



December 14, 2011

Will Lightbourne, Director,
California Department of Social Services
744 P Street
Sacramento, CA 95814

Toby Douglas, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

RE: County Recommendations on Dual Integration Demonstration Projects

Dear Toby and Will:

California is one of fifteen states competitively selected by the federal Center for Medicare and Medicaid Services (CMS) to design “person-centered approaches to better coordinate care for Medicare-Medicaid enrollees.” SB 208 (Chapter 714, Statutes of 2010) specifically authorizes pilot projects for integration of services to dual eligibles in four counties. CSAC, CWDA and CAPA recognize that transitioning the dual eligible population into Dual Integration Demonstration projects presents challenging issues for the state and for counties. There are multiple complex issues that are distinct and inter-related and must be addressed up front in order to develop successful pilot programs. Counties recognize that one size does not fit all for dual beneficiaries/consumers or for local government. A strong and vibrant partnership between the state and counties will be essential to design and implement the Dual Integration Demonstration projects.

Accordingly, we offer our recommendations to inform the state’s thinking about designing the ideal models for serving dual beneficiaries in the four pilot counties. Following are the critical recommendations to be considered. These and additional recommendations are more fully articulated in the attachment:

Person-centered planning (page 1): IHSS should remain an entitlement to participants in the Duals Demonstration. IHSS consumers should retain their ability to select, hire, fire, schedule and supervise their IHSS care provider, should participate in the development of their care plan, and select other individuals to also participate in their care planning.

IHSS Provider Wages and Benefits (page 2): In accordance with SB 208 and the waiver authority granted under the federal demonstration project, the Duals Demonstration should

recognize the Public Authority as the employer for purposes of collective bargaining for individual providers. Additional training opportunities should be made available through the local Public Authority to IHSS consumers and providers under the Duals Demonstration.

Relationships to County IHSS Agencies (pages 3-7): Integrating Entities should be required to contract with the County to administer IHSS services, through individual contracts with the Public Authority and County for IHSS Administration. Integrating Entities should demonstrate their ability to work collaboratively with the County to define the level of services to be provided by the County. At minimum, county IHSS social worker staff will assess and authorize IHSS services and participate actively in local care coordination teams. Other options include having IHSS county staff perform care coordination on behalf of the Integrating Entity, and/or contracting with the County to establish local integration hubs that bring medical and social service providers together to coordinate care based on consumer needs.

In addition, IHSS services should continue to be authorized according to established statutory and regulatory guidelines, and include processes that allow information on the care needs of the clients to be shared between the County and the Integrating Entity and to ensure that services are aligned with the consumer's plan of care.

Financing (page 7): All pilot counties will continue to participate financially in IHSS costs. It is critical to not disrupt the current 1991 Realignment structure to prevent unwanted Proposition 98 challenges that, if successful, could cause the unintended consequence to shift funds away from current health, mental health and social service programs. There are various financial structures that could be established between the county and the Integrating Entity that would preserve the existing financing structure while ensuring counties partner financially in the demonstration. Given the unknown financial impact to county budgets, pilot counties' costs in the demonstration should be negotiated and agreed to by the local Board of Supervisors to ensure that counties do not bear increased cost under the pilot..

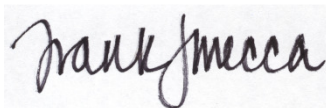
Counties welcome discussion with our State partners to develop a program model that is consumer-focused, client-driven, and which improves the quality of care. Counties believe that a successful Duals Demonstration will result when built on the existing strengths of the IHSS program and county expertise in administering the program and supporting consumers and providers.

Thank you for this opportunity to provide input on the Duals Demonstration.

Sincerely,



Kelly Brooks-Lindsey
Legislative Representative
CSAC



Frank Mecca
Executive Director
CWDA



Karen Keeslar
Executive Director
CAPA



Coordinating IHSS with the Duals Demonstration Pilots: Counties' Recommended Approach

Rev 12-13-11

*Indicates an enhancement to the current IHSS system.

Person-Centered Care Planning:

1. **Maintain Statewide Entitlement to IHSS:** Maintain the statewide entitlement to IHSS services for persons participating in the pilot program. Participating beneficiaries will be entitled to IHSS services regardless of their level of care coordination under the Dual Eligible pilot, so long as they continue to meet current eligibility criteria.
2. **Consumer Direction:** IHSS consumers continue to be the employer of record for purposes of hiring, firing, scheduling, and supervising their IHSS care provider. This includes the continued option to hire family members as personal care providers.
3. ***Consumers and Care Planning:** Consumers are part of their care team and will participate in the development of their care plan with the local care coordination team. Consumers will decide who, amongst their social supports, should also participate in the plan's development (i.e. family members, personal care providers, neighbors/friends, other persons of importance to that individual).
 - State and federal laws grant patients certain rights. Foremost among these is the right for a competent adult to make his or her health care decisions. Every competent adult has the fundamental right of self-determination over his or her body and property. These basic rights are mirrored in the IHSS program by allowing consumers to hire and fire their personal care providers. Individuals who are unable to exercise this right, such as minors and incompetent adults, have the right to be represented by another person who will protect their interests and preserve their basic rights. These basic rights must be preserved with the Dual Demonstration projects, and allow the legal representative of consumers to fully participate in the care planning.
4. ***IHSS Providers and Care Planning:** IHSS consumers may also wish to include IHSS providers as part of the care-coordination and planning process, as well as others who may have a role in providing support to the consumer. Consumers, as the employer of their IHSS provider, ultimately must decide what is in their best interest with respect to their employee's (the provider) participation in care planning. For example, the consumer may approve to have the provider accompany him/her to care coordination planning meetings. With the consent of the consumers, the provider(s) may have an opportunity to give updates to care coordinators on the on-going and changing health needs of the consumer, and give feedback on the implementation of the care plan.
 - IHSS providers will soon receive a "NOA Lite" that will inform providers of the approved duties to be performed for each recipient under the provider's care

and will provide a complete list of supportive service tasks available under the IHSS program.

- Various opportunities, when appropriate, may be explored to engage providers through the pilots (with beneficiary/consumer approval).

Employer of Record/Public Authorities:

5. IHSS Provider Wages and Benefits: The employer of record for purposes of collective bargaining for individual providers currently resides with the Public Authority (PA). Pursuant to SB 208, W&I Code 14132.275(g) the pilots are required to provide services through direct hiring of personnel, contract, or establishment of a public authority or nonprofit consortium. In accordance with SB 208 and the waiver authority granted under the federal demonstration project, the Duals Demonstration shall recognize the Public Authority as the employer for purposes of collective bargaining for individual providers.

- Wages and benefits would continue to be locally bargained through the Public Authority with the elected/exclusive union that represents the IHSS care providers.
- The PA continues to maintain local registries, screen registry providers and assist consumers to obtain care providers, which can include a home visit (with consumer consent) to assist with training consumers on how to effectively hire and direct their care provider. The PA also provides emergency back-up/replacement worker services. In some counties, the PA may continue to contract with the County for provider enrollment of non-registry providers.
- Current caps on state financial participation in wages and benefits of \$12.10 need to be increased in order to develop tiered wage structures. Efforts should also be made to provide health insurance to IHSS workers who are currently on waiting lists due to funding shortages that prevent coverage of all workers.
- We recognize that work stoppages such as strikes can have a devastating impact on those losing support services. Every Public Authority in California has “No Strike/No Lock-out” language in the ordinance and/or contract with the union. This is a critical protection for consumers to ensure that they receive care during periods of labor strife that may occur in the future and must be retained in the implementation of Dual Demonstration projects

6. Contracts between Integrating Entities and Private Agencies for IHSS Services:

Integrating Entities may contract with a non-profit or proprietary home care agency to provide all or part of their IHSS services for those recipients who need care but cannot supervise their care provider, if the recipient does not have an authorized legal representative available or willing to supervise their personal assistance. However, contracting with non-profit/proprietary agencies may be considered only if an Individual Provider employer option is available for recipients who make this request in counties with an IHSS caseload of 500 or more¹. Any Integrating Entity that contracts with a non-profit or proprietary agency must implement a process that ensures consumer-direction and choice, including protections for quality of care oversight and monitoring, selection of providers, and

¹ This is a statutory requirement under Welfare & Institutions Code 12302.25 (a).

notification and consent of consumers and/or their family members for care decisions. The integrating entity would have the responsibility to arrange for these contracts, but data should be tracked through CMIPS.

7. Training of Providers and Consumers: The Public Authority currently offers access to training to IHSS Providers in many areas of consumer care, although recent budget cuts to Public Authorities have reduced training opportunities. For example, the PA provides orientation and access to training of all registry providers (and to non-registry providers in those counties that have contracted with the PA). Public Authorities also offer access to training to IHSS consumers on ways to hire, fire, schedule and supervise personal care attendants, as well as on topics covering nutrition and personal health and safety.

- *Training of Providers - The Integrating entity should contract with the PA for training of personal care providers to meet the needs of dual eligible enrollees. This training may cover geriatric and medical care, infection control, medication management, universal precautions, and nutritional needs of IHSS consumers. Consumers must help design the curriculum, which should include independent living and self-direction and disability awareness, and consumers should be allowed to participate in provider training. Wages and benefits for specially-trained IHSS providers would also be locally bargained. Tiered wages are contemplated, as is compensation for providers who participate in recognized training modules.
- *Training of Consumers –The Integrating Entity may purchase additional training under the pilot.
- *Collaboration on training curriculum – Public Authorities, unions, integrating entities including care coordination and IHSS county social workers, and local IHSS advisory committees should collaborate to 1) identify training and other support needs of personal care providers and create materials, tools and work aids that will enable homecare providers to improve the quality of care and create opportunities for career ladders, and 2) identify training needs of IHSS consumers and develop training, educational materials and other methods of support to help consumers understand how to access and manage personal assistance services as well as other medical and supportive services that are available from the Integrating entity and develop/improve skills required to self-direct their care;

8. IHSS Provider Payroll: DSS and SCO shall continue to be responsible for payroll, workers compensation, unemployment insurance, state disability insurance, FICA, and other deductions. The time worked and payroll process shall continue to utilize the statewide CMIPS. County IHSS staff will continue to process provider timecards (in some counties this is also handled by the PA). Note that CMIPS II roll out must be considered when selecting and implementing the Dual Eligible pilot, as the roll out of the system in each county will consume county and Public Authority staff resources during the transition to the new system. Also, it's important to note that there are currently no FICA or UI deductions for certain IHSS providers; if these providers become employees of an Integrating Entity or home health agency, new funds would be needed to pay for these benefits.

9. Provider Enrollment: Provider enrollment will be provided by County IHSS staff or PA staff (for registry providers or non-registry providers where the county has contracted this to the local PA). These are state-mandated activities which include: Completion of the Provider Enrollment Form (SOC 426), Orientation, and Criminal background clearance (through the

California Department of Justice), which includes appeals and waiver procedures. Additional funding will be needed if personal care provider enrollment requirements are expanded to include tuberculosis and/or other screening.

Program Design

- 10. *No Wrong Door:** Dual Eligible pilot programs should develop and support a local infrastructure that promotes a “no wrong door approach” as opposed to single point of entry through only the Integrating Entity. To accomplish this, Integrating Entities should be required to contract with the County, and as part of that contractual agreement, County IHSS staff will participate in the local coordination team that will serve as the hub to care coordination.

Under a “No Wrong Door” approach, access to home and community-based services through the Duals Demonstration would be coordinated and managed as follows:

- Integrating entities act as “gatekeepers” to any medical care services such as prescription drugs, acute care, nursing home care, etc.
- IHSS acts as “gatekeeper” to personal care services under the existing statutory and regulatory constructs of the IHSS Program.
- Coordination of medical and IHSS services will occur through the Care Coordination Team, described below.

- 11. *Care Coordination Teams:** Under the Duals Demonstration, Health Plans should have three options in contracting with counties. These three options represent increasing levels of coordination with county programs, and allows Integrating Entities to leverage existing local infrastructures where they exist in many counties (for example: counties where program and services such as Area Agency on Aging, MSSP and IHSS are jointly administered by the County):

Option 1: At a minimum, Health Plans will contract with IHSS county programs for referrals, intake, assessments and authorization of IHSS services. Contracted IHSS staff would provide additional case management services for IHSS clients who receive care coordination through the Integrating Entity. IHSS social workers will also participate in care coordination efforts of IHSS consumers participating in the Duals Demonstration.

Option 2: Health Plans could contract to have county staff act as care coordinators, who would be able to simultaneously authorize IHSS services and conduct a comprehensive intake/assessment of the consumer’s needs and link to necessary services funded through the Health Plan and to other community-based care options. County care coordinators, working with the Health Plan, could target and better serve consumers based on acuity and multiple needs. One option for care coordinators is to utilize specialty-trained social worker staff or, as many counties have done, Public Health Nursing staff as care coordinators. One benefit in using Public Health Nursing staff is the higher draw down of federal Medicaid matching dollars for case management, and their training in the health field.

County care coordinators can link consumers to services offered by Health Plans as well as leverage community resources including county behavioral health programs,

transportation and community-programs (i.e. meals on wheels). Many IHSS consumers are high functioning and require minimal care coordination, while other consumers will benefit from having their medical and social services coordinated. Thus, the pilots should explore tiered approaches to care coordination through contracts with the County.

Option 3: Health Plans could contract with the county to establish ADRC or ADRC-type services. The benefit of this model is that it provides a “medical and social” home for care coordination whereby multiple services can be coordinated. An example of an innovative and effective approach that the State could support and fund via the Integrating entity contracts are local county Aging and Disability Resource Centers (ADRC’s). ADRC’s, or ADRC-type approaches, can provide the “home” for care coordination teams that include IHSS, MSSP, Triple A’s and other community supports, and can serve as a bridge between Integrating Entities and county-based and community-based social service programs.

In addition, the following should be pursued to better facilitate care coordination:

- Confidentiality agreements may need to be developed so that medical and other information concerning the consumer can be shared across systems. IHSS social workers need certain medical information to establish eligibility for IHSS services, and to identify the service needs that IHSS can support (such as Protective Supervision or Paramedical care). Shared information will increase operating efficiencies (for example, no need for the IHSS Health Certification Form as information is coming directly from the treating physician to the Care Coordinator). Confidentiality agreements should be developed in collaboration with consumer advocates, such as the National Senior Citizens Law Center and Disability Rights California, to ensure strict compliance with constitutional and statutory privacy rights.
- IHSS social workers will be able to share information concerning the assessment and authorization of services with the care team, and will inform the care coordinator of the consumer’s choice of IHSS service provider(s).
- This may require development of consumer disclosure agreements so that information about the IHSS care provider(s) (specifically, contact information for the provider so that the care team can communicate with that provider, relationship to the IHSS client if any, and possibly work schedule if the client provides such information), can be shared with the care coordination team (for inclusion in the care coordination feedback process, etc.).
- There may also be times when it is appropriate for Public Authority staff to participate in the Care Coordination team.

Services

12. *IHSS Service Authorization: IHSS Services will continue to be authorized by the County IHSS Worker using the Uniform Assessment and guided by the Hourly Task Guidelines. The IHSS Uniform Assessment Tool is based on a Functional Index Scale (not a medical analysis) to evaluate a consumer’s capacity to perform certain activities of daily living, and instrumental activities of daily living, safely. Social workers who have been trained in functional assessment are best equipped to assess the consumers’ needs and determine the amount of time needed for personal care assistance.

In the future, counties will work with the State and Integrating entities to develop a statewide, comprehensive assessment tool that includes health, psycho-social and functional abilities and limitations, and which can be integrated into the CMIPS II System. This information will help inform and support the development of a client-focused plan of care. Until such time, it's possible to utilize the Multipurpose Senior Services Program (MSSP) assessments tools in combination with the IHSS assessment.² In addition:

- CDSS will train Integrating Entities and Care Coordination team members on the use of IHSS assessment tools and guidelines, so that all Care Team members are informed of current statute, regulations and statewide guidelines used by county IHSS programs. California has a good record of providing uniform training to IHSS social workers and Administrative Law Judges through the IHSS Training Academy that could be used to rapidly train integrating entities and care teams about IHSS policies and procedures.
- County IHSS staff will inform the Care Coordination Team of the results of assessments (i.e. authorized hours and Functional Index ranks/scores) for individuals as part of the care planning process, and will provide any additional information, as needed, concerning the assessment and/or individual's strengths and needs.
- The County Social Worker may accompany the Care Coordinator in the client's home to conduct a joint assessment, or the Integrating entity may contract with the county to conduct assessments that address the broader needs of the client beyond IHSS.
- For a discussion on resolving disagreements between the Integrating entity, the IHSS consumer, and the County on authorized IHSS services, refer to the Appeals section below.

13. *Additional Services outside of IHSS: County staff will communicate to the Care Coordination Team (including the Integrating Entity) on any additional services needed, such as additional personal care services, home delivered meals, transportation, pet care, paperwork management, home modification, and other supports or services that may or may not be allowed within the current IHSS Program or supported under the traditional Medi-Cal/Medicare programs.

- Additional supports or services needed that are either not allowed under IHSS or which exceed the program cap will be subject to authorization by the Care Coordination Team and paid for by the Integrating Entity.
- If the IHSS provider(s) is being paid for any additional costs or services, payment will run through CMIPS. Integrating entities would remit funds to the state for these extra costs to maintain payment to providers through CMIPS.

² According to the Department of Aging there are 38 MSSP sites and several operate through the county social services agencies and/or local area agency on aging office.

- The Care Coordination Team will consider recommendations for services and inform IHSS Consumers, Providers, the IHSS Social Worker, and the Public Authority when authorization of additional services impacts the county and/or Public Authority of decisions made.

Financing

14. Contracts between Integrating Entities and Counties: Any expenditure of IHSS county funds and use of county services will be approved through the local Board of Supervisors through contractual agreement. Three separate contracts are needed within each designated county with the Integrating Entity to cover: (1) County assessments, case management, eligibility functions, payroll and other services, (2) Public Authority functions and services, and (3) Behavioral health services. Existing local ordinances and interagency agreements may need to be updated depending on the system design.

15. County Contribution: We anticipate all pilot counties will continue to participate financially in IHSS costs. Currently, the State owes counties approximately \$300 million for counties' expenditures in IHSS services and administration. Future costs to the IHSS program under the Duals Demonstration are unknown, creating risk to counties. However, if the pilots are successful in achieving savings, counties as partners should also receive some of the savings accrued under the pilots.

Given the significant uncertainties with the Duals Demonstration, counties support Duals Demonstration financing options that include "risk corridors," which provide for additional funding to Integrating Entities when expenses exceed the costs under a capitated rate, and which allow for shared savings when expenditures are lower than expected. Counties' fiscal exposure to the Duals Demonstration needs similar protections.

We propose that the county's contribution towards IHSS in the Duals Demonstration should be negotiated and agreed to between the Integrating Entity and local Board of Supervisors. This would enable counties to take into consideration any other potential impacts on local services and county costs. There are several options for financing that would provide reasonable protections for counties. For example, the county could contribute a level towards IHSS that is no greater than it otherwise would be absent the Demonstration, unless otherwise agreed to by the county. There are various financial structures that could be established between the county and the Integrating Entity. For example, the county's funds in could be used as a credit to the Integrating Entity in its capitated rate.

Nothing should be done in the pilot that would jeopardize the availability of Realignment funds for realigned purposes by undermining the nature of Realignment funds as local funds that are 100% available for realigned purposes. It is critical to avoid the possibility of legal challenges that could lead to the designation of these funds as non-local funds and thus subject to Proposition 98 use.

By continuing to contribute financially towards IHSS, counties will be contributing partners with local Integrating Entities in delivering services. By capping the counties' fiscal exposure, counties will have additional incentive towards working towards a common goal of improving care coordination and achieving cost efficiencies, in a similar vein as is contemplated under the capitated-rate proposed to Health Plans. The IHSS Program would however remain a statewide entitlement and existing assessments will continue to result in the provision of IHSS services to those who qualify. To the extent that counties also achieve savings,

counties can re-invest funds into local safety net programs that also may benefit Dual Eligible's, such as Adult Protective Service Programs and local Aging Services.

- 16. Service Funding:** IHSS providers are currently paid by the State Controller's office using county funds which are then combined with federal and state funds. The county funds would need to be paid directly to the State to ensure seamless payment to IHSS providers through CMIPS.

There are at least two options for routing IHSS funding from the federal and state shares of cost to support IHSS services. Option 1: the federal and state shares could continue to come through the State. Option 2: the federal and state shares of IHSS service costs could be incorporated as part of the capitated rate paid to the Integrating Entity; however the Integrating Entity would need to remit its share of cost for IHSS services so that the State can continue to issue payments (including any required withholdings) to IHSS providers. Under either option, the county contribution will be paid directly by the county.

- Any additional costs for personal care services exceeding statutory program caps for services (e.g. 195/283 hours per month) or which are outside of state-allowable tasks will be purchased by the Integrating Entity. Integrating Entities may transfer its share of cost to the state to cover those costs.

- 17. County Administrative and Public Authority Operational Costs:**ⁱ Currently, counties receive State funding for IHSS services through monthly advances. The State funds are an estimated portion based on prior year claims and when combined with the county funds are used to fund IHSS administration. This is reconciled on quarterly basis through the CDSS county expense claim process to enable draw-down of the federal matching funds.

For the Duals Demonstration, we propose that a "per member per month" cost be established for IHSS Administrative services. The rate would include all current basic functions of IHSS County Social Work staff administration, plus any enhanced county staffing/services for case management. A "per-member-per-month" should similarly be applied to cover the costs of Public Authority administration, wages and benefits, Advisory Committee, and payroll functions. The per-member-per-month cost would be determined based on actuarial data and costs.

Integrating Entities would establish separate contracts with the counties and with Public Authorities. Integrating entities would fund counties and Public Authorities under separate contracts on a monthly basis, in advance, similar to current practice.

- 18. *Funding a Broader Service Array:** The Duals Demonstration intends to leverage Medicare and Medicaid funding to improve care and ultimately achieve cost savings. Research indicates that cost savings are possible in the short-term through reduced hospitalization and emergency care, and longer-term savings may accrue through reduced use of nursing home care. Financing of the Duals Demonstration must include:

- Recognition of care coordination as a distinct cost and funded appropriately, rather than being subsumed under a broader "Administrative" cost item under the current Medicare and Medi-Cal rates paid to Health Plans.
- Seamless and available financing of acute and non-acute care and ancillary services so that consumers receive timely access to services between medical and social systems

to meet their needs and to facilitate their return to home and community. Examples of needed services currently not funded or difficult to access include non-emergency transportation (i.e. transportation to appointments), medical equipment (i.e. accessible beds, wheelchairs), electronic monitoring systems (i.e. emergency back-up systems, or monitoring for persons with dementia), and home modifications.

The above should be pursued through the contractual agreement with CMS, funding adjustments under the capitated rate, and incentives to Integrating Entities to re-invest in the local infrastructure.

Local Stakeholder Input

19. *IHSS Advisory Committees: Public Authorities are mandated to establish local advisory committees or independent consumer governing board for IHSS program design, input and support comprised of a majority of consumers (both IHSS consumers and consumers of non-IHSS personal care such as through home health agencies).

- The Advisory Committee³ will continue to provide input to the Board of Supervisors and to County IHSS program, and in addition under the Dual Eligible pilot, will provide input to the Integrating Entity and Care Coordination entities.
- Each Advisory Committee should be required to have at least one IHSS consumer who is dually eligible for Medicare and Medi-Cal.
- Integrating entities will take into consideration the input of the local Advisory Committee.
- The State (DHCS and DSS) shall convene quarterly meetings with stakeholders and the IHSS Advisory Committee in the local pilots to receive regular updates and feedback on pilot status.
- Integrating entities must convene quarterly meetings with the local IHSS Advisory Committee, county and Public Authority officials, union representatives and other local stakeholders to elicit feedback and develop iterative improvements in the dual integration system design and delivery.

Appeals

20. IHSS consumers will continue to have the right to appeals through the State ALJ process, and right to timely Notices of Action from the County IHSS program.

21. *If the consumer disagrees with his/her assessment, the following will occur:

- County IHSS will inform the Care Coordination Team of the client's request for appeal
- The Integrating Entity may choose to be a party to the appeal, and the ALJ will consider that input in the decision-making process. The Primary Care Physician's information (or licensed health professional via the Integrating entity) can also be made available to the ALJ as additional documentation of need.

³ The term "advisory committee" refers to the mandate for each Public Authority's advisory committee under Welfare & Institutions Code 12301.6.

- Results of the appeal will be shared with all parties to the appeal including the Integrating Entity and Care Coordination Team.

One advantage to County IHSS will be working closely with integrating entities and having access to the treating professional's information on the IHSS consumer, to aid decisions in Appeals and service authorizations.

- 22.** *Implement the recommendations of the National Senior Citizens Law Center to ensure robust consumer protections, including:
- Right to appeal eligibility for or enrollment in the model;
 - Right to appeal an assignment to a provider or care team
 - Right to appeal a decision regarding provision of a particular services;
 - Right to appeal elements or non-elements of a care plan;
 - Right to request a second opinion or evaluation;
 - Right to appeal a denial of coverage of a services; and
 - Right to file a grievance/complaint about the integrated model and/or its providers.

Quality Assurance

- 23. Existing, Robust Program Integrity Efforts:** County IHSS programs (PA and Counties) will continue to maintain program integrity procedures according to established federal and state laws and regulations under the Duals Demonstration.

Currently, County IHSS staff are required to visit the IHSS client once every 12 months, or more frequently at the client's request if the client's condition changes warranting a new assessment. State regulations also dictate county responsibilities to conduct quality assurance activities including reviews of case files and in-home visits. In addition, IHSS providers submit timesheets for hours worked to provide direct in-home care to clients, and the hours submitted can be compared to hours authorized using CMIPS reports.

For this Demonstration, we recommend that County staff should visit high-risk, Dual Eligible clients on a quarterly basis, at minimum, or monthly for the highest risk clients, to ensure that critical services are being delivered appropriately and to identify any emerging needs that will help prevent unnecessary hospital or emergency care. The population to receive these visits can be determined by the Integrating Entity. Funding for these additional county caseworker visits would be established through contract with the County.

- 24.** *Should additional quality assurance processes be required under the Dual Eligible pilots, the Integrating Entity and/or the State will adjust the contract with the County IHSS program and county PA to accommodate any increased costs. The State remains under a constitutional obligation to reimburse mandated costs.

Data, Evaluation, and Local Systems

25. CMIPS II is expected to be released in 2012 and will be a major impact to county IHSS program operations. The Duals Demonstration selection process must consider the timing of CMIPS II implementation in counties.
26. The pilots must provide the framework for an aggressive program of quality management and data sharing.
27. Claims data must be shared by the State with the Integrating entity and Care Coordination Teams to determine the highest-risk persons for whom care coordination will be of most benefit. Triaging of individuals should be a continuous process and with input of the Care Coordination Team. Consumers' health conditions can quickly change, and IHSS social workers and other local safety net providers (i.e. behavioral health, Public Authorities and Adult Protective Services) should have an opportunity to refer consumers for care coordination.

Site Selection Criteria

1. Integrating Entities should provide evidence of existing local partnerships and/or demonstrate its formulation of partnerships for purposes of the Duals Demonstration with county IHSS (through the local County Welfare Department), Public Authorities and county behavioral health departments.
2. The state should set caseload standards for care managers (such as County Case Coordinators and county IHSS and Public Authority staff) to ensure that Integrating Entities can meet the needs of consumers and can demonstrate competency in dealing with the medical needs and supports of people with disabilities of all ages.
3. Integrating Entities should provide 24/7 access to a live person to assist consumers/beneficiaries, including during the transition to the Duals Demonstration.
4. Integrating Entities should have a demonstrated ability to meet the linguistic and cultural needs and be able to communicate with consumers/beneficiaries in their own language.
5. Integrating Entities should establish and support a decentralized decision-making structure that empowers Care Coordination Teams to determine and approve services in accordance with consumer needs, increase services in accordance with health/disability status changes, to make referrals to specialists, and to authorize alternative therapies.
6. Integrating Entities should demonstrate effective discharge planning skills and services that ensure a system of long term care supports and services are in place to avoid hospital readmissions, prevent institutionalization, and shift beneficiaries out of nursing homes.
7. Integrating Entities should demonstrate a commitment to ongoing and iterative improvements of the care manager and team approach to supporting their dually eligible members.
8. Integration entities should currently operate as a lead agency or partner agency with the local Aging and Disability Resource Center (ADRC), or should demonstrate 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.

9. Integrating Entities should either operate or show how it has worked with local community-based organizations and programs, such as independent living centers, Area Agencies on Aging, MSSP, etc.
10. Integrating entities should demonstrate financial solvency and fiscal capacity to meet expectations and standards for the dual demonstration projects.
11. Integrating Entities should fully comply with the Americans with Disabilities Act (ADA) in all areas of service provision.

ⁱ Note that County IHSS Administration funding has been severely underfunded for years and recently experienced further cuts in its program operations funding. County IHSS Administration was cut five percent in 2008-09, a cut that remains in effect today. In addition, the State has failed to update its workload standard and failed to fund any increases in cost of doing business since 2001-02. This severe underfunding in county administration has negatively impacted counties ability to perform timely intakes and reassessment of services to IHSS consumers at a time when IHSS caseloads continued to increase.

Likewise, Public Authorities have been hit particularly hard due to state budget decisions that have reduced Public Authority funding 57% statewide from the highest level of \$57.919 million in FY 08/09 to \$24.687 million for FY 11/12. There are nine Public Authorities with less than \$100,000 a year in federal, state and county funds combined to run their program. Another eleven Public Authorities have less than \$200,000 a year for program operations.