



January 9, 2012

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*Delivered via e-mail to: [OMCPRFP9@dhcs.ca.gov](mailto: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 than 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 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-Alatorri 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.