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1	2, 10 & all other places this appears in the draft plan	Paragraph that begins with "In 2013, California intends to implement the demonstration in ten counties."	We oppose implementation in ten counties and believe implementation should be delayed for the three counties (with the exception of San Mateo County) to ensure the State, counties, and health plans are prepared to implement, and protections in place so that beneficiaries experience no break in their health care services. The four counties alone represent nearly 70% of the statewide Duals population. We question the capacity of the health plans, counties, and State to meet the January 2013 date due to the number of outstanding implementation issues currently unresolved, and given that these issues (including rate setting) will not be settled until the late summer and fall.
2	2 & 10	Page 2: "California will use a passive enrollment process through which dual eligible beneficiaries may choose to opt out of the demonstration. Those who do not opt out will be enrolled in the demonstration for an initial six-month stable enrollment period. Enrollment in the demonstration counties will be implemented on a phased-in basis throughout 2013. Page 10: "The Governor's Coordinated Care Initiative, which is pending in the state Legislature, proposes mandatory enrollment in managed care for Medi-Cal benefits."	CMS has indicated that states may request a later date to begin enrollment and at least four other states have decided to delay enrollment for their dual integration demonstration projects until January 1, 2014. We strongly encourage the state to extend the timeline for planning and initiate enrollment in 2014 for three of the four pilot counties (San Mateo being the exception). We are also opposed to passive enrollment and six-month lock-in. As has been seen with the mandatory enrollment of the SPD population, transitions for high need individuals who have well established networks serving their needs can be very disruptive. An opt-in approach would make it less likely that those individuals would be negatively affected and would make it more likely that individuals who join a pilot are those without satisfactory networks who would most benefit from an organized system of care. We also oppose the 6-month lock-in.
3	2 & 17	Page 2: "County social workers will continue determining IHSS hours and the fair hearing process will remain." Page 17: "A grievance and appeals process and other protections for IHSS consumers will remain in place."	These two sections contradict each other. One page 2, the proposal states the current fair hearing process will for IHSS will remain in place, which is not affirmed in the language on page 17. We believe that the current fair hearing process should remain in place whereby consumers can appeal the number of IHSS hours atuhorized following the assessment conducted by a county social worker. We understand the state's proposal to prohibit health plans from providing fewer IHSS hours than the amount authorized by the county, and support the authority of the health plan to authorize additional IHSS hours. But it doesn't make any sense to set up a different appeals process in those instances when a consumer disputes the number of IHSS hours authorized by a county.
4	2	"the demonstration will build on lessons learned during the 1115 waiver transition of Medi-Cal only seniors and persons with disabilities into managed care…"	We do not agree that sufficient lessons have been learned from the transition of SPDs into managed care and think additional time is needed for planning for implementation of the dual demonstration pilots. At the 1115 Stakeholder Advisory Committee meeting on April 23, 2012, DHCS reported that there is currently a backlog of 1500 medical exemption requests. When asked about the timeframe for responding to these requests, DHCS could not give an answer on a response time. In fact, DHCS indicated that when they implemented the mandatory enrollment of SPDs, they never envisioned that there would be such a large number (12,800 to date) of medical exemption requests. This is just one of many examples of problems with implementation related to the SPDs mandatory enrollment.
5	3	"…will require proof of ongoing stakeholder involvement at the local level that includes, at a minimum: a process for gathering ongoing feedback from external stakeholders on program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections."	Our concern about "proof" of a local stakeholder process is based on the overly ambitious timeline proposed by the state. The local stakeholder process must build in sufficient time for comunity input in compliance with the Brown (Open Meeting) Act. Contracts or MOUs must be established between the health plans with the county social services department, mental health department, and IHSS Public Authority. Public hearings should be scheduled before the county Board of Supervisors to solicit input on those contracts to ensure adequate protections are in place for beneficairies, providers and the county itself. Final action on contracts should follow at a subsequent public hearing after consideration of input from stakeholders. It often takes 4-8 weeks for counties to post documents and agendas to comply with Brown Act requirements.
6	4	"Phased-in enrollment process starting January 1, 2013 in up to ten counties."	We respectfully urge the state to request CMS to approve enrollment to commence January 1, 2014 for three of the four pilot counties (San Mateo being the exception to proceed sooner).
7	5 & 9	Page 5: "The selected plans demonstrate a proven track record of business integrity and high quality service delivery." Page 17: "A grievance and appeals process and other protections for IHSS consumers will remain in place." Page 9: "California's demonstration accomplishes this by pairing experienced managed care plans with..."	A study recently released by the National Senior Citizens Law Center (May 2012) titled: "Assessing the Quality of California Dual Eligible Demonstration health Plans" demonstrates significant weaknesses among the selected demonstration plans and puts into serious doubt the health plans' ability to meet the complex needs of the dual eligible population. Every plan with the exception of San Mateo COHS received a plan rating of one out of five stars, based on DHCS's own assessment data.
8	6	"In addition, the demonstration includes strong beneficiary protections that are proposed to be codified in state law."	The proposed trailer bill language released on March 26, 2012 does not contain sufficient beneficiary protections. For example, the state's language indicates there will be "a fair hearing process", but doesn't specify what that process will be.
9	7	Population Descriptions & carve-outs	It is unclear what it means for any IHSS consumer to be carved out of the demonstration project because the proposal requires all IHSS consumers (not just the duals) to enroll in managed care. If an IHSS consumer opts out, are they losing their entitlement to receive home care services? Or will there be separate (non-managed care) services available? Also, the draft proposal is different from the draft trailer bil on the carve-out for children. The proposal says all beneficiaries under age 18 are carved out; the draft trailer bill only carves out foster children. Which is correct?
10	10 & 32	Six-Month Stable Enrollment Period. "Enrollment in the demonstration is optional." ... "The State will use a unified, passive enrollment process through which dual eligible beneficiaries who do not make an affirmative choice to opt out will be automatically enrolled into a demonstration health plan." ..."once enrolled…beneficiaries will have another opportunity to opt-out after a six-month stable enrollment period.."	It is unclear how enrollment is made "optional" when the State is also proposing to move all LTSS services into managed care. An IHSS consumer, for example, would have no choice but to enroll into a demonstration in order to access his/her IHSS benefits under Medi-Cal. We have raised concerns previously with this proposal for passive enrollment with a six-month lock-in. A demonstration should ensure maximum choice to consumers from the start and throughout the life of the demonstration p project. Given the size and scale of the proposed project, we continue to have concerns with health plans' capacity, and the State's capacity, to manage these changes seamlessly for the consumer.

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11	11	"Each health plan will be subject to a joint state-federal readiness review before any beneficiaries are enrolled."	Health plans are required to establish contracts with counties and Public Authorities. It is common for a readiness test to include verification that contracts are in place to ensure health plans can meet the terms and conditions of their contract with the state and/or federal government. The proposal indicates that readiness reviews will be conducted in June-July 2012. Compliance with the Brown Act will make it extremely difficult for counties and Public Authorities to finalize contracts with the health plans in that time frame (with the possible exception of San Mateo).
12	13	"Care Coordination standards…will be developed in collaboration with public stakeholders."	While we appreciate a stakeholder-driven process to identify standards, we are concerned that there is not sufficient time to develop these standards, communicate these standards to the health plans, operationalize the standards through contracts between health plans and providers (including County IHSS), and training of staff. This re-enforces our belief that the pilots will not be ready to proceed on January 1, 2013.
13	13	Comprehensive Assessment	Given that the health plans will be relying on County IHSS, County behavioral health, and possibly other entities to identify the total needs of the beneficiaries served, we suggest this section should reflect that process. Specifically, the "Demonstration plans will be responsible for an in-depth risk assessment process, through a coordinated response with other duals-serving agencies, capable of..."
14	13	"Care management will require close collaboration with a number of agencies, such as county social service agencies for IHSS, county mental health agencies, local Area Agencies on Aging and community-based organizations, to adequately address the complex and various needs of individual beneficiaries."	Public Authorities should be included in the list of agencies that may be involved with care management to assist consumers with finding a replacement IHSS worker or emergency back-up services.
15	14	"Person-centered medical homes and interdisciplinary care teams (ICT). Demonstration plans will offer person-centered medical homes with multidisciplinary care teams. These teams may include the designated primary physician, nurse case manager, social worker, patient navigator, county IHSS social worker (for IHSS consumers), pharmacist, and other professional staff within the provider network."	There will also be times when it is appropriate for Public Authority staff to participate in the Care Coordination team when consumers need immediate assistance to find a replacement IHSS worker.
16	14, 26	"Building on lessons from the transition of seniors….necessary process and procedures…to support timely health risk assessments…promising practices, such as…phone, mail, interactive voice by pone, web-based planning.." (pg 14) and "Health Risk Assessment" section (pg 26)	The draft plan implies a one-sided approach, working in a siloed fashion, to collect minimum information necessary to serve the beneficiary, which will result in poor outcomes for beneficiaries. We support true care coordination, which will be appropriate for high risk, high need populations, for a subset of all dual beneficiaries. The examples listed in this section are not considered promising nor are they effective ways to work with the beneficiary to identify needs and link to appropriate services. Strategies that are effective include use of case coordinators and team-based meetings that include the beneficiary and service providers (including County IHSS, and IHSS providers if the beneficiary chooses).
17	15-16	Behavioral Health Section	California's local recovery and rehabilitation-focused mental health system plays an integral and essential role in California's public healthcare delivery system. While the proposal speaks to integration between various system partners, it should be recognized that California's current county mental health system in many ways already functions as an integrated system for persons with serious mental illness, with county Medi-Cal specialty mental health plans managing outpatient, inpatient and long-term care needs. It is imperative that the state and managed care organizations recognize the complexity of California's current mental health delivery system and do not underestimate the valuable role that counties play in managing risk and financing critical services for Medi-Cal beneficiaries – particularly the counties' role in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries. According to the draft proposal, specialty mental health services, which again are county-administered, will not initially be included in the capitation rate for demonstration health plans. However, according to the draft proposal, "health plans and county mental health agencies will develop coordination and integration strategies, which could include full financial integration in later years." CMHDA believes this statement underestimates the scope and complexity of expanded mental health coverage available to Medi-Cal beneficiaries through our local risk management and financing system. Of particular note is the counties' role today in managing full risk for inpatient and long-term psychiatric care for California's Medi-Cal beneficiaries. Additionally, coverage through the county mental health system includes comprehensive rehabilitation and targeted case management services that have proven extremely effective in reducing costly emergency and inpatient services. Counties currently play an important role in coordinating this coverage with Medicare for both inpatient and outpatient services. Furthermore, county mental health authorities utilize local revenues to match federal dollars. It is imperative that the state and the health plans recognize the complexity of California's current mental health delivery system and do not underestimate the valuable role that counties play in managing risk and financing critical services to Medi-Cal beneficiaries. CMHDA strongly supports the emphasis on person-centered planning, as described in the draft proposal. Person-centered planning is consistent with the mental health recovery and resiliency principles outlined in California's Medi-Cal rehabilitation mental heath services state plan amendment. Effective partnership and collaboration with county mental health will make available to demonstration enrollees a wide variety of comprehensive, high quality, rehabilitative and targeted case management services. Increasing access to effective outpatient and crisis stabilization services provides an important opportunity to reduce costs associated with expensive inpatient and emergency room care and to better meet the needs of individuals with mental illness in the least restrictive manner possible. CMHDA welcomes the opportunity to work with the Department staff and consulting partners over the next few weeks to further develop and refine a strategic framework for coordination and alignment,

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18	17	"Under this demonstration, managed care plans will assume responsibility for the provision and payment of all LTSS, in addition to their current provision of medical services. LTSS includes IHSS, MSSP, CBAS, nursing facility care and other home- and community-based waiver services.	The proposed trailer bill does not make statutory changes to the requirement that local county welfare departments administer the IHSS program with oversight by DSS. The State has not articulated specifically, however, how managed care plans will "assume responsibility" and how the current statutory framework supports this particular statement. We believe this draft plan needs to distinguish between IHSS services (as per current law) and any additional IHSS services purchased by the health plans for which managed care health plans may assume direct responsibility (to authorize additional hours beyond the County's assessment). There also needs to be a distinction between the financial responsibility for IHSS (which will be shared by the counties and health plans through the proposed MOE in the trailer bill) and the programmatic responsibility (which will continue to rest with counties under State oversight).
19	17	"Care coordination teams for IHSS consumers will be established as needed, and will include the consumer, health plan, and county social services agency, and may include others."	We support this statement but believe this statement should be augmented to say that care coordination team will be established "as determined by the health plans and based on the unique care needs of the individual. In addition, county social service agencies will participate on teams, based on local agreements that will be negotiated between the counties and health plans."
20	17	"A grievance and appeals process and other protections for IHSS consumers will remain in place."	The draft plan and proposed trailer bill does not clearly define the specific grievance and appeals process that will be available to the IHSS consumer. Specifically, it's unclear if IHSS consumers will continue to use the State's Fair Hearing process or the managed care arbitration process. Because IHSS is to become a managed care benefit, and the health plan would be able to add hours to the county's IHSS assessment, it's unclear if those additional hours would be treated in the same way (and thus potentially a grievance issue) or differently than the county's authorization. Would the IHSS consumer have a right to grievance if, at the annual recertification, the health plan does not "renew" any previously-authorized hours in excess of the County's assessment?
21	17	"IHSS assessments will be conducted in conjunction with health plan care coordination teams, as needed."	The proposed trailer bill (and this draft Plan) indicate that County Welfare Departments will continue to have sole responsibility to perform assessments and authorize IHSS services. However, this statement indicates that these assessments will be performed with health care coordination teams. We recommend clarifying that the assessments will be performed by the county and "information shared between the county and the health plan as negotiated per local agreements, in order to maximize home- and community-based services to the IHSS Consumer."
22	17	"Health plans may authorize additional home-and community-based services, including IHSS hours above the statutory limits, using the funding provided under the capitation payment."	First, this draft plan should say that these additional services will not be paid using County funds, since these funds could be considered as part of the capitated amount per consumer and covered entirely by the health plan. Second, it's unclear if the additional personal care service hours would be in addition to any authorized IHSS tasks/activities, or if the health plan could purchase services outside of the statutorily-mandated tasks? For example, can the health plan purchase reading services to the blind, which is not currently an IHSS-allowable task? What is the tracking mechanism for enhanced IHSS that is approved by the health plan? CMIPS?
23	17	The demonstration and the Coordinated Care Initiative would allow health plans to enter into performance-based contracts with counties, and contract with counties for additional assessments of IHSS hours.	First, it's unclear if and how the "demonstration" is different from "the Coordinated Care Initiative," aren't' these one in the same? Second, we believe some form of agreement (whether it is an MOU or a contract) between the Health Plan and the county will be necessary (either contract or MOU). Counties currently are not funded adequate to perform additional activities beyond those currently in statute, and specifically, are not able to participate in Care Coordination Teams nor share information with the health plan to facilitate care coordination, without some agreement between the county and the health plan. Thus, the language should be changed to note that health plans will need to enter into agreements with counties for care coordination activities and any other enhanced services beyond what IHSS currently provides.
24	17	"IHSS program structure under the demonstration. Under the demonstration and the Governor's Coordinated Care Initiative, health plans will develop and expand care coordination practices with counties, nursing facilities, and other home-and community-based services, and share best practices. IHSS program structure under the demonstration. Under the demonstration and the Governor's Coordinated Care Initiative, health plans will develop and expand care coordination practices with counties, nursing facilities, and other home-and community-based services, and share best practices. Care coordination teams for IHSS consumers will be established as needed, and will include the consumer, health plan, and county social services agency, and may include others. County social services agencies will continue to perform their current IHSS functions, including assessment, authorization, and final determinations of IHSS hours in accordance with statutory provisions for IHSS eligibility, on behalf of the Med-Cal managed care health plans."	This section should also outline key services provided by Public Authorities. Suggested language, "Public Authorities will continue to peform their IHSS functions, such as operation of provider registries, urgent back-up attendant services, training of IHSS consumers and providers, provider enrollment (when so delegated by the county), and assistance to consumers with their employer-related responsibilities.
25	18	In 2015, California may also implement the Managed Fee-for-Service (FFS) model..."	Counties support exploration of this approach, particularly for smaller and more rural counties where managed care may not be practical and there is a lack of access to services.

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26	21	By the third year of the Demonstration, MSSP will cease to exist as a separate, independent program from the plans' care management operation."	We have concerns that the this successful model program will be completely folded into the managed care structure, thereby eliminating what has been a successful, community-based program that is highly cost-effective in transitioning persons out of nursing home settings. These beneficiaries typically also receive IHSS services; however, they cannot remain at home independently with IHSS support alone, and rely on the case management and ancillary supports that come with MSSP. We believe this program should be preserved, and that the MSSP model should be one that all health plans are required to adapt as a standard practice for persons who wish to transition from nursing home placement, and for those in the demonstration who would otherwise quality for the MSSP program.
27	23	Local stakeholder process	It is important to note that many of the health plans indicated in their applications that the state did not provide sufficient time to collaborate with local agencies, providers and stakeholders.
28	24	Ongoing Stakeholder Feedback section	These stakeholder workgroups have only recently begun to meet and each has an extraordinary number of issues to address. If the workgroups complete their activities on schedule, the policies will still need to be translated into operational guidelines, conveyed to heath plans, embodied in local contracts, and linked to staff training. Again, this assumes the policy issues are satisfactorily resolved on a timely basis. This further reinforces our belief that a delayed implementation is appropriate.
29	27	Appeals and Grievance section	For IHSS consumers, we believe it is appropriate to continue to allow IHSS Consumers the use of the State Fair Hearing (ALJ) process for IHSS appeals.
30	27	Financing and Payment section	There is no reference to the County contribution in the IHSS program, although this is addressed in the proposed trailer bill. It is unrealistic for some counties to establish contracts with health plans or agree to yet-to-be-defined financial commitments until the financing issues are determined.
31	34	"Note also that the (CCI) provides that if (DOF) determines, annually on September 1, that the initiative has caused utilization changes that result in higher State costs than would have occurred absent the Initiative…then the State will discontinue the provisions of the Initiative."	The State needs to articulate the process to discontinue the Initiative and beneficiary protections to ensure no breakage of services.
32	34	Capitation Rate Development	How can contracts be finalized or health plans agree to meet the demonstration standards when they will not know capitated rates until September 2012? Also, it seems unrealistic to require enrollment materials to be mailed on October 1, 2012 -- only weeks after the capitated rates are finalized.
32	35	"Comprehensive Care Coordination in Partnership with County Agencies: In California, community behavioral health services and IHSS are administered by county agencies and are funded in whole or in part by counties."	Suggested change, In California, community behavioral health services and IHSS are administered by county agencies and Public Authorities, and are funded in whole or in part by counties.
33	35 & 42	Ambitious timelines & proposed workplan/timeline	See comment # 2.
34	45	Under IHSS -	The proposal is flawed by only referencing the collective bargaining role for Public Authorities. Public authorities provide the following services for IHSS consumers and providers: a) Establish and maintain a registry of available IHSS Independent Providers (IPs) in the County; • Match IHSS Consumers who request assistance from the Public Authority Registry to obtain properly trained providers who have cleared a background check; • Investigate the qualifications and background of registry applicants, including criminal background checks. • Provide lists of screened IPs for IHSS Consumers to interview; • Provide post-match support services; b) Operate Emergency Back-up or On Call programs that employ IPs who are willing to be called on short notice and dispatched to assist consumers who need a replacement worker; c) Provide orientation and training for IPs. • How to complete timesheets • Skill training such as properly lifting an individual in and out of bed or the bath, properly turning a bed ridden individual, safely administering medications, changing bandages, and other important care related tasks. d) Most counties have contracted with the Public Authority to administer Provider Enrollment activities, including screening criminal records, conducting provider orientation and processing mandated provider enrollment forms. e) Act as employee of record of IPs for collective bargaining purposes f) Assist IHSS Consumers in hiring and supervising IPs; g) Administer individual health benefits for IPs