS provider satisfaction and health care costs. This will establish a baseline to start measuring the role IHSS plays in keeping consumers safe, satisfied with their care and healthy in their homes.

Quality Incentives (p. 12)
In addition to strengthening continuity of care processes, program savings should be reinvested in programs and services that help people receive care at home. Specifically, savings should be reinvested in IHSS provider training and co-training with their clients as well as in the provision of supplementary benefits such as housing transition, transportation and Meals on Wheels.

Ongoing Stakeholder involvement (p.13)
Demonstration sites should be held to public sector standards for open meetings and records.

Qualification Requirements

Business Integrity (p.21)

Demonstration applicants are not limited to those who only provide services in California. Many applicants will be national organizations that provide Medicaid and Medicare services in other states. DHCS must ensure that all applicants demonstrate business integrity by:

a. Certifying they have no unresolved Medicaid or Medicare quality assurance issues anywhere they do business in the United States.
b. Listing all sanctions and penalties taken by Medicare or a state government entity within the last five years.
c. Certifying that they are not under sanction by the Centers for Medicare and Medicaid Services.
d. Certifying that it will notify DHCS within 24 hours of any Medicare or Medicaid sanctions or penalties taken against them in any state where they provider medical services

Project Narrative

Section 2.2: IHSS (p. 25-26)
IHSS should be fully integrated as part of the benefit package offered by the Demonstration in Year 1. If the Demonstration is to achieve the highest possible cost savings that come from reducing emergency department usage, hospital admissions and re-admissions and nursing facility admissions, fully integrating IHSS and the IHSS provider into the care coordination model from the start is critical.

IHSS providers can play an important role not only in care coordination, but also in enhancing consumer satisfaction with care and the plan. The unique position of IHSS providers with respect to their clients allows them to recognize behavior or health changes that are critical to keeping consumers healthy, communicate any changes to their client's status to the patient care team, perform basic interventions under the guidance of the team and generally advocate for their client.

An enhanced role for the IHSS provider on their client's coordinated care team and professional training in Year 1 will realize the full potential of this reform to improve health outcomes and reduce costs.

Further, the Demonstration must ensure that bargaining, including wages and benefit, and other union protections continue throughout the life of the Demonstration.

Section 7.2: Technology (p. 30)
In addition to the two current requirements of describing utilization of technology in providing care, the applicant must describe how the organization will use medication compliance to reduce unnecessary hospital and nursing home usage. Medication compliance includes the provision of in-home medication dispensing and reporting systems for beneficiaries at very high risk of nursing home admission due to medication non-compliance.

Should you have any questions regarding our comments and suggestions, please do not hesitate to contact me at 916-832-6931. We look forward to continuing to work with you and the demonstration participants to determine how IHSS workers may best participate in the program now and moving forward as the program expands statewide.

Thank you for your time and consideration in this matter.

Sincerely,

Robert Harris
Legislative Advocate

Shield Healthcare appreciates the opportunity to provide feedback on the Duals Eligible Demonstration RFS. Please refer to the specific comments below and note them into the official record.

Timeline (Overview Section p. 14):

- This compressed timeline is somewhat aggressive given the large number of beneficiaries impacted and the inherent complexities associated with implementing new demonstration projects. The proposed timeline negates DHCS' opportunity to take advantage of any lessons learned from the SPD transition.

Meaningful Stakeholder Input (Project Narrative Section 5.4 p. 28):

- Shield welcomes the opportunity to participate in meaningful stakeholder input. We hope the engagement plan will entail more than a single provider call or town hall meeting. Stakeholders want to know that their comments and feedback are taken seriously and that DHCS gives thoughtful consideration before taking action.

Enrollment Process (Project Narrative Section 5.5 p. 28):

- The passive enrollment process outlined in the RFS will be problematic and confusing for many dual eligible seniors. There is nothing *passive* about being automatically enrolled into a new program. These individuals are used to self-directing their coverage choices as in the case of Medicare Advantage Plans. The prospect of a six-month enrollment lock-in period will be particularly restricting to this population.

Thanks again for the opportunity to submit this response. Please contact me with questions.

Respectfully,

David Fein | Reimbursement Manager | Phone 661.294.6601| Fax 661.294.1042

Shield HealthCare
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To whom it may concern:

Hello my name is Terrance Henson, I work as a Community/Systems Change Coordinator for Southern California Rehabilitation Services, we are an Independent Living Center in Downey, CA and we also held a Listening Session here at our center in December for this project.

I wanted to point out that in this section of the document below, it mentions for beneficiaries to partner with local Aging and Disability Resource Center (ADRC) which is great, but I would like to state that Independent Living Centers (ILC) are also capable of providing these services; to help beneficiaries in connecting to community social support programs. Therefore, I must insist that ILC's be included and listed as a resource for this Dual Demonstration Project. Our job as an ILC is to be a resource for people with disabilities to help them get connected to these supports and help them live in their own homes and in the community and must be included as a resource for the beneficiaries of this demonstration.

Section 2.3: Social Support Coordination

Applicants must:

- Describe how you will assess and assist beneficiaries in connecting to community social support programs (such as Meals on Wheels, CalFresh, and others) that support living in the home and in the community.
- Certify that you will provide an operational plan for connecting beneficiaries to social supports that includes clear evaluation metrics.
- Describe how you would partner with the local Aging and Disability Resource Center (ADRC), or how the Application demonstrates capacity to establish an ADRC or ADRC-type model that operates multi---disciplinary care teams capable of meeting the full range of a beneficiary's needs.

Thank you and if you have any questions please feel free to contact me anytime,

Terrance Henson

Systems Change Coordinator
Southern California Rehabilitiation Services

7830 Quill Drive, Suite D
Downey, CA 90242

Feedback from the State ADRC Team: Ed Ahern, Karol Swartzlander; Paula Acosta, CHHS

California's Dual Eligibles Demonstration Project Feedback

Since 2004 California has been working with the Administration on Aging (AoA) and Centers for Medicare and Medicaid Services (CMS) to develop and begin to implement a structure of Aging and Disability Resource Connections (ADRC).

ADRC partnerships are a no-wrong-door approach to providing consumers with streamlined access to multiple community services, regardless of consumer age, disability type or income level/source. ADRCs have as a core, a partnership between the AAA and the ILC with extended partner organizations that serve all aspects of the LTSS population.

Demonstration Model Summary

Page 11
Supplementary Benefits: Demonstration sites are encouraged to offer additional benefits, such as non-emergency transportation, vision care, dental care, substance use services, etc. Additionally, a key part of this Demonstration is bringing together social services and medical services (such as Meals on Wheels and other social supports). Demonstration sites are encouraged to contract, utilize, and pay for community-based services that can help beneficiaries remain in their homes and communities.

Comment:

> **Options Counseling (OC)** is a person-centered, interactive, decision-support process whereby individuals are supported in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values. Options Counseling is a core service of California's Aging & Disability Resource Connection (ADRC) and should be considered a supplemental benefit that can assist individuals to remain in their community.
>
> **Skills training**, for the purpose of assisting an individual to adjust after the onset of a disability or chronic condition, may provide additional opportunities to reduce the amount of health care services needed. Examples include learning to take public transportation after a driver's license is revoked; preparing basic meals after a stroke; money management following a brain injury. These services, combined with **enhanced assistive technology** solutions, can assist an individual to rely less on health care services by providing the skills necessary to accomplish certain talks on their own.

Project Narrative

Section 1.2: Comprehensive Program
Page 24/25
The Application must:
• Describe the overall design of the proposed program, including how you will provide the integrated benefit package described above along with any additional benefits provided beyond the minimum Medicare and Medi-Cal limits you intend to provide, if any.
• Describe how you will manage the program within an integrated financing model, (i.e. services are not treated as “Medicare” or “Medicaid” paid services.)
• Describe how the program is evidence-based.
• Explain how the program will affect the duals population.
• Explain how the program will impact the underserved, address health disparities, reduce the effect of multiple co-morbidities, and/or modify risk factors.
• Explain whether/how the program could include a component that qualifies under the federal Health Home Plans SPA.
• Identify the primary challenges to successful implementation of the program and explain how these anticipated risks will be mitigated.
• Explain what you will need from state and federal agencies to assist in the success of the Demonstrations.

Comment:

LTSS Partnership Models: The current LTSS (previously called HCBS) service delivery networks are organized around limited population groups (60+ (AAAs)), adult disabled (ILCs), DD (Regional Centers), MH (county mental health departments), CCS (children) and others (services for the blind, stroke centers, etc.) and/or limited menus of services, like IHSS. It is in the State's interest and the interest of the HMOs to capture and utilize the experience and expertise of these local leaders and provider networks. It would be prudent for each HMO that applies for the Duals Pilot to specify their plan to purchase (through contracts or MOUs, etc.) the full range of LTSS for all populations groups--any age, any disability, any diagnostic profile. Living with chronic disease and/or disability does not follow predictable treatment models and patient profiles. LTSS is highly personal and is of highest quality when the person stays responsible and in charge of life decisions as long as possible. Networks of LTSS providers have valuable experience working with consumer needs, culture, and preferences. They are expert in identifying when self-direction (as opposed to full case management) can be a valuable tool for keeping independence high and costs low. However, they have evolved to be many separate business organizations; ranging from large county governments to small non-profits. Size does not diminish their expertise. In a future RFS, we recommend that the applicant describe purchasing models and innovation in assisting multiple organizations to come together in a partnership (like an Aging and Resource Connection (ADRC)) that can be an LTSS gateway and purchasing agent for the

full range of LTSS. This model would benefit the full array of potential members who choose LTSS over inpatient nursing facility care.

Section 2.3: Social Support Coordination
Page 26

Comment:

Applicant should describe how they will include Independent Living Centers (ILC) and Area Agencies on Aging (AAA) as part of their service mix. These organizations are well versed in the various long term services and supports available to help people remain independent in the community.

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Toby Douglas
Director's Office
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899

Dear Mr. Douglas,

Tarzana Treatment Centers (TTC) is grateful for the opportunity to comment on this Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project. As the Governor's proposed 2012-13 budget makes clear that the demonstration project is the first step in transitioning dual eligibles to managed care it is important that the demonstration projects are designed, managed and evaluated in a way that produces feedback about the most cost-effective designs for integrated care for the dual eligibles.

We have keyed our comments to the page of the 'regular font' version of the RFS and note the page and italicize the first few words of the section on which we are providing feedback.

Page 7 – With any of the following conditions: HIV/AIDS

> Comment: Based on experience with providing services to dual-eligible HIV/AIDS patients including medical care, mental health and substance use disorder treatment, housing, case management, in-home supportive services, access to a comprehensive medication formulary and other services TTC believes that patients will benefit if the demonstration includes persons with HIV/AIDS because of the benefits of improved care coordination and the simplification of processes that will result from a single health plan being responsible for their healthcare.

Page 9 - Behavioral Health: Demonstration sites are required to have a plan to achieve full integration of behavioral health services by January 1, 2015 (i.e. inclusion of behavioral health services into the integrated capitated payment).

> We recommend rephrasing this sentence to read: Substance use and mental health services: Demonstration sites are required to have a plan to fully integrate comprehensive substance use and mental health services into the integrated capitated payment by January 1, 2015.

*Page 9 - **Supplementary Benefits:** Demonstration sites are encouraged to offer additional benefits, such as non-emergency transportation, vision care, dental care, substance use services.*

We recommend rephrasing this sentence to read: Demonstration sites are strongly encouraged to offer additional benefits, such as non-emergency transportation, vision care, dental care, and substance use services expanded beyond those available today in most Medicare Part C benefit plans.

As an example, an insurance plan has found that TTC-provided case management services are effective in preventing readmission to inpatient substance use treatment and reduce the cost of care. These services are today not reimbursable under Part C.

Page 17 – e. Inclusion of additional benefits beyond the minimum Medicare and Medi-Cal benefits will be beneficial, for example: dental, vision and substance use.

We recommend rephrasing this sentence be read: Inclusion of additional benefits beyond the minimum Medicare and Medi-Cal benefits is stongly encouraged, for example: dental, vision and substance use.

Page 36 – 2. Measurable Goals

2a. Describe the specific care management goals including:
These goals must be stated in measurable terms that indicate how the plan will know whether the goals have been achieved. The care management goals should include at a minimum:

• Improving access to essential services such as medical, mental health, and social services;

The bulleted goal should be revised to also reference substance use services.

Page 44 - Framework for Understanding Mental Health and Substance Use

Sentence in first paragraph: Patient-centered, coordinated care models should address the full continuum of services beneficiaries need, including medical care, mental illness and substance use services in a seamlessly coordinated manner.

We recommend revising this sentence to include the text in bold below: Patient-centered, coordinated care models should address the full continuum of services beneficiaries need, including medical care, mental illness and substance use services, **to include medication assisted treatment,** in a seamlessly coordinated manner.

Sentence under item 4: For those with severe mental illness, that health home often will be located with a community mental health provider.

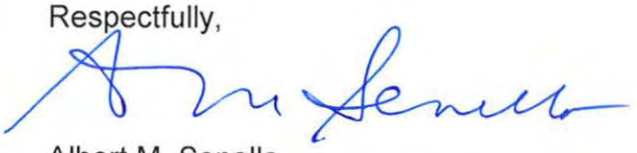
We recommend revising this sentence to read: For those with severe mental illness and or a chronic substance use disorder that health home often will be located with a

community a community-based organization that provides mental health and substance use disorder treatment.

This concludes our suggestions for changes to the RFS. As a provider of a range of services to Medicare and Medi-Cal patients we look forward to the opportunity to provide additional feedback as the demonstration continues and to eventually participate as a provider should a proposal from Los Angeles County be accepted.

Please do not hesitate to contact me by phone at 818-654-3815 or by e-mail at asenella@tarzanatc.org should you have any questions.

Respectfully,



Albert M. Senella
President, Chief Operating Officer

Comment #	Page # of RFS	Section	RFS Draft Language	TSF Comment
1	Page 9	Key Attributes: Demonstration Population	"DHCS is seeking comments on this entire document and in particular on whether the Demonstration should exclude beneficiaries…who have been institutionalized for longer than 90 days."	We agree that the goal of the Demonstration is to address current fiscal disincentives and service fragmentation that dually eligible Californians face by having an integrating entity provide and be at risk for all of an individual's care needs under a blended capitation rate including primary, acute, behavioral, and long-term care regardless of setting. Therefore we recommend that the Demonstration be available as an enrollment option for all dual eligibles in the selected counties, regardless of setting of care at enrollment, including those living in institutional settings. To exclude beneficiaries who have been institutionalized for longer than 90 days changes the fundamental nature of the Demonstration and would decrease the ability for beneficiaries to receive improved care coordination across all settings of care. It would also substantially limit the opportunity for dual eligible beneficiaries in institutions to have access to care coordination efforts to help them transition back into the community. If DHCS ultimately decides to exclude these beneficiaries initially, we recommend that all dual eligibles within the specified geographic region of the Demonstration sites be eligible for enrollment by the end of the first year.
2	Page 10	Key Attributes: Benefits	"…Sites also will be responsible for providing access to all State Plan benefits and services covered by Medi-Cal. Also included will be provision of long-term care supports and services (LTSS), which include State Plan benefits of In-Home Supportive Services (IHSS), Community-Based Adult Services Center services (CBAS Center, formerly called Adult Day Health Care Services), long-term custodial care in Nursing Facilities, and the Multi-Purposes Senior Services Program…"	Though State Plan benefits and services are mentioned as being included as part of the benefits demonstration sites will be responsible for providing, the document is silent on other Medi-cal waiver services including the Acute Hospital Waiver and the Assisted Living Waiver (available only in selected areas). We recommend that such services be included in the demonstration, and should be explicitly mentioned.

Comment #	Page # of RFS	Section	RFS Draft Language	TSF Comment
3	Page 11	Key Attributes: Supplementary Benefits	"Demonstration sites are encouraged to offer additional benefits, such as non-emergency transportation, vision care, dental care, substance use services, etc… Demonstration sites are encouraged to contract, utilize, and pay for community-based services that can help beneficiaries remain in their homes and communities."	One of the promising elements of integration is the potential to redirect savings to provide services and supports that may not be covered by either Medicaid or Medicare, but that are essential to improving, restoring or maintaining the health of individuals. In this spirit, DHCS should require integrating entities to provide access to necessary supports and services, including enhanced benefits (such as home modifications and caregiver training) that are designed to keep individuals living at home and in the community. Identification of a beneficiary's need for services should be ascertained through completion of a uniform assessment that all Demonstration sites use that incorporates measures on health, functional, behavioral, and cognitive status. Provision of all services should be made based on clearly defined standards. Enhanced benefits should also be clearly defined with standards for providing the service clearly outlined.
4	Page 12	Key Attributes: Network Adequacy	"DHCS intends to follow Medicare standards for network adequacy for medical services and prescription drugs and Medi-Cal standards for network adequacy for LTSS."	Integrating entities should provide adequate access to providers that are able to serve the unique needs of California's dual eligible population. In particular, measures of network adequacy need to take into account the high number of dual eligibles who have multiple chronic conditions including dementia, who are very frail, who have disabilities, and limited English proficiency. Integrated model networks must include appropriate ratios of primary care providers with training to serve the diverse dually eligible population, an adequate specialist network including a sufficient number of specialists in diseases and conditions affecting this population and a range of high quality home- and community-based provider options. When setting standards for network adequacy, it is important that standards take into account the number of network providers who actually are accepting new patients, wait times for

Comment #	Page # of RFS	Section	RFS Draft Language	TSF Comment
				appointments, cultural competency, physical accessibility, and geographic accessibility. Many members of this population do not drive and may instead rely on public transportation, which must be taken into account. In urban and suburban areas with public transportation, accessibility criteria should be based on the amount of time required when using public transportation and not rely solely on drive times. In addition to having expertise and being available for appointments, network providers must be prepared to provide special accommodations to dual eligibles. For example, the integrating entity should enforce policies and payment structures that incorporate longer appointment times than are typically allocated for the general population. For many reasons— complex health conditions, limited English proficiency, disability, mental health condition— members of this population may need longer appointments if their needs are to be fully understood and appropriately addressed. Finally, integrating entities should ensure that they can provide 24/7 access to non-emergency care help lines staffed by medical professionals and to non-emergency room medical services. Even where integrating entities have met these standards for network adequacy, DHCS should require them to create and implement a process for granting exemptions to individuals who need to receive services from out-of-network providers when those are the only providers capable of providing the needed care.
5	Page 12	Key Attributes: Monitoring and Evaluation	"Quality requirements will be integrated, and include a unified minimum core set of reporting measures, to evaluate quality improvement of sites during Demonstration period."	We recommend DHCS require, as a condition of participation, that all integrating entities involved in the Demonstration utilize a uniform assessment consistent across all sites to assess the health, functional, behavioral, and cognitive needs of individuals enrolled. Information ascertained through these measures should be used to direct and implement an individualized care plan and that

Comment #	Page # of RFS	Section	RFS Draft Language	TSF Comment
				individuals should be re-assessed at specified intervals. This information should also be incorporated into a uniform set of reporting measures to evaluate quality of care and quality of life. DHCS should also require integrating entities to report this information at a specified interval (i.e. annually, upon change in a beneficiaries condition, etc.).
6	Page 13	Key Attributes: Ongoing Stakeholder Involvement	"Meaningful involvement of external stakeholders, including consumers, in the development and ongoing operations of the program will be required."	We recommend that the final RFS provide a clear definition of "meaningful involvement" of external stakeholders, including consumers, in each of the pilot sites. Integrating entities, at a minimum, should develop a process for gathering ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.
7	Page 21	Qualification Requirements: High Quality	"Applicants must demonstrate meeting or exceeding minimum quality performance indicators, including: a. DHCS-established quality performance indicators for Medi-Cal managed care plans, including but not limited to mandatory HEDIS measurements. b. MA-SNP quality performance requirements, including but not limited to mandatory HEDIS measurements."	We recommend that DHCS consider the work that the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF) are currently engaged in to develop duals-specific quality performance measures, which should be incorporated into the Demonstration.
8	Page 22	Qualification Requirements: County Support	"Applicants must submit letters of agreement to work in good faith on this project from County officials, including the County agency head with operational responsibility for: • IHSS and aging services; • Behavioral Health (both Mental Health and Substance Use, if those are overseen by separate County entities); and, • Health (the County agency with the most direct responsibility for the County public medical center(s), if any)."	We recommend that this list should be broadened and clarified as follows to include the range of LTSS including, but not limited to, transportation, services provided under the auspices of local Area Agencies on Aging, Independent Living Centers, and Aging and Disability Resource Centers; caregiver resources, home modifications; and affordable housing.

Comment #	Page # of RFS	Section	RFS Draft Language	TSF Comment
9	Page 22	Qualification Requirements: Stakeholder Involvement	"Applicants must certify that 3 of the following 5 are true: • The Applicant has at least one dual eligible individual on the board of directors of its parent entity or company. • The Applicant has created an advisory board of dually eligible consumers reporting to the board of directors (or will do so as part of the Readiness Review). • The Applicant has provided five letters of support from the community, with sources including individual dual eligible consumers, community organizations, and/or individual health care providers. • The Applicant sought and accepted community-level stakeholder input into the development of the Application, with specific examples provided of how the plan was developed or changed in response to community comment. • The Applicant has conducted a program of stakeholder involvement (with the Applicant providing a narrative of all activities designed to obtain community input.)"	We recommend that integrating entities applying to be pilot sites in the Demonstration certify that a minimum of four out of five of the elements listed regarding stakeholder engagement are true. We recommend that the RFS clarifies the types of community organizations/representatives from which applicants can receive letter of support, such as advocates for seniors and persons with disabilities, consumers of services, organizations representing LTSS such as community-based organizations providing services to seniors, people with disabilities, and caregivers.
10	Page 25	Project Narrative-Section 2.1: LTSS Capacity	"The Applicant must…describe relevant experience with individuals living in group homes, Residential Care Facilities for the Elderly (RCFE), Intermediate Care Facilities (IFC-DD, ICF-BH), Congregate Living Facilities (CLF) or other type of 'institutionalized' settings."	In addition to demonstrating relevant experience with institutionalized settings, we recommend that DHCS requires integrating entities to describe relevant experience in working with home- and community-based service providers and the broader network of LTSS providers.
11	Page 25	Project Narrative – Section 2.1: LTSS Capacity	"The Applicant must…Describe how you would use your Health Risk Assessment Screening to identify enrollees in need of medical care and LTSS and how you would standardize and consolidate the numerous assessment tools currently used for specific medical	As noted in Comment #5, we recommend DHCS require, as a condition of participation, that all integrating entities involved in the Demonstration to utilize a uniform assessment consistent across all sites to assess the health, functional, behavioral, and cognitive needs of individuals

Comment #	Page # of RFS	Section	RFS Draft Language	TSF Comment
			care and LTSS."	enrolled. Information ascertained through these measures should be used to direct and implement an individualized care plan and that individuals should be re-assessed at specified intervals. This information should also be incorporated into a uniform set of reporting measures to evaluate quality of care and quality of life. We recommend that DHCS also requires integrating entities to report this information at a specified interval (i.e. annually, upon change in a beneficiaries condition, etc.).

United Domestic Workers of America
AFSCME Local 3930 /AFL-CIO
1121 L Street, Suite 508
Sacramento, CA 95814
(916) 554-0931 • www.udwa.org

January 9, 2012

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

RE: Dual Eligible Demonstration Draft Request for Solutions

Dear Mr. Douglas:

UDW/AFSCME Local 3930 represents approximately 66,000 individuals who serve as home care providers in the In-Home Supportive Services (IHSS) program. As you know, the majority of current IHSS recipients are eligible for both Medi-Cal and Medicare (or "dual-eligible"). Because the focus of California's Dual Demonstration Project is to coordinate care and integrate financing for the dual eligible population, we are particularly interested in the project's development, design, and implementation.

UDW recognizes the need for coordinated care models that provide a full spectrum of supports and services to California's dual eligibles. While we are supportive of the conceptual goals of the Demonstration and appreciate the opportunity to provide comments on the site selection criteria, we do have some concerns. UDW offers the following comments regarding the Draft Request for Solutions:

Consumer Choice and Protections

- UDW is committed to protecting consumer choice and preserving continuity of care. We believe that IHSS consumers must maintain their right to receive services in their homes and to self-direct these services. This includes the right to choose the individuals that provide their care and to hire, fire, and supervise these individuals. During the Demonstration, IHSS consumers must be able to keep their current provider as well as maintain the right to employ family members.

Populations and Carve-outs

- In order to achieve cost-effective coordinated care and support services that are truly rebalanced toward home and community based services, Demonstration Sites must assume financial risk for all long term care services and settings. (Full financial risk may be phased-in over several years.) The entity must be responsible for the most expensive care settings, such as hospitals and nursing facilities, as well as the least expensive so that there is an incentive toward supports that allow people to live at home, where they prefer.

  Your proposal to "carve out" individuals who have been institutionalized for longer than 90 days would disincentivize any possible transition into a community based setting because there would be a drastic cost difference between institutionalization for 90 days and ongoing support in the community with no end date. In addition, there are many people currently residing in institutions for longer than 90 days who would greatly benefit from transitioning back into their homes. In order to rationalize decision-making and rebalance services toward community and home-based settings for the dual eligible population, every eligible recipient should be included in the Demonstration. The Demonstration is aimed at rebalancing care away from institutional settings and into the home and community; however specific "carve outs" create a severe bias towards institutionalization. *(DRAFT RFS, Page 9)*

Passive Enrollment and Opt-out Options

- We believe a 6 month enrollment lock-in unnecessarily restricts consumer choice. Passive enrollment and opt-out options can offer a reasonable balance between the needs of the consumer, the benefit of the integrating entity, and the overall success of the Demonstration Project. *(DRAFT RFS, Page 9)*

PACE

- We believe that PACE should be a benefit under the Demonstration project, not an alternative option. PACE should also be given the ability to contract for IHSS services. *(DRAFT RFS, Page 10)*

IHSS Integration

- We believe that integrating IHSS into managed care can provide positive outcomes, however the transition needs to be done strategically and with great attention to and enforcement of existing standards and policies. We see the IHSS provider becoming a unique and valuable addition to the patient care team, and we believe that in order to achieve the core goals established by the Demonstration, transitioning IHSS into managed care should be implemented in year one.

- We noticed that the current criteria for IHSS integration is only provided for one year of the Demonstration. Our concern is that after the first year of the project, anything is possible. It is imperative that existing bargaining rights and other union protections will remain intact throughout the Demonstration. *(DRAFT RFS, Page 11)*

Notifications and Continuity of Care

- Based on the difficulties surrounding the enrollment of the SPD population, clear notification of transition plans and continuity of care protocols should be a major goal of the Demonstration. With regard to IHSS integration, it is important that provisions are established to allow recipients to maintain their existing care providers, including family members. *(DRAFT RFS, Page 1)*

Provider Accountability

- Provider accessibility has been a serious issue throughout the process of transitioning SPD's into managed care. Because plans are limited in their ability to resolve these issues with providers, we believe that Demonstration should provide that DHCS has the authority to directly enforce demonstration standards at the provider level. *(DRAFT RFS, Page 12)*

Program Savings: "Vision for training"

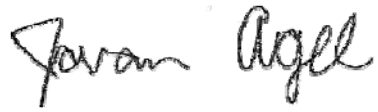
- To further expand on the success of the Demonstration, any cost savings achieved by the Demonstration should be reinvested back into those Medi-Cal programs and services that help people stay in their homes. We believe that investment in IHSS provider training and co-training with their clients can achieve additional savings over time. The PACE model is a shining example of how up-front investments, such as meals-on-wheels, can save money for a program in the long run. *(DRAFT RFS, Page 26)*

Monitoring and Evaluation

- SB 208 requires the Demonstration to show IHSS usage before and after integration. In order to fully realize the true impact of this integration, Demonstration sites should go beyond this initial data collection and evaluate health outcomes and consumer and provider satisfaction in great detail. *(DRAFT RFS, Page 26)*

Thank you for the opportunity to provide these comments. Given the background of our membership and the clients they serve, we believe that our input is valuable in this development process. We look forward to working with you further on this important project.

Sincerely,



Jovan Agee
Director of Political & Legislative Affairs

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1680 East Hill Street, Signal Hill, CA 90755

The purpose of this letter is to give input to the California DHCS draft Request for Solutions (RFS) for California's Dual Eligible Demonstration Project. Overall we are very supportive of the DHCS efforts in this Demonstration Project. We believe the final result will demonstrate improved care for the Dual Eligible beneficiaries who receive care under the project and will result in long term cost savings for the state.

Before we give our feedback we would like to briefly share how we currently interface with Dual Eligible beneficiaries. Universal Care-Brand New Day is a Medicare Advantage Prescription Drug (MAPD) Chronic Special Needs Plan (CSNP) providing services for the Severely and Persistently Mentally ill (SPMI). We currently service over 2,100 Medicare beneficiaries in 5 counties who are disabled because of mental illness. Currently 87% of our members have both Medicare and Medi-CAL coverage. We have developed a specialized Medi-CAL home delivery model which provides for coordinated Medi-CAL and behavioral health services for our members including in home care as needed. We have been providing service to the SPMI population since 2000. Using our coordinated approach we have seen overall improved functioning of our members, which has resulted in decreased hospitalization, decreased emergency room visits, improved pregnancy outcomes, reduced need for long term care services, reduced IMD services, and improved preventative care. For years our Brand New Day program has been providing care and services which include seamless access to the full continuum of Medi-CAL, social, long-term, and behavioral supports and services that the mentally ill dual eligible beneficiary needs to maintain good health and a high quality of life. We have reduced the financial burden for our population to both the state Medi-CAL system and the county mental health systems.

Section: Demonstration Population and Enrollment (pages 9-10)

This RFS refers to MAPD D-SNPs but there are actually 3 types of SNPs and we believe all 3 models need to be considered in the final plan to care for the Dual Eligilbes. The other kinds of MAPD SNPs are Chronic Special Needs Plans (C-SNP) which are for beneficiaries diagnosed with certain chronic and disabling disease conditions; and Institutional Special Needs Plans (I-SNP) for institutionalized beneficiaries.

Both C-SNPs and I-SNPs have extensive experience in caring efficiently and cost effectively with specialized severally ill populations. These programs currently have in place provider networks which are experienced and skilled at providing care to their populations. Current federal legislation does not require C-SNPs and I-SNPs to have direct contracts with the state and these SNPs will continue to be an option for beneficiaries after the dual integration program is implemented. Therefore these specialized programs which are already meeting many of the State's dual requirements will be able to continue and grow based upon their unique programs to provide care to their specialized populations. We

however believe these programs should be integrated into the pilot allowing these specialized programs to be more available to beneficiaries and help achieve the state goals for the pilot.

We propose the following possible modifications to the pilot to include these programs

- Option 1: Allow for the C-SNPs and I-SNPs to directly contract with the State DHCS to provide the required Medi-CAL coverage in addition to the contracted D-SNPs. When the passive enrollment occurs include a default to these plans for their specialized populations.

- Option 2: Require the pilot County Local Initiatives, commercial plans, or County Organized Health System to contract with the C-SNP's or I-SNP's. The state should develop contracting guidelines to ensure fair and efficient contracting with the C-SNP and I-SNPs.

- Option 3: If the State does not incorporate C-SNPs and I-SNPs into the pilot, then during the passive enrollment process C-SNP and I-SNP options should be clearly included on the Choice Form as a beneficiary's alternative option, in addition to the Fee for Service system.

We believe that including C-SNP and I-SNP will result in overall improved care and financial outcomes by adding the most experienced plans and delivery networks to the program rather than having these plans operate outside of the pilot.

Thank you for the opportunity to give input into this exciting initiative.

Sincerely,

Jeffrey Davis

Jeffrey Davis
COO
Universal Care Brand New Day
(562) 787-1404

WESTERN
R
TY

1107 9th Street Suite 700, Sacramento CA 95814
T. 916.442.0753 F. 916.282.5117

Sacramento Office

Elizabeth A. Landsberg
Director of Legislative Advocacy
Brian Augusta
Legislative Advocate
Jessica Bartholow
Legislative Advocate
Vanessa Cajina
Legislative Advocate
Michael E. Herald
Legislative Advocate
Michael Moynagh
Legislative Advocate

January 9, 2012

Toby Douglas, Director
California Department of Health Care Services
1501 Capitol Mall, M.S. 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Delivered via e-mail to: OMCPRFP9@dhcs.ca.gov

Re: Response to Request for Solutions (RFS) for California's Dual Eligibles Demonstration Project 12/22/11

Dear Director Douglas;

Thank you for the opportunity to respond to the Department of Health Care Services' (DHCS) draft Request for Solutions (RFS) regarding California's Dual Eligibles Demonstration Project. This RFS is meant to promote coordinated care models that should provide seamless access to the spectrum of services offered to these beneficiaries, including medical, social, long-term, and behavioral care. Dual eligibles ("duals"), or those who are eligible for both Medi-Cal and Medicare, typically have complex health needs, see multiple health providers, and use a vast array of services. There are currently approximately 1.2 million duals in California. Given the complexity of the care required by this population, in addition to the difficultly with which the Medi-Cal and Medicare payer models interact, the Western Center on Law and Poverty urges extreme caution, a deliberate process, and beneficiary and stakeholder engagement in undertaking this large transition.

California was granted a waiver in November 2010 by the federal Centers for Medicare that requires seniors and persons with disabilities enrolled in just Medi-Cal to move from a Fee For Service (FFS) payer model and enroll in a managed care health plan. Duals were exempted from the waiver. Additionally, the enactment of the Affordable Care Act in 2010 created the Federal Coordinated Health Care Office ("Medicare-Medi-Caid Coordination Office"), which is charged with helping states coordinate their dual populations. The needs of duals are significant, and coordinating payment between the Medi-Cal and Medicare programs is frequently a complicated and cumbersome process. The dual population tends to be older with compound health problems. While Western Center has no general objection to the concept of coordinated or managed care, we feel strongly that California must proceed with extreme caution when attempting any changes that could affect a beneficiary's continuity of care or existing relationships with providers.

Active and Informed Choice Is a Must: Our main concern is with Section 5.5 of the Project Narrative under Enrollment Process. It appears that DHCS will allow sites to passively enroll duals into the pilot program, to which we object. Instead, we encourage an active enrollment, or an "opt-in", for beneficiaries who choose to enroll in the pilot program. It also appears that DHCS will allow for pilot programs to lock beneficiaries into enrollment or a health plan for as long as six months, to which we also object.

In evaluating other managed care transitions, we have seen too many cases where persons with complex health needs were enrolled in a health plan to which their existing provider (or many times, multiple providers) did not belong. Locking beneficiaries into plans would further exacerbate this problem. Frequently these patients had standing prescriptions, appointments, and diagnoses that their previous provider had approved, but that their new health plan did not. These beneficiaries reported that obtaining either continuity of care exemptions or Medical Exemption Requests was extremely difficult and forced them to delay or forgo care. We are extremely concerned that such cases will repeat themselves should the state attempt to pilot these projects too quickly. As such, beneficiaries should have the choice to enroll in a pilot health plan and be able to change plans as often as they need so as to avoid confusion and keep access to their trusted providers.

Due Process and Consumer Protections: Medi-Cal beneficiaries currently have a strong protections process in place when they cannot get a treatment or medication they need, they are dissatisfied with the care they receive or how they are treated by the medical provider, cannot get a doctor's appointment or referral when they need it, or if they receive a bill for which the plan should properly pay. Medi-Cal managed care beneficiaries in a health plan have the right to file a complaint with their health plan and can ask for an Independent Medical Review (IMR), which has timelines in place to ensure that beneficiaries are treated fairly in a timely manner so that care is not delayed. Medi-Cal beneficiaries in any delivery system of care also have the right to file a Medi-Cal state hearing. The hearing and appeals process in Medicare is quite different from that in Medi-Cal, and consumer safeguards that establish a clear process incorporating the Medi-Cal appeals and due processes must be in place prior to establishing any pilot programs. We concur with the comments of the National Senior Citizens Law Center that DHCS and CMS develop a uniform process so that beneficiaries will not be required to undergo different processes when attempting to remedy situations in regards to their right to obtain health care.

Start Slowly, Learn from Experience: Transitioning even four pilot counties will be a large change for DHCS, counties, health plans, and most importantly to the beneficiaries involved. We ask that Department commit to keeping the pilot to four counties and that evaluations and stakeholder input be taken into account prior to transitioning any more beneficiaries. We understand that the Governor's 2012-13 budget proposal includes what will ultimately be a full transition for all 1.2 million duals in California. We ask that the selection of pilot sites stay autonomous from budget negotiations and that DHCS fully commit to the successful implementation of four pilot counties prior to selecting more sites.

Once again, thank you for the opportunity to comment on this RFS. Please do not hesitate to contact us should you have questions as to our comments or should you want further input. Please contact Vanessa Cajina, Legislative Advocate, at (916) 282-5117 or via email at vcajina@wclp.org.

Sincerely,

Vanessa Cajina
Legislative Advocate