NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

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Sacramento, CA

Delivered via e-mail to: info@CalDuals.org

Dear Ms. Carrol, Ms. Tatar, Ms. Connolly and Mr. Shen,

The National Senior Citizens Law Center submits these comments on California's August 6, 2012 draft, "Duals Demonstration – Draft LTSS/IHSS State Readiness Review Standards," shared with stakeholders as part of the final meeting of the combined LTSS.

We appreciate the administration's willingness to engage in a dialog about this important part of the proposed duals demonstration project. As the Department is well aware, LTSS are not within the expertise of most managed health care plans, and thus significant development of expertise and capacity will be needed in order for plans to appropriately provide these needed benefits.

We understand based on information shared at the August 8 workgroup meeting that the proposed readiness standards represent a "high level" document that does not flesh out the substantive standards that will be used to check for plan readiness. We are disappointed that the Department has not shared a draft checklist during the course of the stakeholder workgroup process. We hope that the public engagement process will continue so that stakeholders have an opportunity to contribute to more substantive plan readiness tools.

Our comments below address the major topics included in the draft readiness review standards. That document excluded several important types of long-term support services, including home health and hospice services. Any checklist for plan readiness should include the entire range of LTSS. In addition, the checklist must cover in detail the provision of enhanced case management to members of the *Darling* plaintiff class who are not eligible for CBAS.

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Futhermore, NSCLC also endorses Disability Rights California's proposal for general readiness standards that would include requirements such as a local stakeholder process, minimum quality measures, accessible facilities, accessible communications, and a commitment to ensure consideration of the health care choices made by dual eligibles.

IHSS

Organization and Administration of Plan

Preserve Services for Independent Living. One of the greatest risks in giving plans responsibility for IHSS, even if county agencies continue to perform major administrative functions, is that while plans may be properly incentivized to reduce expensive hospitalizations and nursing home stays, they will also be incentivized to pressure their subcontractors to reduce home-care hours that support independent living (rather than simply keeping people out of emergency rooms or nursing homes). To address this risk, the draft and the corresponding MOUs should be amended to explicitly state that new recipients should not experience reductions in needed services compared to current recipients. These documents should also explain that all recipients should continue to receive IHSS in a manner that fulfills the California *Olmstead* plan's intended purposes of community integration and self-determination.

Quality Improvement System

Consumer Assessment of Quality. Consistent with the IHSS purpose of fulfilling the state's *Olmstead* obligations, plans should be required to incorporate consumer satisfaction and fulfillment of independent living goals as part of the quality improvement system.

Provider Relations

Specify that the IHSS provider is included in the care coordination team "if requested by the member."

Access and Availability

Other Home-Care Benefits. This section (and paragraph 5 of the "Organization and Administration of Plan" section) should address the assessment and access standards that plans will use to determine access to in-home care beyond that currently provided by the IHSS program (e.g., home-care waiver services or additional services that a plan chooses to provide in response to consumer needs that are currently unmet by IHSS). These should include specific explanations of the scope of these additional benefits, substantive appeal rights, and notices to consumers.

Assessor/Reviewer Qualifications. These and other access standards should specify that assessors and reviewers have appropriate expertise in independent living services to assess IHSS needs (e.g., a social worker instead of or in addition to a nurse).

Case Management and Coordination of Care

Person-centered Planning. These detailed plans should include evidence that the care plan is person-centered; specify procedures for monitoring provider provision of services; and establish a detailed back-up plan in case of provider unavailability.

Member Grievance System

No Wrong Door. We strongly support the ability of plans to offer additional IHSS services beyond those currently allowed by the Welfare & Institutions Code (e.g., accompaniment to doctors' visits). We are concerned, however, that establishment of a separate internal grievance system for those services, while preserving the existing appeals systems for most of IHSS, will result in confusion for consumers. Plans should be required to take a "no wrong door" response to grievances and complaints that guarantees that a request for an appeal is heard in the proper forum regardless of whether the consumer initiates the process through the state fair hearing system or through the plan grievance process.

Community Based Adult Services

Quality Assurance and Improvement

Assessor/Reviewer Qualifications. This section should specify that plans' assessment of CBAS quality should include a team with expertise in all of the CBAS services, e.g. medical social workers; occupational, physical and speech therapists; nutritionists, etc.

Darling *Agreement Compliance*. This section should also ensure that plans engage in the activities needed for the state to meet its obligations under Section XVI of the *Darling* settlement.

Care Management

Darling *Agreement Compliance*. This section should also ensure that plans engage in the activities needed for the state to meet its obligations under Section XI of the *Darling* settlement.

Provider Network Adequacy

Darling *Agreement Compliance*. Consistent with the state's obligations under the *Darling* settlement, the readiness standards should require that plans show that the

availability of CBAS services in the plan's service area is no less than what existed at the time of execution of the *Darling* settlement.

Linguistically and Culturally Competent Provider Access. Likewise, while we appreciate the statement in the draft that plans must remediate cultural or linguistic barriers to access to CBAS, this falls short of providing culturally and linguistically competent services to all who need them. At minimum, plans must show that they are at least as able to provide linguistically and culturally competent CBAS services as existed at the time of the *Darling* settlement. A better alternative would be readiness standards that mandate the expansion and proactive notification to all potential consumers of the availability of linguistically and culturally competent CBAS providers.

Plans should also show that they are able to provide access to LGBT individuals.

Availability of Unbundled Services. For those receiving unbundled CBAS services, plans should be required to show not just policies and procedures for arranging those unbundled services, but also actual availability of the range of providers of those services (OT, PT, etc).

Member Grievance System

Need for Clarity on Grievances and Appeals. This draft appears to conflate the concept of a process for filing grievances against a plan with federally required appeal rights. These concepts and related requirements should be separately set forth. Requirements for appeal rights must include notice of adverse actions, member rights to aid paid pending appeals, fair hearings, and all other due process requirements.

No Wrong Door. As we discussed in the IHSS section above, plans should be required to implement a "no wrong door" approach to grievance and appeals systems, so that consumers are able to get their concerns heard in the proper forum regardless of where the issue is originally presented.

Assessor/Reviewer Expertise. As discussed in the IHSS section above, plans must have staff with the adequate range of expertise to evaluate need for CBAS.

Darling *Agreement Compliance*. Plan readiness standards must incorporate the applicable notice requirements set forth in Section XV of the *Darling* settlement for class members.

Multipurpose Senior Services Program

Organization and Administration

Training and Orientation. While we strongly support a requirement that plans provide program-specific training and orientation to those acting as care managers, we are confused about why this requirements is only in the MSSP section. Program-specific training should cover all options for LTSS.

Member Grievance System

Need for Clarity on Grievances and Appeals. As with CBAS, this draft appears to conflate the concept of a process for filing grievances against a plan with federally required appeal rights. These concepts and related requirements should be separately set forth. Requirements for appeal rights must include notice of adverse actions, member rights to aid paid pending appeals, fair hearings and all other due process requirements.

No Wrong Door. As discussed above, plans should be required to implement a "no wrong door" approach to grievance and appeals systems, so that consumers are able to get their concerns heard in the proper forum regardless of where the issue is originally presented.

Assessor/Reviewer Expertise. As discussed in the IHSS section above, plans must have staff with the adequate range of expertise to evaluate need for MSSP.

Nursing Facilities and Sub-Acute Facilities

Contracting and Provider Network

Licensing. Terminology should be consistent with California licensing categories. California licenses "skilled nursing facilities."[1] There is no licensing category, however, for a subacute facility – rather, a "subacute care unit" is a unit within a skilled nursing facility that meets certain standards set by the Medi-Cal program.[2]

Ambiguity in Current Language. The current draft states that plans should contract with facilities in the covered zip code "to the extent possible." There needs to be more clarity here – the phrase "to the extent possible" seems to give plans some leeway, but it is not clear how much leeway has been granted, and under what conditions. Also, subparagraph (3) requires that a plan incorporate "information of access … for nursing facility services." It is not clear what this means.

[1] 22 Cal. Code Regs. § 72103.
[2] 22 Cal. Code Regs. § 51215.5.

Appropriate Status. The term "good standing" is not specific enough. Participating skilled nursing facilities should be clearly required to hold a current license and be certified to participate in both the Medi-Cal and Medicare programs.

Minimum Quality Standards. CMS's Nursing Home Compare web site rates facilities on a 5-star rating system on health inspections, staffing, and quality ratings (based on outcome data). This leads to an overall rating from one to 5 stars. Skilled nursing facilities with an overall one-star rating or with a one-star rating in any one of the three specific domains should not be eligible to participate in the demonstration.

Capacity. The current draft does not require any specific capacity – a plan could comply with the existing draft standards simply by contracting with two skilled nursing facilities, even though such a small number of facilities would be clearly inadequate to meet members' needs. The next draft should include much greater specificity to assure that a plan has sufficient capacity related to skilled nursing facility care.

Terminology to Describe Ineligible Facilities. The draft refers to termination from Medi-Cal or Medicare participation, and also to the "Suspended and Ineligible Provider list." It is unclear that this latter terminology is correct. Federal law refers to termination, and also to denial of payment generally, and denial of payment for new admissions.[3] In addition, health care providers (including but limited to skilled nursing facilities) can be "excluded" from participation in Medi-Cal and/or Medicare.[4]

Provider Relations

More Specificity Required. The draft requires that plans train participating facilities on (among other things) the "conflict resolution process." More details are needed, to clarify what conflicts are involved and what the process might be. Also, the following subparagraph refers to "member-facilities relation issues" — again, this phrase is not specific enough.

Quality Improvement

This section generally is much too vague — rather than merely requiring policies and procedures, the readiness standards should include some content on what those policies and procedures should include. At a minimum, there must be much greater transparency, so that all information is available to the public in an accessible format. Also, subparagraph (7) refers to quality assurance and improvement in care transitions "at least annually." Instead, such processes should be conducted continuously.

[3] 42 C.F.R. § 488.406(a).
[4] 42 U.S.C. § 1320a-7.

Utilization Management

This section also is much too vague —the standards should include more specificity on what policies and procedures must include. For example, the policies and procedures on authorization should utilize eligibility criteria that are no more restrictive than current Medicaid criteria. Also, transition to community settings would be more frequently successful if plans were required to employ persons specifically for planning and implementing such transitions.

Member Services and Communications.

Member Services Staffing and Training

Staff Levels. There will be a need to define "sufficient" staff. Numbers of staff proficient in non-English languages should be an element in determination of sufficiency.

Training. The training discussed in Item 5 should be required of all MCO staff, not just member services. Specific training about the needs and concerns of LGBT members should also be included. Further, training should specifically include training in protocols for working with an interpreter.

Member Materials and Website

Alternate formats. MCOs should be required to announce the availability of alternate formats on all communications. Standards should be set for timeliness of providing alternate formats.

Plain language. All standard plan documents should be produced at no higher than sixth grade reading level. All should be submitted for review in advance of first enrollment.

Languages other than English. The member materials section does not make any reference to the availability of translated materials. Standards must be set for when translations are required and for which documents. Standards should require that all mailings include an insert in multiple languages announcing the availability of translations and the availability of interpreter services without charge. The MCO should be required to demonstrate that it has adequate systems in place to capture language preference both upon enrollment and, if not identified at enrollment, in other contacts with the member. The MCO should also be required to demonstrate that language preference is attached to an individual's record in a way that ensures that translated materials, if available, are routinely mailed to the individual, that when the individual calls the MCO, his language preference will be recognized, and that language needs will be routinely flagged for providers.

Website. Standards should require that links to transition policies and appeals procedures be prominently displayed on the main MCO web page. All MCO websites should be available in Spanish. All translated documents that the plan has created should be available on the website. Websites should be required to prominently display, both in English and in all threshold languages, the availability of interpreter services. Websites should comply with S. 508 of the Rehabilitation Act, including web-fillable and submittable forms.

Provider Transition at Enrollment

MCOs should be required to demonstrate dedicated phone lines and dedicated, trained personnel to address provider transition issues. MCOs should be required to have pre-approved fact sheets for non-network providers that explain a straightforward process for billing the plan. Standards should be set for MCO timeliness in paying non-network providers and MCOs must demonstrate that they can meet those standards. MCOs must demonstrate that systems are in place so that, during the transition, non-network providers will receive at least the rate they were paid prior to the member joining the MCO.

The draft standard says that the transition from a no- network provider to a network provider should be accomplished within 60 days, to the extent possible. While we agree that MCOs should be expected to have procedures in place to effectuate a timely transition, the standards should not override the beneficiary's right to a transition of up to 12 months, as set forth in the DHCS proposal.

Member Advocacy

We appreciate that there should be particular attention to MCO readiness to support beneficiaries with chronic conditions and disabilities. Readiness should also be assessed for ability to support all members who need assistance with navigating the complaint and grievance process.

In addition to a designated staff person for overseeing ADA compliance, the MCO should be required to designate an individual to oversee language access compliance under Title VI of the Civil Rights Act of 1964. As a recipient of federal funds, the MCO also should have a written language access plan in place.

We note more generally the lack of discussion of MCO readiness to handle appeals of denial or reduction of services. We assume that because this important area is broader than LTSS, it will be addressed elsewhere (see also our comments on specific appeals issues with CBAS and IHSS).

Please do not hesitate to contact us with any additional questions. We look forward to working with DHCS on the development of future substantive readiness standards.

Sincerely,

Anna Rich, Georgia Burke & Eric Carlson
National Senior Citizens Law Center