National Senior Citizens Law Center
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Comment #	Page # of Proposal	Relevant Language	Proposal Draft Language & Comment
1	1	Demonstration goals: Optimize the use of resources	The demonstration seems less designed to optimize resources then to decrease current Medi-Cal expenditures. The proposal should be explicit about that since the Administration has been. For example, the Trailer Bill Language indicating that the demonstration would end if savings are not achieved immediately. We note that there is not similarly strong language related to ensuring quality and increased access to home and community based services.
2	2	Rigorous selection process to identify plans with the requisite qualifications and resources best suited to participate	The selection process does not appear to be rigorous. All plans but one were selected. Multiple plans selected have poor performance records in both programs. And several plans failed to include information required in the RFS application. See more detailed comments in our comment letter and our report, "Assessing the Quality of California Dual Eligible Demonstration Health Plans."
3	2	Managed FFS models	The state, at the persistent request of stakeholders, has been promising to explore managed FFS models for two years with little to show for it. We believe more should be done in this area. A true demonstration would include a Managed FFS county in the initial year for the sake of comparison to the capitated risk model.
4	2	Enrollment process	We object to the proposed enrollment process. See our letter comments for more details.
5	4	Summit on SPD learning	When will this summit be held? Time is running out to absorb the lessons of that process.

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6	5	Responsibility for dual eligibles	While it's true that no *single* entity is responsible for dual eligibles now, the proposal fails to mention that multiple entities are responsible - the Department of Health Care Services, the Department of Social Services, the Centers for Medicare and Medicaid Services and more. The state in particular has long been responsible for ensuring the needs of Californians are met and that they receive the services to which they are entitled. The state has also long had the incentive to provide care in less restrictive, less expensive settings. The state, and the other entities will remain responsible for this population even under the demonstration.
7	5	New systems should support and build on existing programs	We agree.
8	5	Partner health plans experience	This section should be clear that the experience to date has been primarily limited to coordinating medical services. And that the bulk of the experience in Two-Plan and GMC counties is with children and families. Experience with the SPD population is still brand new in those counties. Also, experience in the Medicare program is limited, especially among plans selected for the demonstration. In total, the 8 plans selected for the four counties currently provide Medicare benefits to just 35,544 duals - only 6% of all duals in their counties.
9	5	Stakeholder process	The stakeholder process must be robust at the state level as well. This process should not be farmed out to managed care plans. DHCS and CMS, the entities that will monitor and oversee these plans, must have an independent process for gathering input and feedback.
10	6	Person-centered planning	The proposal implies that a person-centered approach will result from the new financial incentives imposed on plans. That is not good enough. There must be clear standards and evaluation measures for the provision of person-centered care.

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11	6	Enhanced HCBS	The proposal again relies on financial incentives and the theory that these incentives will improve access to HCBS. That is not enough. There must be clear requirements spelled out for plans to ensure that access to HCBS is improved. Plans should be required to ensure that LTSS expenditures, as a percentage of total expenditures on dual eligibles, remain at or above the current percentage and that community LTSS expenditures, as a percentage of total LTSS expenditures, remain at or above the current percentage.
12	7	Prevention	Again, theories about incentives are not good enough. Standards must be created.
13	7	Enhanced quality and monitoring	Which incentives will focus on performance outcomes? When will the quality measures and evaluation process be ready?
14	7	Lessons learned from three transitions	This is not comforting. The transitions we are most familiar with - SPD and CBAS - have not gone smoothly. The planning for the CBAS transition cannot be described as careful, collaborative or transparent. It was the result of litigation that stopped the state from terminating services and has been contentious, rushed and confusing to beneficiaries and providers.
15	7	SOC	Many IHSS recipients meet their SOC each month.
16	8	PACE	As described in our letter comments, we are extremely worried about the impact passive enrollment will have on PACE - the country's most successful model for integrating care for duals. Converting PACE into a subcontractor of manage care plans will change the nature of the program harming an effective, model program.

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17	8	D-SNP	How many dual eligibles are enrolled in D-SNPs in each county? In the four demo counties how many are enrolled in the selected plans? Other plans? Which ones? The D-SNP policy the Department released after this proposal is extremely confusing and does not bring us closer to a more integrated, coordinated delivery system. It will be nearly impossible to explain to beneficiaries and community based organizations.
18	9	Rigorous selection process	See comment 2 and our letter comments. We note again that the D-SNP experience of many of the selected plans is quite limited. In LA County, the plans are serving, combined, just 2% of all duals in the county. In San Diego County, the plans are serving combined about 8% of all duals in the County, but no one plan is serving more than 2,500 duals. And for many of the plans, the experience serving dual eligibles has been accompanied by poor quality ratings.
19	10	Geographic service area	Two of the counties listed (Contra Costa and Sacramento) did not have enough plans respond to meet the requirements of the RFS. It is hard to imagine how the demonstration could be implemented in those counties without adjusting the RFS or forcing additional plans to apply in those counties. The local stakeholder support and process in these counties varied significantly. DHCS does not appear to have set any benchmarks for what would qualify as local support and process. We oppose the expansion of the demonstration into any more than 4 counties. See our letter comments for more detail.
20	10	Enrollment process	See comment 4 and our letter comments.

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21	10	Sufficient volume	DHCS and plans continue to fail to indicate what would consistent sufficient volume. If all dual eligibles did enroll into the plans selected the number of dual eligibles each of them serve would skyrocket. If half of all dual eligibles in LA County joined LA Care the number of duals to whom they are providing Medicare benefits would be 65 times larger than it is now (2,860 growing to 186,970). Is that what is meant be sufficient volume?
22	11	Contracting with local advocacy organizations	This should not be allowed. Plans should be required to provide support for beneficiary outreach and assistance, but not through direct contracting relationships with local organizations and providers. Assistance provided to beneficiaries must be funded but it must also be conflict of interest free. See our letter comments for more.
23	11	Networks	Just 8 months from implementation, the proposal should be much more specific about what the network adequacy standards should be. In the CBAS experience the state has refused to impose specific network adequacy standards on managed care plans. Plans should be required to sign agreements with existing HCBS providers to ensure continued provision of those services. The proposal says the state will monitor provider networks, but we think it is essential that Medicare play a role in determining whether duals enrolled in the demos have sufficient access to Medicare providers. The section on monitoring network adequacy provides no definition of how 'sufficient' will be defined.
24	11	Readiness Review	Again, the proposal lacks details that should now be available. What will the readiness review be? Who will do it? When will it be done?
25	11	ADA obligation	The language should say "advised of *and comply with* ." We applaud the required use of the facility site review and encourage plans to be required to work with groups like DREDF to prepare for serving individuals with disabilities.
26	11	Geographic analysis, cultural competency and non-medical providers	All plans should be required to describe this analysis. The Department should also conduct an analysis to confirm that the plans' analysis are correct.

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27	11	Provider education and model of care	All plans should be required to educate providers on their model of care. They must also be required to explain how they will ensure that providers buy in to their model.
28	12	Value-added supplemental benefits	These benefits must be guaranteed as a benefit to dual eligibles if they are being passively locked into these plans. The plans must provide a more robust benefit package.
29	13	Relationships with CBO's	Plans should be required to contract with the organizations listed.
30	13	Medical necessity standards	This language is confusing. This section should make clear that current medical necessity standards will apply as a 'floor." Plans will not be able to limit availability of services using more restrictive medical necessity criteria than exist in the programs today. Plans will, however, be allowed to provide services that would not be available under current medical necessity criteria.
31	13	Person-centered care coordination	Much more detail is needed in this section. How will the state define person-centered? What will the care coordination standards be? When will they be developed? They must be developed before these programs are allowed to begin.
32	13	Assessments	A uniform assessment tool, process and qualifications/training requirements for people administering the tool must be developed before implementation of the demo begins - not in 2015 as is currently provided by the TBL. Beneficiaries must have access to the tool and it results from the assessment must be appealable. The assessment should be provided by a independent entity that does not have an incentive to under-assess the need for HCBS services.
33	14	ICT	There needs to be much more information provided about how the ICT will do the activities described here. How will DHCS ensure that the care team will be built around the beneficiary and ensure that decisions are made collaboratively? This is an important and welcome program element, but how will it be defined and enforced? Plans should be required to provide enrollees the option of including a LTSS coordinator on their ICT. This is an idea that MA has adopted in their proposal.
34	14-15	Care transitions	This section refers to a transition of care process, but does not define what it is referring to. Have all plans adopted a single process for processing care transitions? What is the screening tool?

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35	16	Missing text	The proposal fails to affirm the IHSS purpose of maximum inclusion and integration. See our comment letter for more details.
36	16-17	LTSS Care Coordination	The complexity of the task of integrating LTSS into managed care should be enough to persuade the state to limit the demonstration to no more than four counties.
37	16-17	Rebalancing	We support the emphasis on HCBS and rebalancing. We are worried, however, that the state's proposal rests too heavily on the untested assumption that capitated managed care plans will be incentivized to provide more HCBS. Stronger protections are needed to ensure that this will be the case. Opportunities to stop and evaluate the demonstration before expanding statewide are needed so that the course can be created if the incentives develop differently than anticipated.
38	17	The CCI would require dual eligibles to enroll in Medi-Cal managed care to receive LTSS	We oppose the mandatory enrollment of dual eligibles into Medi-Cal managed care. See our comment letter for more details.
39	17	County social services will continue to perform current IHSS functions…in accordance with existing statutory provisions.	We support the use of current IHSS processes and the preservation of exiting consumer protections. More explanation is needed about how care coordination teams will be established and what role the consumer will play in the development of the team and how the role and activities of the team are defined.
40	17	Universal assessment process	We support the development of a uniform assessment process, but waiting until year three of the demonstration to use the tool is not sufficient. The tool should be developed before the demonstration is implemented. It is also unclear how this assessment process will interact with the health risk assessment discussed at pages 13 and 14
41	18	Managed FFS models	We support the development of a managed FFS model.
42	18	Strong foundation for integrated services	We disagree. The non-COHS plans are just now learning how to provide medical services to seniors and person with disabilities. The demonstration introduces two much more complicated tasks - integrating Medicare services and providers and integrating LTSS. The health plans have very limited experience with these tasks. Delaying implementation of the demonstration and beginning the demonstration as a voluntary program, will provide plans the time they need to learn how to provide the full array of services to this medically complex and diverse population.

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43	19	Incorporating SPD lessons	We have yet to see any policy proposals that reflect the lessons the Department has learned from the SPD process. Instead, the policy in this proposal moves faster while providing fewer rights to beneficiaries.
44	19	Medi-Cal managed care health plans will have had many months to adapt to the unique needs of the SPD population and to adjust their networks accordingly.	It is important to note that they have not had to adjust their networks to include Medicare or LTSS providers since they are not responsible for providing those services to the SPD population. To the extent plans have made adjustments as indicated, these should become requirements, not optional adjustments.
45	20	Waiver programs	This is another area where more detail is needed to evaluate the state's proposal. The intent to provide greater access to waiver like services is a good one that has broad stakeholder support. But more information is needed to understand what will happen to current waiver programs and how slots and funding for services will be allocated. We appreciate that the proposal promises to engage stakeholders in figuring out these details, but doing so will take more time than is currently allocated.
46	21	By the second year of the demonstration, MSSP and managed care plans' care management will be fully integrated. By the third year of the Demonstration, MSSP will cease to exist as a separate, independent program from the plans' care management operation.	We disagree with this approach. The MSSP program is a model for the type of care coordination and integrated service delivery that the demonstration is deigned to advance. MSSP has a tremendous track record of providing needed case management to keep nursing facility eligibles persons in the community. The MSSP program should be preserved and built upon, not dismantled and replaced by medically oriented managed care plans. Plans should be required to contract with MSSP or provide services to high need individuals.
	21	CBAS is a benefit offered by managed care plans.	CBS will be a managed care plan benefit, but is not yet. Stating otherwise implies that plans have more experience providing LTSS than they do.
47	21	Plans models of care will include eligibility, protocols and guidelines on utilizing CBAS.	Plans will be required to follow the processes for assessing need for CBAS found in the Darling v. Douglass settlement agreement.
48	22	Stakeholder process	The Department has done a good job sharing drafts and final versions of documents with stakeholders. The Department should continue to maintain the dedicated website and should continue to post relevant documents there. Going forward, MOU and plan contract negotiations must be conducted in a transparent manner.

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49	24	Beneficiary protections	We appreciate the Department's continued emphasis on consumer protections in this and other documents. We believe, however, that additional, stronger consumer protections are necessary, starting with the right to voluntarily enroll and disenroll from the demonstrations at any time.
50	25	Self Direction	We appreciate the attempt to preserve these important protections, but more information is needed on how the Department plans to make these rules enforceable.
	25	Notification about Enrollment Process	We admire the state's intent to develop a through outreach, education and notice campaign, but there is not enough time to plan and implement a successful strategy before January 1, 2013. Any process which is just now being planned will not be ready by then. At this point, the process will have far less time than the recent SPD process or the 2006 Part D process - both of which had significant problems. Unfortunately, this transition is even more significant and complicated than either of those.
51	25	Contingent upon available private or public dollars other than moneys from the General Fund, contract with community based…	This demonstration should not go forward unless and until a stable, ongoing source of funding is identified and dedicated to providing independent choice counseling for dual eligible beneficiaries, who will be required to make some very complex decisions concerning whether to participate in the demonstration. The state must also provide funding for a dedicated, independent ombudsman who will be able to track and report problems while helping to develop solutions. The Ombudsman program function should be part of an existing advocacy organization with experience serving dual eligibles.
52	25	At least 90 days prior to enrollment…	The notices also need to include information about plan benefits, networks and other features if beneficiaries are going to be able to compare plans and make an informed enrollment decision.
53	26	Health Risk Assessment	The assessment process is only a protection if there are clear standards for conducting the assessment that counteract the incentive plans will have to under-assess the needs of enrollees. A uniform assessment tool and process must be in place before the demonstration begins. Quality assurance measures must be in place to ensure that plans are conducting assessments properly. Individuals must have access to their assessment and be able to appeal them.

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54	26	Network adequacy and care continuity	The Medi-Cal access standards for LTSS need to be set soon to ensure that plans can meet those standards by January. The proposal should make clear that plans will be required to meet Medicare network access standards for medical services and prescription drugs.
55	26-27	Care continuity	These care continuity provisions are not strong enough. We are seeing in the SPD and CBAS transitions that many providers are not willing to accept payment from the plan. This makes the care continuity provisions found here meaningless. The best approach to care continuity is a voluntary enrollment process. If enrollment is mandated or locked in any way, a Medical Exemption Process must also exist.
56	27	Appeals	This process must be developed before the demonstration goes live. Aid paid pending must be available for all services covered under the demonstration. Individuals must retain the right to go straight to a straight fair hearing - they should not be required to endure multiple internal appeals before getting to an independent decision-maker.
57	27-28	Financing and payment	We have serious concerns with an approach that seeks to guarantee savings in year one of the demonstration. The literature suggests that it will take time for these models to produce savings. Emphasizing the need for immediate savings will put pressure on plans to hold costs down. A short term approach to savings will lead to long term damage to beneficiaries and the system.
58	28	Financing and payment	The proposal does not address what incentives will exist when the cost of keeping someone in the community is higher than it would cost to treat them in an institutional setting.
59	28	Financing and payment	This section should include safeguards to ensure that the portion of LTSS spending does not decrease under the demonstrations. Examples are included in our letter comments.
60		Potential improvement targets	There should be explicit targets related to increased numbers of people receiving IHSS, CBAS, MSSP and waiver services. In addition total IHSS hours and average IHSS per person should increase.

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61	31	The State will use a combination of existing resources and additional infrastructure to implement this demonstration.	The state has severe capacity issues that is adversely impacting the ability to effectively design and, we are afraid, oversee this demonstration. We are uncomfortable having this demonstration move forward until the state is able to address the key design issues sufficiently in advance of implementation so all stakeholders know what is being proposed, and what role the various state agencies, the EQRO, consumers and others will have in overseeing and evaluating the demonstration. The severe, ongoing budget crisis in this state is driving premature implementation of this proposal for the wrong reasons and is hindering the development of capacity required to make this demonstration successful. It is clear from this document that the state is resource constrained and is unwilling or unable to invest necessary resources, the most blatant example being the express unwillingness to invest in choice counseling for beneficiaries.
62	31	CDA may expand HICAP counselors for the 2012 Open Enrollment period for the Demonstration counties.	This is an unrealistic suggestion at this point in time. Open enrollment starts in October. The open issues will not be resolved in time to train HICAP counselors for the 2012 open enrollment period, and at this late date HICAP is not going to be able to recruit and train sufficient counselors in the four selected counties. Counselors will need to be adept at explaining not just Medicare options, but Medi-Cal as well. This may be a realistic suggestion for the 2013 open enrollment period, but not for this year.
63	32	Waivers	The proposal should be much more specific about what type of authority is necessary to implement this demonstration and when it will be sought.
64	32	Six month stable enrollment period	We oppose the proposed enrollment process.
65	33	Expansion	We oppose the expansion. The state will not be ready to responsibly implement the demonstration in the four counties currently authorized in 2013. It should not be expanded until the four county demonstrations are successfully implemented and robustly evaluated. It is imperative that the state take a cautious approach to putting vulnerable older adults and persons with disabilities into risk-based managed care plans. The proposed capitated financing arrangement for medical services and LTSS will change incentives, undoubtedly in ways that cannot all be anticipated, particularly with most managed care plans having no experience in administering LTSS. These demonstrations need to be subjected to careful evaluation prior to an expansion as proposed in this document.