



January 10, 2012

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RE: Draft Request for Solutions – California’s Dual Eligible Demonstration

Dear DHCS staff & Harbage Consulting:

As you know, the counties and Public Authorities have been working together to coordinate input and develop joint recommendations for the Dual Integration Demonstration projects. The Governor’s new state budget proposals on mandatory managed care, dual integration, IHSS and Phase II realignment add significant complexity to the challenges associated dual integration. Counties and Public Authorities are prepared to work in partnership with the state to reasonably implement current law that specifically authorizes pilot projects for integration of services to dual eligibles in four counties. It is premature to expand the number of pilots from four to ten counties while simultaneously implementing a statewide mandatory Medi-Cal managed care system over the next three years. We believe various models should be tested before deciding on a statewide change that would affect the 1.2 million dual eligible beneficiaries and all IHSS consumers in California. Notwithstanding our concerns about the Governor’s new state budget proposals, Welfare and Institutions Code 14132.275 clearly requires the state to establish dual integration pilot projects in up to four counties. Our questions and comments about the Governor’s new budget proposals will be addressed separately and over the course of the budget process. Accordingly, we offer the following comments to the Request for Solutions that are exclusively focused on developing pilot projects in four counties to preserve and enhance home-and-community based services to seniors and people with disabilities.

Our comments reflect page numbers from the draft RFS released in the regular font size and, therefore, the page numbers will not track with sections in the large font version.

Following are our specific comments:

Page 4 – Authority

- This section should clearly state that the pilots must comply with existing state law or regulations. We believe this is essential to differentiate between the four pilots authorized under current law and the budget proposals related to dual integration and managed care that were released by Governor Brown on January 5, 2012.
- This section only refers to CMS's interest in testing "capitated payment models" and should be expanded to reflect the second model authorized by CMS to test fee-for-service approaches to integration. The final site selection criteria should allow integrating entities to submit applications that test both capitated and fee-for-service models.

Page 4 – Background

- The draft says there are 1.1 million dual people enrolled in both Medicare and Medical in California and the A-pages of the budget proposal says there are 1.2 million dual beneficiaries. Please clarify which number is correct.

Page 5 – Additional Comments on the Background section

- The last paragraph should be deleted. While the administration may want to expand the number of counties to integrate services for dual beneficiaries, current law only authorizes pilots in four counties. The administration's proposal to expand the number of counties should be discussed through the legislative and state budget process, and should not be intertwined into the RFS that is limited to the provisions enacted in SB 208.

Page 6 – Demonstration Goals

- We agree with the goals listed for the demonstration, particularly those related to expanding access to home and community based services and preserving and enhancing self-direction. An additional goal should be added to minimize disruption of care for beneficiaries who are enrolled in the dual integration projects and to improve the quality of care provided to dual eligible. For all the goals, the Department needs to explain in this document or others how progress towards each goal will be measured.

Page 7 – Demonstration Population

- The document uses contradictory terms about the target population. This section states, "All full benefit dual eligibles in the selected Demonstration **areas** will be eligible for enrollment." On page eight, under "Geographic Coverage" the document states, "To be considered for the Demonstration, potential sites must be capable of covering the entire county's population of dual eligibles. SB 208 does

not mandate the pilot projects to cover 100% of the eligible population of dual beneficiaries. In fact, Welfare and Institutions Code 14132.275 (c) specifically authorizes DHCS to implement the pilot projects in phases. We think the RFS should delete the requirement for project sites to cover all of a county's dual eligible so applicants can create and DHCS can test different models with high quality standards.

- Under the paragraph that says "Note:..." this language is not sufficiently clear about the carve-out of individuals receiving care under the Home and Community Based Services Waiver for the Developmentally Disabled (HCBS-DD).
- Carve-outs & Exclusions – we strongly recommend that DHCS delete the language to exclude beneficiaries with specific chronic conditions as well as the exclusion of dual beneficiaries who have been institutionalized for more than 90 days. These carve-outs are discriminatory, create disincentives about developing efforts to move people out of institutional care, violate the Americans with Disabilities Act and *Olmstead* decision, and would allow integrating entities to cherry-pick out the most expensive cases to protect their financial bottom-line.
- Clarification is needed about whether beneficiaries who have a share-of-cost are included in the pilot projects.

Page 8 – Enrollment

- We oppose passive enrollment and prefer voluntary enrollment as previously conveyed in comments submitted to DHCS. Voluntary, "opt in" enrollment processes have been used by integration models that are generally regarded as positive, beneficiary-centered programs. For example, the Program for All-Inclusive Care for the Elderly (PACE) is an "opt in" model. Massachusetts' Senior Care Options, Minnesota's Senior Health Options and Wisconsin's Family Care Partnerships all use an "opt in" enrollment model.
- Likewise, we are strongly opposed to the suggested six-month lock-in. The recent experience with passive enrollment in the state's transition plan for ADHC is revealing. In August, a letter and application packet went out to about 26,000 people in the adult day health care system, a program slated for elimination as a Medi-Cal benefit on December 1, 2011. Beneficiaries were asked to choose between three options: They could sign up for one of the managed care options; they could send in a form to opt out of those plans; or they could do nothing, and would be automatically enrolled. Of those 26,068 patients, 654 chose a managed care plan, and another 10,297 people did nothing and were automatically enrolled in a managed care plan. The majority -- 15,117 people -- chose to remain in their fee-for-service plans.
- At a minimum, the DHCS should test both passive and voluntary enrollment.
- If mandatory enrollment is required, DHCS should establish exceptions if the beneficiary has a chronic medical condition that is being treated by a specialist physician who is not a part of the managed care network or good cause for not

wanting to enroll.

Page 8 – 3rd paragraph on PACE

- Additional language is needed to inform beneficiaries about options to receive services through PACE. We think information about PACE should be included in all enrollment materials and outreach efforts so that beneficiaries are fully aware of it and are able to directly enroll in it, and that beneficiaries who are enrolled in plans who become eligible for PACE should have the option to disenroll and enroll in PACE at that point.

Page 8 – Integrated Financing

- We are extremely concerned by the lack of information about how Demonstration plans will be financed. It is critical to not disrupt the current 1991 Realignment structure to prevent unwanted Proposition 98 challenges that, if successful, could cause the unintended consequence to shift funds away from current health, mental health and social service programs. In its call on January 5, when asked by a plan representative whether plans would be bound by their responses to the RFS in light of the fact that rates have not yet been established, the response was that neither plans nor DHCS would be bound until final contracts were negotiated and signed. The lack of guidance on funding for the demonstration projects as well as the rates to be paid to integrating entities makes it extremely difficult for plans to realistically propose what services they could offer and even more difficult for stakeholders and DHCS to compare proposals since there is no guarantee that responses to the RFS will in any way correspond with the final package of services that any applicant can or is willing to offer.
- This section only refers to CMS's interest in testing "capitated payment models" and should be expanded to reflect the second model authorized by CMS to test fee-for-service approaches to integration. The final site selection criteria should allow integrating entities to submit applications that test both capitated and fee-for-service models.
- We are concerned about the statement that, "The rate will provide upfront savings to both Medicare and Medicaid." It should be recognized that savings are unlikely to be quickly achieved and that high quality systems are essential to avoid preventable hospitalizations and nursing home placement. Better primary and preventive care can, likewise, produce long-term savings. The heavy emphasis on upfront savings implies that service reductions are likely to be imposed by the integrating entities on beneficiary services. Therefore, this sentence should be deleted.

Page 8 – Benefits

- Clarification should be added that Demonstration sites must provide seamless access to benefits but may do so utilizing a range of models that include

coordination with existing agencies providing such services to integration under the Duals demonstration.

Page 9 – IHSS

- We are extremely concerned the draft RFS requires Demonstration sites to contract with County social service agencies for only one year rather than for the full three years of the demonstration and fails to require a separate contract with the local Public Authority (see additional comments below). Demonstration sites do not have any experience in administering the IHSS program. This draft RFS would allow Demonstration sites to suggest an expanded role without identifying the criteria that would ensure Demonstration sites are capable of such an expanded role, nor does it describe the criteria to allow for such an expanded role that ensures adequate protections to IHSS consumers. One year is an extremely short and inadequate amount of time to ensure that Demonstration sites are capable of meeting the unique and diverse needs of IHSS consumers. Nor is it an adequate amount of time to allow Demonstration sites, working in partnership with counties and Public Authorities, to realize care and service improvements for IHSS consumers. Also starting in 2014, an additional two million individuals will become eligible for the Medi-Cal program which will result in greater demands on the health care service delivery system at the very time the department proposes to allow Demonstration sites to assume greater responsibility in the administration of the IHSS program.
- The RFS allows Demonstration sites to expand its role but lacks details in what way the sites may expand. Would the role of the County IHSS or the local Public Authority change and in what way? Or would IHSS services potentially change, and if so, in what way? It is unclear how the County IHSS or Public Authority roles would change, and how this would fit with existing IHSS statutes and regulations which require counties to perform assessments and other IHSS functions. The RFS is completely deficient in this section and doesn't even reference Public Authorities.
- We recommend the Demonstration sites must contract with the County social services agency for a minimum of three years (or during the course of the demonstration). During the three years, the sites may contract and purchase different models of IHSS case management and service delivery so long as it conforms to existing IHSS statute and regulations, including tiered case management based on the individual needs of IHSS consumers served under the Duals demonstration. (note: refer to our comments on page 9-Care Coordination and pages 23/24-IHSS for additional suggestions).
- Likewise, we recommend that the demonstration sites be required to establish a separate contract with the local Public Authority. Welfare and Institutions Code 14132.275 (g) specifically requires demonstrations projects to provide IHSS through "direct hiring of personnel, contract, or establishment of a public authority or

nonprofit consortium, in accordance with, and subject to, the requirements of Section 12302 or 12301.6, as applicable.” WIC 12301.6 is the code section that establishes the authorities, functions and mandates of local Public Authorities. In compliance with state law, the RFS should clearly require integrating entities to contract with the local Public Authority for the duration of the demonstration project.

- The RFS should be revised to require demonstration sites to comply with existing consumer rights and protections, including their ability to select, hire, fire, schedule and supervise their IHSS provider (including the right to have family members serve as their provider) through the duration of the demonstration projects and not leave it to the health plans to describe what they want to do in years 2 and 3.
- We are assuming that current law will govern financing of the pilot projects, which means that counties would financially participate in IHSS services. The simple fact that county dollars will be used in the capitated rate underscores the necessity to have contracts in place between counties and integrating entities for the entire period of the demonstration project, not just in Year 1.
- We support the concept of shared information between the sites and counties; however, we note that given current IHSS state laws and regulations that additional support may be needed from the State to facilitate information exchange.

Page 9 – Care Coordination

- It is disappointing that the RFS contains so little detail about what will be expected from the integrating entities for care coordination. The entire theory that is being tested by the dual demonstration projects is that strong care coordination and case management will lead to better care at a lower cost. We support person-centered care coordination and think the RFS should require demonstration sites to include the consumer in the development of their care plan with the care coordination team. The RFS should also require consumers to decide whether their IHSS provider would participate in the care coordination team. CSAC-CWDA-CAPA provided the following suggestions in our December 14, 2011 letter to DHCS Director Douglas and CDSS Director Lightbourne:
 - Under the Duals Demonstration, Health Plans should have three options in contracting with counties. These three options represent 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.

Page 9 – Supplementary Benefits

- We recommend stronger language to ensure Demonstration sites offer supplementary benefits not covered under Medi-Cal and/or Medicare that are integral to helping persons remain in their home and communities. The list should also be expanded to include social services and supports noted by consumers and providers to be critical, such as access to housing modifications.

Page 9 – Technology

- The RFS should advise applicants that the conversion to CMIPS II may impact the timeline to implement demonstration project.

Page 10 – Appeals

- It is unclear what the impact will be on IHSS appeals processes, rights of the IHSS consumer, and what will be the role of the county and the health plan. We understand this will be clarified in a future proposal and will provide additional feedback at that time.

Page 11 – Medical Loss Ratio

- Rather than waiving the 85/15 medical loss ratio, we recommend that DHCS establish line item in the rate under the 85% medical cost side that would cover the costs of care coordination.

Page 12 – Timeline

- We think the proposed timeline is overly aggressive and needs to build in time for local input and compliance with the Brown Act prior to the deadline to submit applications (currently slated for mid to late February 2012). The timeline doesn't contain any consideration of the time needed at the local level to comply with provisions of the Brown Act prior to approving and submitting letters of support/agreement in partnership with integrating plans as part of the application process. It often takes 4-8 weeks for counties to post documents and agendas to comply with Brown Act requirements. Boards of Supervisors, County Administrative Officials, as well as other local stakeholders should be given an appropriate amount of time to provide input to entities that are interested in applying to become demonstration sites before applications are submitted to DHCS.

Page 18 – D-SNPS

- There are currently only about a dozen D-SNPs in California. We are hearing that some of the C-SNPs are rapidly moving to qualify as a D-SNP. The language in this section should clarify whether applicants must have D-SNP status when they apply or as of the target date to begin enrollment of dual beneficiaries in the integration pilots on January 1, 2013.

Page 20 – County Support

- Counties and Public Authorities strongly support the preservation of consumer rights in the IHSS program to hire, fire, schedule and supervise the IHSS provider. Some health plans have expressed concerns about liability exposure if they are held responsible for tort claims associated with the provision of service by an IHSS provider. Under current law, the state and counties enjoy total immunity from tort claims when IHSS is administered through a local Public Authority. We believe that contract language can be established between demonstration sites and Public Authorities that will address liability concerns and preserve the right of consumers to have the person they want perform personal care assistance. There is also an

expectation that IHSS providers may receive training under the dual demonstration pilots. One of the core mandates of the Public Authority is to provide access to training to IHSS consumers and providers. For these reasons, we believe that demonstration sites should be required to submit a separate letter of agreement from the local IHSS Public Authority must be submitted by the applicant.

Pages 23-24: IHSS

- 1st Bullet – Require 3-year contracts for the course of the demonstration, per our previous comments.
- 3rd bullet – We recommend indicating that sites must be able to articulate how IHSS workers will participate in care teams based on the negotiated discussions with the county program. We recommend adding that sites may contract with counties for additional supports and services beyond the current IHSS program. Examples include but are not limited to: purchasing additional care coordination (tiered case management) and contracting with counties for care coordination to other social services besides IHSS, 7th bullet – The process for purchasing additional service hours needs to be clarified. Does this mean the Demonstration site has the ability to question the county IHSS assessment? Does this mean the Demonstration may increase IHSS hours beyond what is authorized? Additional clarification is needed. Also, when and how will CMIPS be changed to accommodate?
- Professional training of the IHSS worker –
 - The RFS should require demonstration sites to contract with Public Authorities for training of IHSS providers. The RFS should require collaboration between the Public Authority, integrating entity, local IHSS Advisory Committee and exclusive union that represents IHSS providers to 1) identify training and other support needs of personal care providers and create materials, tools and work aids that will enable homecare providers to improve the quality of care and create opportunities for career ladders, and 2) identify training needs of IHSS consumers and develop training, educational materials and other methods of support to help consumers understand how to access and manage personal assistance services as well as other medical and supportive services that are available from the Integrating entity and develop/improve skills required to self-direct their care.
 - Training implies that the providers who are more skilled will be paid higher wages for their services, which is likely to increase costs to the program. Tiered levels of training and certification should be considered.
 - Note that IHSS County Social Work staff currently receive training from the California Department of Social Services via a grant with CSU Sacramento. Will this change in the future, and if so, how?

Page 25: Care Coordination

- How will plans establish levels of care coordination, this should be described and

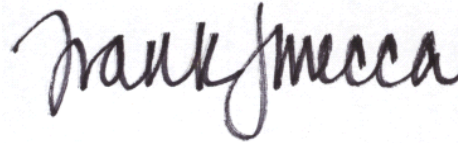
expectations articulated, such as timely client access to care coordinators, caseload sizes, etc.

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 draft Request for Solutions for the four-county dual demonstration pilots.



Sincerely,



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