Organizations that Submitted Comments on the Coordinated Care Initiative Transition Plan

1. Access to Independence
2. Anthem Blue Cross - CareMore
3. California Academy of Family Physicians.pdf
4. California Association of Health Facilities
5. California Association of Social Rehabilitation Agencies (CASRA).pdf
6. California Association of Physician Groups
7. California Council for the Blind
8. California Dental Association
9. California Health Advocates
10. California Hospital Association
11. California Medical Association.pdf
12. California Medical Transportation Association
13. California Mental Health Planning Council
14. California Optometric Association
15. California Podiatric Medical Association.pdf
16. California Primary Care Association
17. California State Rural Health Association
18. CalOptima.pdf
19. Coalition for Compassionate Care of California (CCCC)
20. County of San Diego, Aging & Independence Services
21. County Welfare Directors Association
22. HealthNet
23. IHSS Consumers Union
24. Imperial Care Center Comment Template
25. Infocrossing
26. Joey Riley and Michael Condon
27. Keiro Senior HealthCare
28. LA County Department of Public Social Services
29. Maggie Dowling
30. Molina
31. Northridge Care Center
32. National Senior Citizens Law Center
33. Group Letter NSCLC DRC WCLP HELP CHCR CHA
34. CalPACE
35. PEACH
36. Pico Rivera Healthcare
37. San Diego County Aging & Independence Services
38. Sharp HealthCare
39. Shield HealthCare
40. Silicon Valley Independent Living Center
41. The SCAN Foundation
42. UDW AFSCME
43. Western Center on Law and Poverty and National Health Law Project
44. West Hills Rehab Center

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Access to Independence
Contact Name: Amy Kalivas, Program Manager
E-Mail: akalivas@a2isd.org

Page	Section Title	Existing Text	Comment or Suggested Edit
2	CCI Fact Sheet- HCBS Waiver	**Will there be any new enrollment in the HCBS waivers in the eight CCI counties?** No. HCBS waiver enrollment will be closed in the eight CCI counties for dual eligible beneficiaries and Medi-Cal-only seniors and persons with disabilities (SPDs). Beneficiaries not enrolled in the HCBS waivers will receive care coordination and HCBS services through managed care.	In San Diego County, we work with individuals transitioning from nursing homes into the community. Without the In-Home Operations Waiver, many of these people would not be able to move into their own homes. It would be extremely detrimental to people with disabilities in San Diego County to stop allowing new applications for the IHO waiver. I can say with certainty that many of our consumers would not be able to discharge from a nursing home without this waiver. The State should allow new applications for the IHO waiver, even in Counties that will be part of the Duals pilot.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Anthem / CareMore
Contact Name: Kathryn Duarte
E-Mail: Kathryn.Duarte@wellpoint.com

Page	Section Title	Existing Text	Comment or Suggested Edit
7	**Health Plan Selection, Readiness, Contracts, and Oversight**	The readiness review will concentrate on the plan's operational capability to serve the Medicare-Medicaid beneficiaries, including the delivery of all Medicare Part A, B and D services, as well as all Medicaid long term services and supports, and behavioral health services.	Concerning "all" LTSS and behavioral health services – is readiness being assessed for all covered LTSS and behavioral health services (rather than all LTSS and behavioral health services)?
11	**PART A - ACCESS AND QUALITY OF SERVICE**	Medi-Cal Continuity of Care: Beneficiaries may, under specified conditions, have access to out-of-network Medi-Cal providers for up to 12 months after enrollment. (W&I §14182.17 (d)(5)(G)).	Continuity of Care (W&I 14182.17(d)(5)(G) indicates the twelve month period for out of network coverage is contingent upon the provider accepting Plan rates. We should be clear that we are not required to pay rates in excess and that we will pay requested rates only until we can arrange referral to a same or similar provider and that we are expecting the State to notify us in advance of continuing care issues so that we can arrange for care within or outside the network as appropriate.
13	**(1) Ensure timely and appropriate communication with beneficiaries.** Enrollment and Notification Strategy:	Beneficiaries will be sent an informing notice at least 90 days prior to the health plan enrollment effective date, followed by a 60-day notice with plan information and selection materials and a 30-day reminder notice. A final confirmation letter will be sent to the beneficiary confirming his/her plan choice and the effective enrollment date. All notices will be released for stakeholder review at least 60 days prior to mailing to the beneficiaries.	Is the plan information part of the notice or supplemental to the notice? Will plan information be released for stakeholder review? All beneficiary notices will be released for stakeholder review at least 60 days prior to mailing to the beneficiaries.

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Organization: Anthem / CareMore
Contact Name: Kathryn Duarte
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Page	Section Title	Existing Text	Comment or Suggested Edit
14	**(1) Ensure timely and appropriate communication with beneficiaries.** Health Plan Oversight for Enrollment Communication:	DHCS will ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures. Communication and services will be available in alternative formats that are culturally, linguistically, and physically appropriate through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language and written translations.	**Suggested Edit:** DHCS will ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures. Written and verbal communication ~~and services~~ will be made available in alternative formats that are culturally, linguistically, and physically appropriate ~~through means~~ including, but not limited to, assistive listening systems, sign language interpreters, captioning, ~~written communication,~~ plain language and written translations.
17	**(4) Care Coordination** Recording and storage of documentation and data	The State requires the plan to ensure a care management system that documents, for each managed care member: the member's completed health assessment, care plan, care notes, service provided, utilization pattern and record of claims paid. This documentation/data may be subjected to random sampling and detailed case review by state reviewers or auditors for accuracy.	Should clarify that the documents and data elements listed need only be retrievable for each member, not that they be housed in a single document.
19	**(5) Network Adequacy** Nursing facility and Community Based Adult Services (CBAS)	Nursing facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care. Community Based Adult Services (CBAS): Demonstration plans must contract with all willing, licensed, and	What does "without encumbering citations" mean in regards to NF and CBAS services? There appears to be a typo in the CBAS paragraph – perhaps "without encumbering citations" should be in parenthesis?

Page	Section Title	Existing Text	Comment or Suggested Edit
		certified CBAS centers, without encumbering citations that are located in the covered zip codes areas and in adjacent zip code areas, not more than 60 minutes driving time away from the eligible individual's residence.	
19	**(5) Network Adequacy** Multipurpose Senior Services Program (MSSP):	Health plans must allocate to the MSSP providers the same level of funding they would have otherwise received under their MSSP contract with CDA.	Does MSSP providers refer to the MSSP sites or the MSSP providers contracted by the MSSP sites? Does "same level of funding" mean utilization of the same reimbursement schedule as used prior to the demonstration or to some annual amount?
19	**(5) Network Adequacy** Community Based Adult Services (CBAS):	If a CBAS center does not exist in the targeted zip code areas, does not have service capacity, or does not have cultural competence to service specific Demonstration plan beneficiaries, Demonstration plans must coordinate IHSS and home health care services for CBAS-eligible enrollees.	What is the intent of coordination of IHSS and home health care services for members who need CBAS but who might not have access to an appropriate CBAS? Is it to provide these services as a substitute for CBAS – so these would be authorized on a daily basis to cover the hours a member might otherwise attend CBAS? How will DHCS ensure DSS will authorize these IHSS hours?
22	**Key Milestones and Timeline**	23. Develop and Implement Quality Measurement and Evaluation Plan … · Collect data from health plans (July 2013 and ongoing)	What data is needed from health plans by July 2013?
22	**Key Milestones and Timeline**	24. Reports to Legislature… · Annual Duals Enrollment Status, Quality Measures and State Costs Report – May 1, 2013 and annually thereafter	What data is needed from health plans for these legislative reports?

Organization: Anthem / CareMore
Contact Name: Kathryn Duarte
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Page	Section Title	Existing Text	Comment or Suggested Edit
		· Annual LTSS Enrollment Status, Quality Measures and State Costs Report – May 1, 2013 and annually thereafter · MSSP Waiver Transition Plan – January 1, 2014 (Initial report) · Health Plan Quality Compliance Report – January 10, 2014 · Annual Plan Audit and Financial Summary Report – June 1, 2014 (first report) · Annual Demonstration Evaluation Outcome Report - October 1, 2014 (first report)	
33	**APPENDIX A** **CCI Timeline**	Demonstration plans begin monthly Medicare and Medicaid Encounter data submissions and other reporting requirements	Please confirm the first reporting and encounter submissions are due to DHCS beginning 9/1/2013.

CALIFORNIA ACADEMY OF
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September 7, 2012

Attn: Coordinated Care Initiative: State Demonstration to Integrate Care for Dual Eligible Individuals
Mr. Toby Douglas
Director's Office
Department of Health Care Services
1502 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Douglas:

We are writing in response to the invitation to provide public comment on the "Programmatic Transition Plan: Coordinated Care Initiative Beneficiary Protections" (the Transition Plan). The California Academy of Family Physicians (CAFP), representing more than 8,000 family physicians and medical students in California, recognizes that coordinated care and the establishment of integrated delivery and payment for individuals eligible for both Medicare and Medi-Cal could be a significant step toward the improved health and well-being of a particularly vulnerable population. We are long-standing advocates for quality health care and improved access for dual eligible individuals and appreciate the state's efforts to improve care. As advocates for this population, we have specific concerns about the proposed Transition Plan that we address in the attached template. Of particular concern is the failure to delineate a plan for assigning each Coordinated Care Initiative (CCI) beneficiary a medical home, as is required by statute. We describe our concerns about this deficiency in this letter. We thank you for the opportunity to share our views.

Medical Homes

We note that Senate Bill 1008 requires, in Section 14182 (c)(13)(A), that each managed care health plan participating in the CCI:

> Establish medical homes to which enrollees are assigned that include, at a minimum, all of the following elements, which shall be considered in the provider contracting process:
>
> (i) A primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions.
> (ii) Care management and care coordination for the beneficiary across the health care system including transitions among levels of care.
> (iii) Provision of referrals to qualified professionals, community resources, or other agencies for services or items outside the scope of responsibility of the managed care health plan.
> (iv) Use of clinical data to identify beneficiaries at the care site with chronic illness or other significant health issues.
> (v) Timely preventive, acute, and chronic illness treatment in the appropriate setting.
> (vi) Use of clinical guidelines or other evidence-based medicine when applicable for treatment of beneficiaries' health care issues or timing of clinical preventive services.

Despite these requirements, we see no reference to the medical home in the Transition Plan and are concerned that there will be a failure to meet this statutory requirement. We urge the state to correct this in the final Transition Plan with the inclusion of requirements for health plans to situate enrollees in medical homes that meet these requirements.

The Transition Plan describes the role of the Interdisciplinary Care Team (ICT), formed for care management of medical Long-Term Supports and Services and behavioral services. While we view the ICT positively and are enthusiastic about a team-based approach to health care, a number of key differences exist between the composition of and requirements for the ICT, as described in the Transition Plan, and the statutory requirements listed above:

- The statute requires all beneficiaries have a medical home, but the Transition Plan limits the beneficiaries who will require an ICT to "plan members who require complex care coordination or case management." CAFP encourages the state to ensure that each beneficiary has a medical home; we believe this will lead to quality improvement for beneficiaries and cost savings for the state.

- The Transition Plan states that "ICTs will include trained care managers or health navigators, and other health care professionals such as RNs and Licensed Social Workers, and the members' primary care physicians as the core team members." In another paragraph, the Transition Plan states that the "ICT will involve nurse practitioners, physician assistants **or** primary care physicians…" (emphasis added). We believe there is a difference between this and the statutory requirement that a primary care physician be the primary clinician for the beneficiary, providing core clinical management functions. We believe it is of the utmost importance for beneficiaries to have an ongoing relationship with a personal physician who is directing the health care team.

- While the Transition Plan describes forthcoming care coordination standards, no mention is made of the other roles played by a medical home and enumerated in the statute. CAFP urges the state to consider the various roles of a medical home. We believe the state has a legal obligation to consider the elements listed in (ii) through (vi), above, and urge the state to consider the "Joint Principles of the Patient Centered Medical Home" adopted by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association.

We appreciate that the state has the opportunity, under the statute, to alter the medical home elements described in the statute. We note, however, that the alteration must be **necessary** to secure increased federal financial participation made available under the Affordable Care Act.

These and other comments are included in the attached template. Again, we appreciate the opportunity to comment on the Transition Plan. The CCI represents an important effort to improve the quality of health care and services provided to dual eligibles. As family physicians, we will continue to champion the health and well-being of our dual eligible patients and appreciate the state's attention to our concerns.

Sincerely,

Susan Hogeland, CAE
Executive Vice President

Page	Section Title	Existing Text	Comment or Suggested Edit
11	**Access and Quality of Service**	Beneficiaries may, under specified conditions, have access to out-of-network Medi-Cal providers for up to 12 months after enrollment. Beneficiaries will have access to out-of-network Medicare providers for the first six months of enrollment.	CAFP urges the state to include, in a final Transition Plan, requirements that plans communicate to beneficiaries that these carve-outs exist and describe the process by which they can maintain their out-of-network provider. This is particularly important given the stable enrollment period at the start of the Coordinated Care Initiative (CCI). Heavy administrative burdens should not be placed on beneficiaries or providers who wish to maintain their current physician-patient relationship during the stable enrollment period.
13	**Enrollment and Notification Strategy**	Beneficiaries will be sent an informing notice at least 90 days prior to the health plan enrollment effective date, followed by a 60-day notice with plan information and selection materials and a 30-day reminder notice. A final confirmation letter will be sent to the beneficiary confirming his/her plan choice and the effective enrollment date.	CAFP believes that beneficiaries should be engaged in the health care decision-making process, beginning with the ability to opt out of new delivery models, demonstrations and pilots that may result in disruptions in care. We are concerned that the passive enrollment process limits beneficiary choice and urge the state to include, in each of these notices, explicit statements about the ability to opt out or be automatically enrolled in the demonstration for an initial six-month stable enrollment period, during which they must remain in the same health plan. CAFP is concerned about continuity of care for CCI beneficiaries and urges the state to include information about beneficiaries' ability to continue to see their primary care physicians

Page	Section Title	Existing Text	Comment or Suggested Edit
			and other specialists with whom they have an ongoing relationship, if they are enrolled in the CCI. CAFP joins the California Medical Association (CMA) in urging the state to begin notifying physicians and patients immediately upon the completion of the MOU, as opposed to only 60 and 30 days ahead of enrollment. We encourage the state to work with the CMA and CAFP on building an effective communication strategy for reaching Medicare provider physicians.
14	**Initial Assessment Process**	Health plans will be responsible for an in-depth risk assessment process capable of timely identification of primary, acute, LTSS and behavioral health and functional needs…This assessment will help inform the interdisciplinary care team to assist in creating an appropriate individual care plan, and beneficiaries in accessing all necessary resources.	CAFP appreciates the need for risk assessments with this population. We urge the state to clarify, in the final Transition Plan, that the care plan will be created, independently of the health plan, by the primary care physician-led practice team. We note several concerns with the conceptualization of the interdisciplinary care team (ICT) in our cover letter and below.
15	**Primary Care Physician Assignment**	Health plans are required to— Not interfere with a beneficiary's primary care physician choice under Medicare Not assign a full-benefit dual-eligible beneficiary to a primary care physician except for specified circumstances	CAFP supports these protections and is pleased to see that DHCS will ensure they are incorporated into contracts with managed care health plans.
15	**Primary Care Physician Assignment**	Health plans are required to— Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-	CAFP opposes the assignment of patients to physicians. We understand that these provisions are a part of SB 1008 and there is limited flexibility, but we urge the state to preserve

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		Cal managed care plan	beneficiaries' choice in physicians whenever possible. We do not understand why, as a policy matter, a distinction is made between full and partial-benefit dual eligible when it comes to physician selection.
15	**Primary Care Physician Assignment**	Health plans are required to— Provide a mechanism for partial-benefit dual eligible beneficiaries to request a specialist or clinic as the primary care provider.	SB 1008 states "[a] specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of conditions of the enrollee." CAFP urges the state to consider the distinction between the Transition Plan and statutory language and to include the full statutory language in contracts with managed care health plans. Primary care physician-led practice teams do more than provide discrete medical services. They provide acute care, chronic care, preventive services and end of life care. They coordinate care across the complex health care system. The state should ensure that specialists or clinics are in fact serving as primary care providers by asking them to agree to serve in that role and ensuring that they are qualified to treat the required range of conditions of the enrollee.
16	**Composition and leadership of the ICT**	To coordinate the care of members residing in the community, ICTs will include trained care managers or health navigators, and other health care professionals such as RNs and Licensed Social Workers, and the members' primary care physicians as the	Senate Bill 1008 requires, in Section 14182 (c)(13)(A), that each managed care health plan establish medical homes that will be responsible for care management and care coordination across the health care system. Further, the law states that the medical home will include "A

Page	Section Title	Existing Text	Comment or Suggested Edit
		core team members… in nursing facilities, ICT will involve nurse practitioners, physician assistants or primary care physicians…	primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions." As we state in our cover letter, we believe there are significant differences between the statutorily-required medical homes and the ICTs of the Transition Plan. We believe this section on the composition and leadership of the ICT is missing a statement about the leadership role of the primary care physician as the "primary clinician" responsible for "core clinical management functions."
17	**Frequency of ICT meetings**	Frequency of the ICT meetings will be based on complexity and acuity of the medical, behavioral, and LTSS needs. Plans will need to establish policies and procedures guiding assessments and reassessments according to the approach and intensity of care management.	CAFP believes that decisions about the frequency with which the care team should meet and the approach and intensity of care management should be made by the primary care physician and team. These are medical decisions and not decisions that health plans should make.
18	**Identifying beneficiaries requiring an ICT**	Individual plan members who require complex care coordination or case management are those who have multiple acute and chronic diagnoses, functional impairments (vision, hearing, upper/lower extremities, bowel and bladder), cognitive impairments, behavioral problems, ADL/IADL needing human assistance, and/or high utilization of medical, behavioral health and LTSS resources. Specific criteria will be established by the plans and approved by DHCS. The	Senate Bill 1008 requires, in Section 14182 (c)(13)(A), that each managed care health plan establish medical homes to which enrollees are assigned. CAFP urges the state to require plans to establish medical homes for every CCI beneficiary.

Page	Section Title	Existing Text	Comment or Suggested Edit
		beneficiary's medical conditions will be assessed and ranked as low, medium or high complexity, each requiring a different approach and intensity of care management. Beneficiaries with ICTs could range from disabled individuals who are able to direct their own care to individuals with highly complex conditions needing intensive case management.	
18	**Network Adequacy**	State Medicaid network standards shall be utilized for LTSS and the prescription drugs covered by Medicaid which are excluded from Medicare Part D. Medicare network standards shall be used for Medicare prescription drugs and other services for which Medicare is the primary coverage. Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards. In a later section, the Transition Plan states that the "State and CMS will jointly review the health plan's provider network to ensure an adequate number of providers are available to beneficiaries."	CCI moves a population from health care that is largely paid for by Medicare fee-for-service to care paid for by Medi-Cal managed care plans operating under a capitated payment model. This kind of transition has significant implications for access and physician-patient relationships. We believe the state is moving a population with expansive health care needs into a much more limited pool of care providers. The foreseeable result is a decline in access to care, particularly primary care, and a resulting decline in quality of care and increase in costs. CAFP is concerned that the standards on page 18 are overly complicated and will be impossible to enforce. We urge the state to streamline and clarify. CAFP sees no explicit plan for the review of health plan provider networks. We are very concerned about continuity of and access to care, and urge the state to formulate such a plan, with stakeholder input, quickly.

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			CAFP joins the CMA in urging DHCS and CMS to consider the unique needs of dual eligible patients when assessing plan networks. We believe it likely that the plans will need more and different physicians than they contract with for other groups of patients. We agree with the CMA that both DHCS and DMHC should perform a complete review of staff levels, to ensure that both departments have enough staff and staff with the right expertise for the CCI. We also join the CMA in noting that nothing in this plan mentions plans contracting with solo and small practice physicians, as required in SB 1008. We urge the state to include these important providers in the final plan.
20	**Grievance and Appeals Process**	The unified [Grievance and Appeals] process will be reviewed with stakeholders and will be communicated to beneficiaries and providers.	The state provides minimal detail on the Grievance and Appeals process in the Transition Plan. We think the process should be vetted by, not just communicated to, beneficiaries and providers. We look forward to seeing the process publicized.
5	**Introduction**	The CCI will use a capitated payment model to provide both Medicare and Medi-Cal benefits through the state's existing network of Medi-Cal health plans.	CAFP acknowledges that changes to the CCI payment model are unlikely at this stage, but must urge the state to consider blended payment models that combine fee-for-service, capitation and shared savings or bonus payments based on quality and savings. These models have led to significant cost savings and quality improvements in other states.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: California Association of Health Facilities
Contact Name: Nancy Hayward
E-Mail: nhayward@cahf.org

Page	Section Title	Existing Text	Comment or Suggested Edit
Page 5	Introduction, CCI	The health plans will be responsible for delivering a full continuum of Medicare and Medi-Cal services, including medical care, behavioral health services, and long-term services and supports (LTSS), including home- and community-based services such as IHSS, Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP), in addition to care in nursing facilities when needed.	CAHF has been meeting with health plans and has learned that some plans may delegate responsibility for Medicare Part A and B services (Acute, post-acute SNF, and physician services) to physician groups while retaining responsibility for LTSS, including Medi-Cal skilled nursing facility services. DHCS should carefully review their contracts with the health plans to assure that all services for the duals are integrated. Having two organizations manage the care for the same beneficiary is contrary to the rationale for implementing CCI and integrating care.
Page 6	Person-Centered Care Coordination	Health plans will be responsible for seamless access to networks of providers across this broader continuum of care.	Se comment above. Having different organizations provide Medicare services and Medi-Cal services is certainly not going to be seamless.
Page 9	State Administrative Background	Each health plan seeking to participate in the CCI holds a current license issued by the DMHC under the Knox-Keene Act.	County organized health systems (COHS) are exempt from the Knox-Keene Act, according to prior DHCS documents. Will the DMHC Health Center provide assistance for beneficiaries enrolled in COHS?
Page 10	State Administrative Background	A urgent nurse process for treatment denials that require immediate assistance;	We suggest that this be expanded to include denial of post-acute skilled nursing facility care at the Medicare Part A level of care. The delay of critical rehabilitative and medically complex services for three days can cause significant loss of functionality and harm.
Page 11	Part A	& I Section 14186.6 (c) (3)	Should be W & I Section 14186.**3** (c) (3)
Page 12	Part A-Health Plan Liaisons	& I Section 14182.17(5)(F) and (G)	Should be W & I Section 14182.17 **(d)** (5)(F) and (G). If DHCS is not going to require that health plans contract with all skilled nursing facilities in counties with occupancy rates above 80%, as previously suggested, CAHF is concerned that there will be a significant

Organization: California Association of Health Facilities
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Page	Section Title	Existing Text	Comment or Suggested Edit
			number of beneficiaries that reside in skilled nursing facilities that will be "out-of-network." The health plan should be required to document that it has sufficient liaison staff to execute letters of agreement with every non-contracted facility in the county within three days of being contacted by the facility. For example, there are approximately 40 nursing facilities in Los Angeles that have Medi-Cal patients. If a health plan only contracts with 50 facilities, it should have sufficient staff to process individual letters of agreements to assure continued access for Medi-Cal patients that reside in the remaining 350 facilities.
Page 13	Enrollment and Notification Strategy		The Medi-Cal Eligibility Determination System is notorious for having incorrect address information. For residents of skilled nursing facilities, the patient may never get the notification. DHCS should consider using treatment authorization request data and/or claims data to send patient information to the facility where the patient resides. They are more likely to receive the notifications.
Page 17	Composition and Leadership of the ICT	For members in nursing facilities, ICT will involve nurse practitioners, physician assistants or primary care physicians to work with NF staff to manage medical conditions in nursing facilities and to facilitate nursing facility-hospital transitions.	This should be changed to require that nurse practitioners, physician assistants or primary care physician be part of the ICT, not just "involved." In order to reduce re-hospitalizations, skilled nursing facilities need access to health plan contracted medical expertise during evenings and weekends. Otherwise, many physicians that are on call will refer patient in distress to the emergency room. The hope is that the CCI will provide better access to physician services for patients.

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Page	Section Title	Existing Text	Comment or Suggested Edit
Page 19	Network Adequacy	Nursing facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care. Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility.	The term "encumbering citations" should be removed from this provision. Any facility that is licensed or certified should be able to contract. In addition, this term is not defined. resident transfer from an out-of-network to an in-network facility must be orderly and carefully planned as trauma associated with such transfers is significant and well documented concern within this fragile population. At a minimum the transfer process must demonstrate that : 1. Transfers occur with resident and family input, understanding and agreement. 2. A resident-centric transfer/discharge plan of care is created and implemented to assure continuity of care and services. 3. There is direct communication between the sending and receiving physician(s) and nursing professionals prior to and at the time of transfer. 4. The resident and family receive orientation to the receiving facility prior to transfer. 5. Resident response to transfer is tracked by the managed care plan and any resident decline post-transfer is part of the data on beneficiary outcomes as reported to DHCS. Additionally, managed care plans should be bound by the Code of Federal Regulations (CFR), specifically Section 483.12(a)(2) which prohibit resident from being **involuntarily** transferred or discharged from a facility **unless:**

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			1. The transfer and discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; 2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; 3. The safety of individuals in the facility would otherwise be endangered; 4. The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid) under Medicare, or Medicaid to stay at the facility; 5. The facility ceases to operate.
Page 20	Network Adequacy	The state will require that health plans contract a sufficient number of providers for durable medical equipment.	This should be expanded to include other types of ancillary providers that have existing relationships with skilled nursing facilities, such as medical suppliers, radiological services, and laboratory services. The state should require health plans to contract with these types of providers and require that the contracted providers have established relationships with skilled nursing facilities. If health plans contract with vendors that do not have existing relationships, the health plans should be required to notify all skilled nursing facilities in the county about the contracted vendor(s) prior to CCI implementation.
Page 20	Network Adequacy	Health plans will be required to use the most recent common procedure terminology (CTP) codes, modifiers, and correct coding initiatives.	Health plans will also be required to use Medi-Cal accommodation codes for long term care services and accept the forms currently submitted to the Medi-Cal Fiscal Intermediary. Se LTC Provider Manual:

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			http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/accomcdltc_l00.doc http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/payltccomp_l00.doc
Page 25	11. Develop LTSS Provider Network Adequacy Standards		CAHF submitted extensive comments o the first draft of the adequacy standards for skilled nursing facilities. We respectfully request that DHCS meet with us prior to releasing the next draft.
Page 25	13. Determine Supplemental Benefits Policy		DHCS needs to recognize that residents of skilled nursing facilities continue to be entitled to the optional services that were eliminated by the States, including both dental and visions services. DHCS should clarify if these services are to be provided by the health plans or Medi-Cal fee-for-service for both non-duals and duals that opt out of the Medicare services.
Page 28	Part C-Consumer Complaints	The verbiage provides for days for denials of services for urgent medical problems.	We suggest that this be changed to have a more timely review of the denial of post-acute skilled nursing facility care at the Medicare Part A level of care. The delay of critical rehabilitative and medically complex services for three days can cause significant loss of functionality and harm.
Page 29	DHCS/Ombudsman		DHCS should expand the capability of their toll-free number to assure that wait times d not exceed 5 minutes and that inquiries are responded to within 24 hours by DHCS staff.
Page 29	CDPH		The term “nursing homes” should be replaced with “nursing facilities”.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: California Association of Health Facilities
Contact Name: Nancy Hayward
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None	Veterans		The CCI provides that residents of Veteran's Homes will not be enrolled in the CCI. There are contractual relationships with the Veteran's Administration (VA) and individual skilled nursing facilities where VA pays for skilled nursing facility care. This question was raised at the stakeholder meeting. CAHF would like confirmation that in these cases the VA would show as "other health coverage" o the Medi-Cal Eligibility File, which would mean that these beneficiaries would not be enrolled in managed care.
None	Prompt payment for skilled nursing facility services		CAHF continues to request that DHCS require the health plan to reimburse skilled nursing facilities within two weeks of submission of a clean claim. Also, health plans are required to process electronic claims and to pay facilities by electronic fund transfer.

Contact Name: Joseph Robinson
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Due September 7, 2012

Page	Section Title	Existing Text	Comment or Suggested Edit
11	Part A – Access and Quality of Service	Medi-Cal Continuity of Care for Nursing Facility Care: …managed care health plans will recognize any prior treatment authorization made by DHCS for at least six months after enrollment into the health plan. Medicare Continuity of Care: Beneficiaries will have access to out-of-network Medicare providers for the first six months of enrollment.	These provisions should be extended to one-year consistent with the Medi-Cal Continuity of Care provisions that allow "access to out-of-network Medi-Cal providers for up to 12 months of enrollment." Having separate timelines will be confusing and risks disruptions in care.
11-12	Part A – Access and Quality of Service	Medicare 20-21 D Continuity of Care: The department and CMS will implement and enforce Medicare Part D transition of care provisions …	Detailed beneficiary rights should be provided. For individuals with a psychiatric condition or complex chronic conditions, medication access is critical to maintaining wellness. There needs to be specific and concrete protections built in and stated in this plan. i.e. "If a prescribed medication is not on a health plan's formulary the beneficiary is entitled to a 90-day supply of their current medication to allow time to navigate the appeals process."
12	Part A – Access and Quality of Service	DHCS, CHS and DMHC are currently reviewing responsibility for monitoring compliance with state and federal timely-access provisions.	When reviewing current timely-access provisions the state needs to consider that as a group dual eligibles are a more fragile population and that current timely-access provisions may not be sufficient to adequately meet the needs of this vulnerable population.
13	Part B – Operational Steps, Timelines and Key Milestones for Beneficiary Provisions of	Beneficiaries will be sent an informing notice at least 90 days ….. A final confirmation letter will be sent to the	This should be amended to read; "A final confirmation letter will be sent to the beneficiary confirming his/her plan choice and

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	CCI	beneficiary confirming his/her plan choice and the effective enrollment date.	the effective enrollment date. *This notice shall be sent within 14-days of the enrollment date and include specific information as to the beneficiaries rights to opt-out of the program and instructions on how to do so."*
14	Part B – Operational Steps, Timelines and Key Milestones for Beneficiary Provisions of CCI	Outreach Plan: Contingent on available funding, this plan will include contracting with …. assistance organizations … in assisting beneficiaries in understanding their health care coverage options.	This plan should detail alternatives if "available funding" is not available. Costs savings from the initiative should be used to ensure future funding.
14	Part B – Operational Steps, Timelines and Key Milestones for Beneficiary Provisions of CCI	Health Plan Oversight for Enrollment Communication	A dedicated toll-free number for beneficiary inquiries should be available.
15	Part B – Operational Steps, Timelines and Key Milestones for Beneficiary Provisions of CCI	(3) Primary Care Physician Assignment – Not assign a full-benefit dual-eligible beneficiary to a primary care physician except for specified circumstances	This plan should include criteria and examples of "specified circumstances."
17	Part B – Operational Steps, Timelines and Key Milestones for Beneficiary Provisions of CCI	Identifying beneficiaries requiring an ICT – The beneficiary's medical conditions will be assessed and ranked as low, medium or high complexity, each requiring a different approach and intensity of care management.	A provision should be added that a beneficiary may request they be moved to a higher or lower 'tier' of care management if they do not agree with their assessed level of need.
18	Part B – Operational Steps, Timelines and Key Milestones for Beneficiary Provisions of CCI	Behavioral Health Care Coordination – Health plans will enter into an MOU with county behavioral health agencies ….	The lack of specificity in this section is concerning. Behavioral health care coordination will have a great impact on the overall health of the beneficiary. Therefore benchmark expectations of MOUs between health plans and

Comments on CCI Transition Plan

Organization: California Association of Social Rehabilitation Agencies (CASRA)
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Due September 7, 2012

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			county behavioral health agencies should be established and made known.
19	Part B – Operational Steps, Timelines and Key Milestones for Beneficiary Provisions of CCI	Nursing facility: … until a safe transfer can be made to an in-network facility.	This provision should state that all transportation costs will be the responsibility of the health plan.
20	Part B – Operational Steps, Timelines and Key Milestones for Beneficiary Provisions of CCI	The State will require that health plans ensure that each health plan has non-emergency, accessible medical transportation … so that individuals have timely access to scheduled and unscheduled medical care appointments."	This should include transportation to CBAS and MSSP programs.
21- 22	Part B – Operational Steps, Timelines and Key Milestones for Beneficiary Provisions of CCI	(9) Local Stakeholder Advisory groups Established by Health Plans – With CMS, DHCS is developing joint readiness review standards for health plans, which will include requirements for local stakeholder advisory groups. As noted below, all health plans have already met with local stakeholder, and most have established ongoing stakeholder advisory groups… Examples of health plans stakeholder meetings are provided below…	The listed examples of participants at health plan stakeholder meetings do not include actual stakeholders that are impacted by the demonstration program. Dual eligible beneficiaries should be included in stakeholder activities. Although there are stakeholder activities that include beneficiaries, those activities are not localized to the individual counties. For example, San Mateo County meets with hospital and provider groups to address their concerns but ignored are the concerns of the beneficiaries that are most impacted by this program.

Comment Template for CCI Transition Plan
September 7, 2012

Organization: California Assoc. Physician Groups
Contact Name: Bill Barcellona, Sr. VP
E-Mail: wbarcellona@capg.org

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6	Introduction	Pending CMS approval, those who do not opt out will be enrolled in the demonstration for an initial six-month stable enrollment period, during which they will remain in the same health plan.	A stable enrollment period is essential to the establishment of successful coordinated care system and to build patient-provider relationships (like Medical Homes) within the system. The goal of the CCI was to move beyond fragmented, sporadic care. The elimination of this mechanism by CMS undermines the successful transition into coordinated care and threatens patient safety. During the SPD roll-out from 2011-2012, it became apparent that beneficiaries did not understand their assigned network and access rules. It takes time to educate any patient population about change in their benefit plan and/or delivery model. Given the fact that continuity of care provisions allow for up to 12 months of ongoing treatment with a prior out-of-network provider, it appears that the proposed stabilization period would have no adverse effect on an enrollee-beneficiary. It also destabilizes the financial solvency of capitated providers who will incur liabilities for patient treatment charges without the benefit of long term capitated payment revenue.
6	Introduction	*Continuity of care.* Beneficiaries and stakeholders have repeatedly emphasized the importance of care continuity when considering new delivery models. Beneficiaries will be informed about their enrollment rights and options, plan	Providers were not given access to the health risk assessments performed by health plans during the SPD roll-out. This omission greatly interfered with the provider's ability to coordinate patient care and establish safe

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		benefits and rules, and care plan elements with sufficient time to make informed choices. This information will be delivered in a format and language accessible to enrollees.	transfer during a continuity of care period. Additionally, the prior instance of the SPD roll-out revealed that failure to provide risk assessments to delegated model provider groups created financial instability where groups received lives under capitation with no ability to determine the level of acuity (i.e. utilization risk)). This resulted in an unfair shifting of financial risk from health plans to providers. Where public funds are expended to create health risk assessment, health plans should be compelled to provide this information to their contracted, network providers.
6	Introduction	*Beneficiary Protections.* The demonstration will include unified requirements and administrative processes that accommodate both Medicare and Medicaid, including network adequacy requirements, outreach and education, marketing, quality measures, and grievances and appeals processes. (emphasis added)	The references to network adequacy requirements throughout this paper are ambiguous. Further reading creates uncertainty over whether DHCS and DMHC will conduct physician network adequacy reviews, or whether this oversight function will be left to CMS, and thus whether federal network standards apply, or Knox Keene standards. A clarification at this section, and later at page 11, Part A – Access and Quality of Service, the first and second bullets.
6-7	Introduction	*Provider Outreach and Engagement.* The State and CMS will coordinate efforts to engage and educate providers about the CCI leading up to and during	CAPG can serve as an effective communication conduit to all delegated model physician groups. No provider complaint and appeals process has

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		implementation. This work already is underway through the stakeholder work group focusing on provider outreach and engagement	been set up in this program to ensure that contracted health plans are following state law in the administration of their provider agreements.
7	Introduction	In addition, during the fall of 2012 the State and CMS will jointly assess each health plan's readiness using a jointly developed tool to ensure the plans will meet the operational requirements.	Will the assessment tool and its individual elements of the checklist be made public so that providers can understand the basis of the DHCS and CMS readiness certification of health plans and their contracted provider networks? This would be very helpful.
8	Introduction	The readiness review process demonstrates the health plan's ability to: Provide timely access to medical care to beneficiaries, and measure the adequacy of the provider networks for medical, long-term care, and behavioral health services.	It would be helpful to know what benchmarks are being used in the tool, especially for timely access to medical care, and adequacy of provider networks for medical services. Will these benchmarks be made public?
9	State Administrative Background	Each health plan seeking to participate in the CCI holds a current license issued by the DMHC under the Knox-Keene Act. To maintain its license, each health plan is required to continuously meet defined regulatory standards, including timely access to care through adequate provider networks, care coordination, continuity of care, financial solvency, and treatment decisions (emphasis added)	COHS plans are not statutorily required to hold Knox Keene licenses, however almost all COHS plans currently hold them, because they have administered Healthy Families Program coverage for their enrollees. Will all COHS plans continue to submit to jurisdiction during the 3 year period after the HFP transition to Medi-Cal? It is unclear whether demonstration plans will be held to all Knox Keene requirements, several of which do not apply in Medi-Cal. A additional issue exists concerning the preemption of Knox

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			Keene law by federal law, which prevents state regulator enforcement. This statement at page 9 creates the impression that all Knox Keene protections will be available to beneficiaries. Will they? Please clarify.
10	State Administrative Background	External review of medical necessity and experimental/investigational disputes;	Will the Knox Keene medical necessity standard apply to federally-mandated Medicaid health benefits? Will the current DMHC interpretation of autism spectrum disorder coverage by health plans apply even though Medi-Cal provides specifically-defined behavioral health benefits through County-level provider systems? Please clarify.
11	Access & Quality of Service	Note that DHCS and DMHC are collaborating to determine the applicability of state standards to services funded by the federal government. Network adequacy reviews, conducted by the Centers for Medicare and Medicaid Services (CMS) and DHCS, are a key process to ensure that health plans have sufficient providers in their network to meet the needs of members and provide sufficient access to care. For Medicare benefits, CMS has reviewed health plan networks and ensured they meet Medicare Advantage adequacy standards.	Please clarify when this determination will be completed. Please clarify whether network adequacy reviews for medical services by physicians will be performed by CMS or DMHC, and which standard for networks will apply – federal or state-level Knox Keene Act, respectively.
11	Access & Quality of Service	Medi-Cal Continuity of Care: Beneficiaries may, under specified	CAPG members have asked for clarification of this continuity of care standard because it differs

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		conditions, have access to out-of-network Medi-Cal providers for up to 12 months after enrollment. (W&I §14182.17 (d)(5)(G)). *[Insert the referenced standard:* *(G) Maintain a liaison and provide access to out-of-network providers, for u to 12 months, for new members enrolled under Sections 14132.275 and 14182.16 who have a <u>ongoing relationship</u> with provider, if the provider will accept the health plan's rate for the service offered, or for nursing facilities and Community-Based Adult Services, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues in accordance with guidance from the department, including all-plan letters. A partial-benefit dual eligible beneficiary enrolled in Medicare Part A who only receives primary an specialty care services through a Medi-Cal managed care health plan shall be able to receive these Medi-Cal services from an out-of-network Medi-Cal provider for 12 months after enrollment. This subparagraph shall not apply to out-of-network providers that*	from the common Knox Keene Act continuity of care provisions. A key uncertainty concerns the phrase "ongoing relationship" as cited in the applicable W& I Code text in the column to the left (underscored). Our members are delegated by the Medi-Cal plans for the provision of continuity of care services and their capitated payments include an actuarial factor for such obligations. In order to correctly administer this provision, our members need to know whether "ongoing relationship" is limited to an ongoing treatment relationship, or as used in Knox Keene parlance, an "active course of treatment."

Organization: California Assoc. Physician Groups
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		furnish ancillary services.]	
11 (Also, referenced section at Part B, paragraph 5, located at pages 18-20)	Access & Quality of Service	DHCS, CMS, and DMHC will monitor and enforce these provisions as part of the readiness review process, throughout implementation, and on an ongoing basis. Additional information on implementation of these provisions is described in Part B, paragraph 5 of this report Part B, paragraph states: (5) Network Adequacy State Medicaid network standards shall be utilized for LTSS and the prescription drugs covered by Medicaid which are excluded from Medicare Part D. Medicare network standards shall be used for Medicare prescription drugs and other services for which Medicare is the primary coverage. Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards. Provider networks will be subject to confirmation through Demonstration plan readiness reviews in October and November 2012, including the following:	Please clarify whether this means that a federal standard will apply to the network adequacy determination of CMS for professional medical services. If so, please clarify what that standard includes.

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		In Home Supportive Services (IHSS): Demonstration plans are required to have an MOU or contract with their respective county social services agencies to provide IHSS for their beneficiaries. Such agreements will require the county to provide - IHSS eligibility assessment and authorization of IHSS hours; - Coordination of IHSS delivery with other Demonstration plan covered benefits; - Quality assurance; - IHHS Provider enrollment and training; - IHHS Background checks and registry services; - Data sharing; and - A local IHSS advisory committee. Demonstration plans must contract with the California Department of Social Services to perform the following: - Pay wages to IHSS providers and perform provider payroll obligations and related technical assistance; - Share beneficiary and provider data; and Provide an option for Demonstration plans to participate in quality monitoring activities.	

Organization: California Assoc. Physician Groups
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		Demonstration plans may contract with other agencies to provide emergency backup personal care services, or in cases where a beneficiary cannot find a provider, for so long as such agencies are certified by the California Department of Social Services. Nursing facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care. Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility. Demonstration plan's contracted facilities will be located in zip code areas covered by the Demonstration and, to the extent possible, in adjacent zip code areas. Multipurpose Senior Services Program (MSSP): Demonstration plans must contract with MSSP organizations in good standing with the California Department of Aging (CDA) in the covered zip code areas included in the Demonstration, and to the extent possible, in the adjacent zip code areas. The contract will cover the provision of MSSP case management and waiver services for waiver participants, and beneficiary data sharing. Health plans may contract with an MSSP organization to provide care coordination and MSSP-like services to non-waiver beneficiaries as needed. Health plans must allocate to the MSSP providers the same level	

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		of funding they would have otherwise received under their MSSP contract with CDA. Community Based Adult Services (CBAS): Demonstration plans must contract with all willing, licensed, and certified CBAS centers, without encumbering citations that are located in the covered zip codes areas and in adjacent zip code areas, not more than 60 minutes driving time away from the eligible individual's residence. If a CBAS center does not exist in the targeted zip code areas, does not have service capacity, or does not have cultural competence to service specific Demonstration plan beneficiaries, Demonstration plans must coordinate IHSS and home health care services for CBAS-eligible enrollees. The State will require that health plans ensure that each health plan has non- emergency, accessible medical transportation available in sufficient supply and so that individuals have timely access to scheduled and unscheduled medical care appointments. The state will require that health plans contract with a sufficient number of providers of durable medical equipment.	
12	Access & Quality of Service	Listing of Providers' Ability to Accept New Patients: Health plans will maintain an	This undertaking should be coordinated with the California Health Benefits Exchange, so that a

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		updated, accurate, and accessible listing. (W&I §14182.17(d) (5) (C)).	single, statewide registry of physicians in managed care networks can be maintained, rather than creating separate, somewhat duplicative, databases.
12	Access & Quality of Service	DHCS, CHS and DMHC are currently reviewing responsibility for monitoring compliance with state and federal timely-access provisions. DMHC recently promulgated regulations regarding Timely Access to Non-Emergency Health Care Services (California Code of Regulations Section 1300.67.2.2). DHCS and DMHC are reviewing the applicability of the regulation to the Duals Demonstration Project	Please clarify when this determination will be completed and how it will be made available to the public.
15	Part B: 2. Initial Assessment Process	Building on what was learned from the transition of the Medi-Cal-only SPD population into Medi-Cal managed care, the State will work with plans and providers to ensure necessary processes and procedures are in place to support timely health risk assessments. In addition, California's health plans will use promising practices, such as repeated attempts to gather assessment information via various modes (phone, mail, interactive voice by phone) and web-based care planning tools that allow providers and beneficiaries to view and add to the care plan.	May we see an example of this communications model? Does this provision of the report ensure that plans will share health risk assessments with providers in this Demonstration?

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15	Part B: 2. Initial Assessment Process	Strategies will also include review of fee-for-service utilization data to prioritize assessment and care planning, and to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part D drugs that are not on the demonstration site's formulary. DHCS is developing data files for health plans for this purpose. (emphasis added)	Can we obtain more information about this tool and when it will be made available to providers responsible under delegated capitation agreements? Is there any contractual provision that would require a Plan to make this information available to its delegated providers? CAPG strongly suggests that the Department carefully consider mechanisms like these in its plan contracts to financially stabilize delegated, capitated physician groups who take risk for this patient population.
15-16	Part B: 2. Initial Assessment Process	Provide a mechanism for partial-benefit dual eligible beneficiaries to request specialist or clinic as the primary care provider. Some of these provisions will be incorporated into existing Medi-Cal managed care health plan contracts as early as October 1, 2012. DHCS will ensure that the remaining provisions are incorporated into the contracts, effective upon mandatory enrollment of dual eligible beneficiaries, and will monitor and enforce these contract provisions	Please clarify under what circumstances a plan must assign a partial benefit dual eligible to a receiving primary or specialty care physician. Plans hold onto members for several months and do not assign them to capitated providers until the enrollee needs acute intervention. They fail to pay capitation to delegated physician groups during that time period prior to assignment. Plans should be required to auto-assign members to provider home within 30 days. This practice undermines the financial stability of the delegated, capitated physician group. An accounting by the plan of all retained capitation acquired through delayed assignment to a PCP should be made to DHCS and either paid retrospectively to the capitated delegated physician group or refunded to the state, since

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			the money was not used for professional medical services.
17	Part B: Interdisciplinary Care Teams	ICTs will be under the oversight of the plan's medical leadership or Medical Director. The State expects plans to designate individuals with experience working with seniors and persons with disabilities to lead the care management effort.	CAPG suggests that the advantages of the delegated/capitated model are not fully exploited under this care management model. Delegation of coordination activities by the Plan's Medical Director should be made to the responsible physician group under capitated payment for the assigned beneficiaries.
20	Part B: (8) Monitor Health Plan Performance…	DHCS, DMHC, and CDSS will implement the monitoring requirements of this subdivision by doing the following: The State and CMS will jointly: 1) review the health plan's provider network to ensure an adequate number of providers are available to beneficiaries; 2) examine financial solvency of the health plans; 3) verify that requirements of timely access to medical care being met; and 4) conduct medical	This appears to contradict the prior statements concerning responsibility for review of physician networks because it implies that state agencies will play an active role in the review physician networks. In prior statements in this document, no state authority or function is reference with respect to the review of physician networks. Clarification of this point is greatly needed.

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		surveys with beneficiaries and onsite surveys of health plans on a recurring basis.	
22-26	Key Milestones and Timeline	16. By February 2013, implement fully executed Managed Care Health Plan Contracts. • Coordinate with CMS to finalize demonstration contract boilerplate (Fall 2012) • Amend existing Medi-Cal health plan contracts to add LTSS benefits and dual-eligible beneficiaries enrollment-related provisions of SB 1008 (Fall • 2012) • Fully execute all contracts (Winter 2012/2013) • Submit contracts to State Controller's Office (Winter 2012/2013)	CAPG members have noted that there does not appear to be a milestone for an agreed-upon reimbursement model to the plans, which would include a population-based risk-adjustment factor. When will plan rates be negotiated? Would you please clarify how this will be handled?

Donna Pomerantz, President

CALIFORNIA COUNCIL OF THE BLIND
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CALIFORNIA COUNCIL OF THE BLIND

September 5, 2012

Coordinated Care Transition Plan Comments

The California Council of the Blind is the largest organization of Californians with visual impairments, having a membership of approximately 1, 500, with local affiliates throughout the state. Many of our members are Medi-Cal recipients, and many of those are dual eligibles.

We appreciate the opportunity to provide comments to you on the transition plan. The following represent the primary concerns of the council.

(1) Alternate Formats.
We are pleased that the plan contains several references to the need of the state and the plans to provide information to individuals who are blind or who have low vision in alternate formats. However,
A Recipient with visual impairments who does not receive his or her information at the same time as other recipients will not be able to make health care decisions critical to his/her well-being, as evidenced by the failure of such information to be provided under the current SPD waiver. However, the transition plan does not specify the types of alternative formats that will be required. For a variety of reasons, people with visual impairments require different types of formats in order to effectively understand the information being conveyed. The plan should specify that the state and plans will offer, braille, large print, CD's, computer disk, e-mail and cassette. Moreover, if large print information is not provided in accordance with best practices that have been developed by consumers, its readability for individuals with low vision will be severely limited and for many negated completely. Thus, we have attached a copy of guidelines developed by the Council of Citizens with Low Vision International (CCLVI) on how best to provide this information. The state and health care plans need to follow these guidelines if they are to successfully carry out their mandate.

(2) Electronic Communication.
Both federal and state law requires that the state, its contractors, and recipients of public funds provide electronic communication that is accessible to those with disabilities, including those with visual disabilities. As an illustration of documents that are inaccessible to persons using screenreader software,, whether placed on a website, or emailed, security-protected and image-based documents cannot be read by persons using screenreading software. Moreover, the most usable documents for persons with visual impairments are word or text-based documents. To ensure compliance with access requirements for electronic communication, it is necessary to meet the requirements of the Web Accessibility Guidelines 2.0, which we have attached.

(2) Vision Services.
Well over half the population of persons with vision loss are seniors and the population of those with visual impairments is growing extremely rapidly. Longer life spans, macular

degeneration, and the diabetes epidemic are just a few of the causes for this trend. Given these facts, it is extremely important that Medi-Cal managed care, whether for dual eligibles or just those eligible for Medi-Cal benefits, include vision services. Without such services, it is impossible to live independently.

The inclusion of these services requires several components. First, plans must have an adequate number of ophthalmologists and optometrists, including those with expertise in severe visual impairments. Such expertise is crucial not only in the diagnosis of diseases and conditions affecting vision, but also in providing assistance with respect to the most appropriate use of low vision aids for those suffering vision loss.

Moreover, vision services must include aids for those with vision loss, including glasses, video magnifiers, white canes, and other related items. These items are no less essential than wheelchairs or hearing aids for purposes of an individual's ability to live independently with vision loss, avoid institutionalization, and maximize his/her potential.

(3) Care Coordination Plans.
Having plans for care coordination be functional, rather than medical, in nature is essential in making the managed care system both responsive to the needs of enrollees and cost-effective for the state and managed care plans. Thus, we applaud this transition plan's requirement in this regard. However, one important element is missing in the description of how such a care plan will be created, both with respect to those who are able to self-direct their care and those who may not have that capacity. Specifically, information needs to be collected from the enrollee and others as to the degree of independence to which the individual hopes to attain or retain, and the ways he/she intends to spend his or her time. Such quality-of-life information is essential in determining those services, that a managed care plan offers that can best assist the enrollee in meeting his/her goals.

Do not hesitate to contact Jeff Thom at 916-995-3967 if we can provide any assistance or answer any questions regarding our comments.

Respectfully,

Donna Pomerantz
President
California Council of the Blind

Jeff Thom
Chair, Governmental Affairs Committee
California Council of the Blind

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: California Dental Association
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20	Part B – Operational Steps, Timelines and Ke Milestones for Beneficiary Protection Provisions of CCI: Section (6) Medical and Social Needs	**(6) Medical and Social Needs** Dental, Vision and Home- and Community-Based (HCBS) Plan Benefits might be required benefits depending upon rate development. If these services are required, the scope of benefits will be described in the health plan contract. If they are not required, health plans may choose to offer these benefits. Health plans will be required to incorporate referrals to communit resources into their Models of Care and to provide other activities or services needed to assist beneficiaries in optimizing their health status. These services will be specified in the health plan contract requirements. Health plans will be required to use the most recent common procedur terminology (CPT) codes, modifiers and correct coding initiative edits.	The California Dental Association is pleased to see the Department of Health Care Services is considering requiring the inclusion of dental benefits in the plans available to the beneficiaries who will be included in this pilot project. Oral health is integral to overall health and is often an overlooked component of an older person' general health and wellbeing. Poor oral health contributes to systemic inflammation, negativel affecting other chronic diseases, such as diabetes, cardiovascular disease, and increases the risk for inhalation pneumonia for the frail elderly. Left untreated, dental decay can become severe enough to require costly emergency room treatment. In 2007 California's hospitals experienced over 83,000 emergency room visits for preventable dental problems at a cost of $55,000,000. In addition, oral health problems can cause pain and suffering a well as difficulty in speaking, chewing, and swallowing. Compromised chewing and

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			eating abilities directly affects nutritional intake, which may ultimately lead to low immune response; exacerbating or extending an illness. In addition, of particular relevance to the goals set forth in this pilot project, the effective treatment of systemic diseases can be complicated by oral bacterial infections if they go undetected or untreated. California has some of the highest rates of dental disease in the nation, with millions of residents with active, untreated disease. This pilot project may be designed to hel address this serious health concern. Therefore, we encourage the Administration to maintain its stron advocacy with the Center for Medicare and Medicaid Service in the development of the structure and funding mechanism for this project to ensure critical dental benefits are ultimately included services.

Comment Template for CCI Transition Plan
Due September 7, 2012

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To DHCS at Calduals.org,

California Health Advocates hereby submits written comments (attached) on the draft CCI Transition Plan. In addition to the attached comments on specific sections of the draft CCI Plan, we have the following general comments:

- An effective enrollment date of June 1, 2013 is very ambitious considering that the State is still developing policies, documents or procedures, as noted in several places in the draft CCI Plan.

- Has DHCS officially announced its decision to go with staggered or simultaneous enrollment process? It is not clear in the draft CCI Transition Plan. The timeline for a staggered enrollment process is even more ambitious since the first notice would have to go out December 2012.

- Policies and processes for MER and continuity of care have to be simple, clear, established in advance, and communicated consistently to health plans, providers, beneficiaries and other stakeholders. We cannot repeat the experience with SPD's transitioning into Medi-Cal managed care where continuity of care rules kept changing and the final rule was not disseminated to health plans until after the transition had started.

- Although the draft CCI Plan includes reaching out to providers, DHCS and other state agencies need to be persistent in engaging them. One complaint we heard from beneficiaries eligible for CBAS was that their providers said they can no longer treat CBAS participants.

- Outreach and education to beneficiaries are key. For the SPD transition, although the State scheduled information meetings for beneficiaries, the attendance was low. DHCS and other state agencies need to work with community-based organizations to reach beneficiaries, and this can be effective only if there is funding.

Thank you for the opportunity to submit these comments. We are available to answer any questions or discuss these comments further.

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Due September 7, 2012

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Contact Name: Elaine Wong Eakin
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6	**Introduction** Continuity of Care	Beneficiaries will be informed about their enrollment rights and options, plan benefits and rules, and care plan elements with sufficient time to make informed choices. This information will be delivered in a format and language accessible to enrollees.	Need to specify who will inform beneficiaries about their enrollment rights and options, plan benefits and rules, and care plan elements. If CA receives funding for options counseling, SHIP and ADRC would be the main programs but the State should also leverage other community resources for more personalized communication with beneficiaries. Furthermore, policies and processes for Medical Exemption Requests, continuity of care, and any disruptions in the provisions of DME and pharmaceuticals should be simple and clear.
7	**Health Plan Selection, Readiness, Contracts, and Oversight**	The State held a rigorous joint selection process with the Centers for Medicare and Medicaid Services (CMS) to identify health plans with the requisite qualifications and resources best suited to provide beneficiaries seamless access to an integrated set of benefits for the initial eight counties.	When will CMS make its determination regarding which plans it will approve for participation in the demonstration?
7	"	In addition, during the fall of 2012 the State and CMS will jointly assess each health plan's readiness using a jointly developed tool to ensure the plans will meet the operational requirements.	Will time allow all aspects of the readiness review to take place in the fall? Written readiness review criteria have not yet been shared with stakeholders for comment.
10	**State Administrative Background**	CDSS provides state-level oversight and fiscal services for the county-administered In-Home Supportive Services Program.	Doesn't CDSS also handle fair hearings for IHSS?
11	**PART A - ACCESS AND QUALITY OF SERVICE**	Note that DHCS and DMHC are collaborating to determine the applicability of state standards to services funded by the federal government.	What does this mean?
11	"	Medi-Cal Continuity of Care: Beneficiaries may, under specified conditions, have access	Policies and processes for Medical Exemption Requests and continuity of care should be simple and clear. Include

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		to out-of-network Medi-Cal providers for up to 12 months after enrollment. (W&I §14182.17 (d)(5)(G)).	stakeholders in establishing and reviewing draft policies and processes. Plans to communicate these policies and processes to beneficiaries must include SHIP and ADRC (if funding is approved) and other CBOs.
11	"	Medi-Cal Continuity of Care for Nursing Facility Care: For nursing facility care, managed care health plans will recognize any prior treatment authorization made by DHCS for at least six months after enrollment into the health plan. (W&I §14186.6 (c) (3))	The plan should also be required to provide aid paid pending if the individual appeals a denial of continued treatment after the prior treatment authorization period. Also, does this apply to both people in the demonstration and those only in Medi-Cal managed care?
11	"	Medicare Continuity of Care: Beneficiaries will have access to out-of-network Medicare providers for the first six months of enrollment. (W&I §14132.275 (l)(2)(A)	Please confirm that the 6-month limit applies only to duals who are enrolled in a demonstration plan (whether voluntarily or passively) and not duals who have opted out. How will duals be informed about this?
12	"	Health plans will maintain liaisons to coordinate access for out of network Medi-Cal providers, and to coordinate with regional centers. The continuity of care liaison will ensure provider access and a smooth transition for each beneficiary into the demonstration. (W&I §14182.17 (5)(F) and (G))	How many liaisons? Sounds like only one per plan? Policies and processes for Medical Exemption Requests and continuity of care should be simple and clear.
12	"	To further strengthen provider access, DHCS and CDPH are conducting a provider outreach workgroup and related activities to ensure that health care providers receive information about the CCI, and to document and address any concerns that they may have.	Outreach efforts to providers must be extensive and timely. Some providers may need to be approached several times.
13	**PART B - OPERATIONAL STEPS, TIMELINES AND**	The key operational steps to implement these provisions are listed below.	There is no reference here to getting Medicaid waiver approval as one of the operational steps. CMS plan approval is also not mentioned. Further it appears to us that Step (3) the Readiness Review

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	KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI		process should follow Step (4), the three-way contract.
13	"	A final confirmation letter will be sent to the beneficiary confirming his/her plan choice and the effective enrollment date.	What notice or letter to beneficiaries who did not choose a plan or opted out for Medicare benefits?
13	"	All notices will be released for stakeholder review at least 60 days prior to mailing to the beneficiaries.	Is this enough time to collect comments, then translate, print and mail?
13	"	All beneficiary notices and enrollment materials will require a reading proficiency no higher than sixth grade level and will be available in all the Medi-Cal threshold languages required under current state law, as well as in alternative formats, all of which are culturally, linguistically, and physically appropriate.	Suggest clarifying that, in addition to just being available, alternate format/language mailings will send to individuals whom Medi-Cal has already been identified as wanting particular languages or formats. In addition, the availability of alternate versions should be highlighted through prominent statements o the material and multilingual inserts.
13		For in-person enrollment, disability accommodation such as assistive listening systems, sign language interpreters, captioning, and written communication will be available.	Will interpreter services be provided without charge? Will health plans be required to provide such services to accommodate duals who need them?
14	Transition of Care for Part D Benefits	Through the readiness review process, CMS and the State will ensure that health plans have policies and procedures to address the effective transition of beneficiaries from Medicare Part D plans not participating in the demonstration.	What are the formulary requirements for demonstration plans? Same as for Medicare Part D plans per chap 6 of the Medicare Prescription Drug Benefit Manual? How will non-participating Medicare Part D plans be notified that these beneficiaries will be enrolling in demonstration plans?

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14	Outreach Plan:	Contingent on available funding, this plan will include contracting with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting beneficiaries in understanding their health care coverage options.	If funding is available for SHIP and ADRC to provide options counseling, when will these organizations be informed about the outreach and education program and receive specific info about each demonstration plan?
14	Health Plan Oversight for Enrollment Communication:	DHCS will ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures.	When will materials be ready? If funding is available, when will SHIP, ADRC and other CBO receive the materials?
14	"	Communication and services will be available in alternative formats that are culturally, linguistically, and physically appropriate through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language and written translations.	Add: Plans will be required to have measures in place to identify individuals wishing alternate materials and ensure that those individuals routinely receive materials in the formats they request.
14	"	The multi-tiered process will begin with health risk assessment of each beneficiary conducted upo enrollment.	How soon after enrollment will initial risk assessment take place? Where will risk assessment take place? If beneficiary has to go to provider's office or facility, will transportation be provided for those who need such assistance?
15	Initial Assessment Process	Care plans will be developed for beneficiaries that include member goals and preferences, measurable objectives and timetables to meet his or her medical, psychosocial and long-term support needs that are identified in a comprehensive risk assessment.	When will the comprehensive risk assessment be done?
15	Initial Assessment	In addition, California's health plans will use promising practices, such as repeated attempts to gather assessment information via various modes	Beneficiary orientation o how managed care works in general and how demonstration plan works specifically would help beneficiaries adopt a different mindset (than

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	Process	(phone, mail, interactive voice by phone) and web-based care planning tools that allow providers and beneficiaries to view and add to the care plan.	FFS) and use the resources available.
16	The Interdisciplinary Care Team	For individuals identified as needing such care management, the ICT functions will include assessment, care planning, service authorization, coordinating delivery of needed services (plan covered Medicare/Medi-Cal benefits or other community resources), monitoring health status and service delivery.	California's proposal to CMS seems to imply that an ICT could be available to anyone who wished to have one, not just those identified as needing care management.
16	Composition and leadership of ICT	ICTs will include trained care managers or health navigators, and other health care professionals such as RNs and Licensed Social Workers, and the members' primary care physicians as the core team members	How to ensure retention of ICT members and prevent frequent turn-over?
17	Composition and leadership of the ICT	In keeping with the "person-centered" goals of the demonstration, when possible the member will be a major factor when deciding the make-up and direction of the ICT.	Change to: " . . . when possible the member will decide the make-up and direction of the ICT."
17	"	Health plans will also develop care plans to successfully transition beneficiaries into the community to the extent possible without jeopardizing the safety, health and welfare of the beneficiary.	Require health plans to connect/contract with community resources.
17	"	The State expects plans to designate individuals with experience working with seniors and persons with disabilities to lead the care management effort.	Emphasis on experience with LTSS is missing.
18	**(5) Network Adequacy**	State Medicaid network standards shall be utilized for LTSS and the prescription drugs covered by	Since the goal is alignment and to integrate care, why not use the higher standard for all benefits whether Medicare

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		Medicaid which are excluded from Medicare Part D. Medicare network standards shall be used for Medicare prescription drugs and other services for which Medicare is the primary coverage. Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards.	or Medicaid? This would remove the necessity for the State to show that State standards are at least as stringent and beneficiary-friendly as Medicare standards.
18	“	Provider networks will be subject to confirmation through Demonstration plan readiness reviews in October and November 2012.	How does this coordinate with national readiness tools being developed by CMS? Also need opportunity for stakeholder review of tool.
19	In-Home Supportive Services	Demonstration plans may contract with other agencies to provide emergency backup personal care services, or in cases where a beneficiary cannot find a provider, for so long as such agencies are certified by the California Department of Social Services.	This contracting for back up services should be required, not optional.
19	Nursing facility:	Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility.	Although the Department at a listening session provided assurances that plans had no intention to move long-term nursing home residents, even if their facility did not join a network, these assurances should be spelled out as requirements. Add a sentence as follows: If a beneficiary wishes to continue to reside in an out-of-network facility, the plan must make provisions, such as a single-case agreement, that allows the beneficiary to stay in place, absent documented health or safety concerns.
20	DME	The state will require that health plans contract with a sufficient number of providers of durable	Clarify “sufficient.” Since DME is a Medicare benefit, must demonstration plans

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		medical equipment.	comply with the Competitive Bidding Program in CBAs?
20	**Grievance and Appeals Process**	The unified process will not be more restrictive than the current Medi-Cal process, and might initially be combined with the Medi-Cal and Medicare process for health plan review of appeals, while maintaining the beneficiary option to use other current federal and state avenues for appeals.	There is no reference to the availability of aid paid pending during the first level of appeal.
21	"	The grievance and appeals process for prescription drugs under Medicare Part D remains the same, and requires beneficiaries to coordinate with their health plan and CMS.	Please confirm that the process is the same as provided in chap 18 of the Medicare Prescription Drug Benefit Manual, including allowing prescribers to request a reconsideration on beneficiary's behalf without obtaining an appointed representative form, or file appeal with the Independent Review Entity.
21	"	DMHC and DHCS will submit an annual joint report on financial audits performed on health plans.	To whom will the reports be submitted? Will they be made public?
21	"	In conjunction with the demonstration evaluation efforts, DHCS and CDSS will monitor the utilization of medical services and LTSS (including IHSS), and will identify and share any significant changes in aggregate or average utilization among beneficiaries participating in the demonstration or the CCI.	This is a very important and useful element. Add CMS? Also, with whom will changes be shared? Will the info be made public? Missing from this list is a mechanism for real time identification of problems in service delivery.
21	**Local Stakeholder Advisory Groups Established by**	As noted below, all health plans have already met with local stakeholders, and most have established ongoing stakeholder advisory groups.	Which plans do not yet have advisory groups?

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	Health Plans		
22	Hospital and Provider Groups:	Health plans throughout the state have convened advisory committee and town hall meetings with hospitals and provider groups.	All health plans have met with such groups?
22	Stakeholder Workgroups	Health plans have conducted workgroup meetings with a broad spectrum of community advocates and LTSS providers to engage them in the duals planning process.	All health plans?
22	County Collaboration	Health plans have ongoing meetings with county social service agencies and local public authorities.	All health plans?
22	LTC Facility Outreach	Health plans have been meeting with the California Association of Health Facilities, as well as individual facilities, to further establish a dialogue on long-term services and supports for dual eligible and Medi-Cal only beneficiaries.	All health plans?
24	8. Develop Enrollment Process	Finalize enrollment phase-in process and timeline (August 30, 2012)	The State proposed a staggered enrollment process and a simultaneous enrollment process, and seemed to lean in favor of staggered. Has a final decision been made?
24	9. Develop Beneficiary notices	Share beneficiary Notices and Enrollment materials with Stakeholders (September -October, 2012) Maximus finalize notices and program into systems—including translations (November 2012)	Will stakeholders see draft Notices and Enrollment materials in English only and not the translations?
24	"	Begin initial notification mailings for December notices (November 20, 2012)	Do December mailings mean that the State has decided to use the staggered enrollment process?

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25	10. Prepare Beneficiary and Provider Outreach and Education Plan:	• Conduct outreach activities (webinars, forums, presentations, etc.) (November 2012 – June 2013)	Outreach will need to continue as long as duals have to make a choice: choose a demonstration plan, opt out for Medicare benefits, or choose PACE.
25	13. Determine Supplemental Benefits Policy	Develop draft guidelines for the scope, duration, and intensity of HCBS Plan Benefits and share with stakeholders (August - September 2012)	When will stakeholders see draft guidelines?
25	14. Amend 1115 Waiver	DHCS will determine which changes are necessary to the Waiver (August 2012)	Has this happened? When will the information be made public? Has DHCS submitted a waiver request or begun waiver negotiations with CMS?
26	18. Plan and Complete IT System Changes	All	Does this schedule allow adequate time to test the systems?
27-28	**PART C – PROCESS FOR ADDRESSING CONSUMER COMPLAINTS**	The State currently has several avenues for receiving beneficiary complaints about managed care health plans.	This section does not respond to the requirement of SB 1008. It does not describe the ombudsman function envisioned for the demonstration and it does not describe how the roles and responsibilities of existing complaint mechanisms will be coordinated. Further, it does not discuss how the state will respond to the statutory requirement for "a 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints."

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11	Part A: Network Adequacy Reviews	"For Medicare benefits, CMS has reviewed health plan networks and ensured they meet Medicare Advantage adequacy standards."	**CHA urges CMS and DHCS to provide the documentation in support of the conclusion noted to the left that finds that current networks are adequate. In particular we would like to see that broken down by health plan and county.** CHA remains concerned that narrow networks will be implemented and beneficiaries will lose access to their primary and specialty providers after the continuity of care provisions are no longer in place. CHA members report that currently many plans will be using their existing networks rather than expanding them to meet the needs of this vulnerable population. These decisions will likely force Medicare beneficiaries to either change providers or opt out of the demonstration – neither of which is optimal. More must be done to expand existing networks to preserve access to care for this vulnerable population. CHA urges DHCS and CMS to ensure that health plan networks are adequate for services that may not be addressed in existing Medicare Advantage (MA) standards, such as standards for long term care services and supports (LTSS) and services for mental health and substance use disorders. For example, long term residential care in a skilled nursing facility is presently reimbursed on a fee-for-service basis ; MA and Medi-Cal managed care plans have not needed to have extended networks of skilled nursing facilities. While we support the general guidelines included in the draft standard for LTSS, we note that they do not include clear benchmarks for assessing the number of providers relative to the population served, or to ensure that the network includes the various types of providers that will be required (i.e., suabacute care, availability of dialysis, etc) to care for this medically complex and vulnerable population.
12	Part A	To further strengthen provider access, DHCS and CDPH are conducting a provider outreach workgroup and related activities to ensure that health care providers receive information about the CCI, and to document and address any concerns that	**CHA urges DHCS and CMS to more actively engage hospitals and health systems in joint conversations with health plans regarding enrollment and outreach as well as network adequacy and beneficiary protections that remain of great concern to hospitals.** These conversations are key and must have all three parties at the table to ensure accountability and continued dialogue. These conversations should take place before the Memorandum of Understanding is finalized.

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		they may have. Provider engagement and participation in health plan networks is a key component of maintaining access for beneficiaries.	
12	Part A	DHCS, CHS and DMHC are currently reviewing responsibility for monitoring compliance with state and federal timely-access provisions. DMHC recently promulgated regulations regarding Timely Access to Non-Emergency Health Care Services (California Code of Regulations Section 1300.67.2.2). DHCS and DMHC are reviewing the applicability of the regulation to the Duals Demonstration Project.	As part of the transition plan, CHA urges DHCS to provide a timeline for evaluation and discussion of these provisions so that current transition plan has a set of concrete follow up steps and a timeline in which additional information will be provided.
13	Enrollment and Notification Strategy	NA	This section does not address how enrollment and communication will occur with beneficiaries currently housed in institutions such as hospital based skilled nursing facilities or long term acute care hospitals in which a patient may exceed any 90 day period. Further, there is no detailed plan for hospital and other provider education and engagement. **DHCS should move quickly to add language to the transition plan that addresses these critical issues.**
16	Care Coordination	DHCS is currently developing care coordination standards for the health plans	CHA seeks to provide input and to comment on the care coordination standards as they are developed. This process is not outlined as part of the current transition plan timeline. Health plans are not the only responsible party for care coordination. The ability of care providers such as hospitals to interact with and work with care coordination teams and to manage transitions of care will be essential to the success of the initiative and improved health outcomes for patients. This should be a high priority for DHCS and we look forward to work to craft those guidelines.
18	5) Network Adequacy	Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be	We ask that DHCS provide the standards for review and public comment and to demonstrate how it plans to show each standard meets the appropriate criteria. The level of specificity in this document should be strengthened so that there is clear understanding of the metrics used to make the network adequacy determinations

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		subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards.	across the board. Further, if the plan fails on those specified metrics DHCS should also document what corrective actions must be undertaken and in what timeline to address these failures. **CHA urges that this level of detail be provided in the transition plan for greater clarity.**
19	Nursing Facility	Nursing facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care. Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility. Demonstration plan's contracted facilities will be located in zip code areas covered by the Demonstration and, to the extent possible, in adjacent zip code areas.	**Many SNF providers do not currently contract under managed care and additional work must be done to ensure that these services remain available to Medicare beneficiaries.** In particular, the critical role of the hospital based SNF should not be overlooked when reviewing the network of providers. These providers are currently caring for the most complex patients and are essential to the fabric of a coordinated care system. The current Medi-Cal rate structure recognizes the unique role of hospital based skilled nursing providers, and consequently reimburses hospital based distinct part SNFs at higher levels than free-standing nursing facilities. While present DP/NF rates are already well below the cost of care provided, we urge DHCS and CMs to ensure that rates for care provided in hospital based skilled nursing facilities continue to support the unique role these facilities serve in the continuum of care, and do not erode further.
20	(7) Grievance and Appeals Process	The unified process will not be more restrictive than the current Medi-Cal process, and might initially be combined with the Medi-Cal and Medicare process for health plan review of appeals, while maintaining the beneficiary option to use other current federal and state avenues for appeals. The unified process will be reviewed with stakeholders and will be communicated to beneficiaries and providers.	Please provide in the transition plan the timeline for when this discussion will occur with stakeholders as it is critical for maintain access to Medicare benefits for Medicare beneficiaries. This is not noted in any of the timeline information
28	PART C – PROCESS FOR ADDRESSING CONSUMER	NA	This section does not currently reflect provider and stakeholder input regarding patient complaints and appeals and we urge DHCS and CMS to go back to this section and make several revisions including but not limited to the following.

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	COMPLAINTS		1) **DHCS and CMS must ensure that dual eligible beneficiaries have access to an effective "real-time" appeals process to resolve care denials.** The appeals process for hospital discharge/transition to a post-acute setting should be completed **within 48 hours**. The current 3 day timeline specified in the transition document is not sufficient and must be revised. The ability to access the appropriate level of care in the days and weeks following an acute hospitalization is an important factor in beneficiaries' ultimate success in transitioning back to home and community. Additionally, appropriate post-acute care will reduce readmissions and reduce health care costs. 2) **Health plans should be prohibited from transferring the patient until an appeal decision is rendered, and should be required to continue to be financially responsible for the patient's care pending the results of the appeal.** 3) **Providers should not be prohibited from assisting beneficiaries with appeals and should be able to advocate on their behalf in particular in a situation where the patient is unable to take action due to physical or cognitive impairments.** **On page 28 it notes, "**In certain cases, beneficiaries may request an independent medical review as part of their complaint filing process." DHCS has not detailed what would allow for an independent review and further has not shared who would be the independent reviewer. CHA remains concerned that the plan will be incentivized to provide the lowest level of care at the lowest cost, which may not result in the best outcomes. Without adequate, timely and clear processes for care denials to be addressed by an independent reviewer, Medicare beneficiaries will have limited access and providers will remain financially responsible for providing the right care at the right time.

California Medical Association
Physicians dedicated to the health of Californians

September 7, 2012

Mr. Toby Douglas
Director, Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Mr. Douglas:

On behalf of the 35,000 physician and medical student members of the California Medical Association (CMA), thank you for the opportunity to comment on the Programmatic Transition Plan related to the Coordinated Care Initiative.

Although CMA remains concerned about the size and scope of the proposed project, we appreciate the amount of time and effort that DHCS has invested in working with stakeholders to understand and address our concerns.

With that in mind, we respectfully offer the following comments:

1. **Network Adequacy Requirements (Pages 11-12, 18).**

There is possibly no issue of greater concern to CMA than the adequacy of provider networks in the plans that will be covering the dual eligibles. Without adequate provider networks, the plans will be offering dual eligibles an insurance card without true access to care.

CMA appreciates the language in both Senate Bill 1008 and the transition plan about ensuring that plans have robust provider networks. However, CMA must request that, when DHCS and the Centers for Medicare and Medicaid Services are assessing the plan networks, they do so with an eye toward the unique needs of dual eligible patients in a state as large and diverse as California.

Dual eligibles are among the most vulnerable patient populations, and many were uninsured prior to their enrollment in Medicare. It is likely that the plans will need more and different physicians than they contract with for other groups of patients.

Furthermore, CMA continues to be concerned about whether staffing levels at the Department of Managed Health Care (DMHC) and in the Medi-Cal Managed Care Division are sufficient to allow them to perform the needed oversight. Despite the fact that both departments received a modest increase in staff in the 2012-13 State Budget, they are being asked to take on a tremendous number of new tasks. They will be reviewing for adequacy of both medical provider networks, as well as long-term services

and support (LTSS) networks that have not been assessed previously. CMA renews our call for both DHCS and DMHC to perform a complete review of staff levels, to ensure that both departments have enough staff and staff with the right expertise.

Finally, CMA notes that nothing in this plan mentions plans contracting with solo and small practice physicians, as required in SB 1008. CMA views this as an important beneficiary protection, since many dual eligible patients will come into the project with existing physician-patient relationships. The plans must do everything possible to ensure that traditional Medicare providers are included in their networks.

2. Beneficiary and Provider Notices (Pages 13-14)

CMA strongly supports your intent to provide beneficiaries with multiple notices in their primary language, and to provide these notices to physicians before they are mailed. This latter provision will help physicians to aid their patients in selecting the right plan.

We would ask that the Department plan to begin notifying physicians and patients immediately upon the completion of the MOU, as opposed to only 60 and 30 days ahead of enrollment. There is already a large amount of misinformation "on the street" regarding this project. And, as we have discussed with your staff, the confusion is being exacerbated by the ongoing community-based adult services (CBAS) transition, which affects largely the same population.

CMA is more than happy to work with you on building an effective communication strategy for reaching Medicare provider physicians, as we are on the upcoming webinars regarding the CBAS transition.

3. Interdisciplinary Care Teams (Pages 15-19)

The concept of the Interdisciplinary Care Team (ICT) shares many characteristics with the patient-centered medical home (PCMH) model supported by CMA and many other provider organizations. If done correctly, the ICT could provide vulnerable patients with highly integrated quality care.

CMA is concerned about how undefined the proposal for the ICTs is in this plan. There are many questions that need to be answered regarding the proposal, including: Will the state be able to assist small practice providers with technical and infrastructure needs to allow them to participate in an ICT? How will providers be compensated for the extra time and effort required to provide the increased level of service envisioned? Will the primacy of physicians in medical decision making be maintained?

CMA requests that the Department convene stakeholder meetings, including representatives from the health plans, specifically to discuss this concept. We believe we could work through many concerns through open discussion, and develop a model that works for providers and patients.

Furthermore, any ICT proposal must ensure the primacy of the physician in medical decision making, in accordance with the state's scope of practice laws. While mid-level practitioners can be important parts of a functioning care team, it is only the physician who has been trained to assess all of patient's health needs.

4. **Memorandum of Understanding (Page 24)**

Many of the physician and patient protections that were written into SB 1008 were, of necessity, made subject to federal approval. This will make the memorandum of understanding between the state and CMS an incredibly important document for everyone involved with this project.

It raises some degree of concern among stakeholders that the MOU will be negotiated in private, and only released after it is signed. This raises the possibility of technical errors or other problems that will be difficult to correct after the fact. An undertaking as ambitious as this project can only benefit from more involvement by the public.

CMA thus requests that DHCS request permission from CMS to release a draft MOU at least two weeks prior to it being fully executed. This will give stakeholders time to review the document and guarantee that it aligns with the intent of the legislature and those who negotiated with the state in good faith.

Conclusion

Thank you again for the opportunity to comment on the draft plan. CMA looks forward to working with you in the future to make this demonstration successful for patients and their physicians.

Sincerely,

David Ford
Associate Director, Medical and Regulatory Policy

Comment Template for CCI Transition Plan Organization: California Medical Transportation Association
Due September 7, 2012 Contact Name: William E. Barnaby
E-Mail: wbarnaby@wbarnaby.com

Page	Section Title	Existing Text	Comment or Suggested Edit
20	(5) Network Adequacy	*The State will require that health plans ensure that each health plan has nonemergency, accessible medical transportation available in sufficient supply and so that individuals have timely access to scheduled and unscheduled medical care appointments.*	*"Network adequacy of nonemergency medical transportation (NEMT) should not rely solely upon services arranged by brokers, but will be enhanced if all enrolled NEMT providers are able to render services to beneficiaries. Traditionally enrolled providers have established relationships with some of the most chronically ill beneficiaries plus proven experience in working within Medi-Cal rules."*

Comment Template for CCI Transition Plan Organization: CMHPC – Health Care Reform Committee
Due September 7, 2012 Contact Name: Narkesia Swanigan
E-Mail: Narkesia.Swanigan@dsh.ca.gov

Page	Section Title	Existing Text	Comment or Suggested Edit
14	Enrollment and notification strategy	DHCS is working with the enrollment contractor, Maximus, to clarify the process for authorizing legal representatives, such as a caregiver, family member, conservator, or a legal services advocate, to communicate with the contractor …	DHCS will ensure that residential community programs working with seriously mentally ill persons be included in all beneficiary education efforts, including offering format in which those providers can discuss helpful strategies.
6	Introduction – Coordinated Care Initiative, second bullet	*Person-Centered Care Coordination.* Health plans will be responsible for providing seamless access to networks of providers across this broader continuum of care, as well as upholding strong beneficiary protections established by the state through the stakeholder process. The model of care will include person-centered care coordination supported by interdisciplinary care teams.	For persons with serious mental illness the model of care will incorporate the lessons learned from the Mental Health Services Act and will include the core components of cultural competence, recovery and wellness focus, consumer driven care and integrated service experiences for clients and families

Comment Template for CCI Transition Plan Organization: California Optometric Association

Due September 7, 2012 Contact Name: Jason Gabhart

E-Mail: jgabhart@coavision.org

Page	Section Title	Existing Text	Comment or Suggested Edit
Entire Document	All Sections	All Text	The California Optometric Association (COA) would like to extend our appreciation for the opportunity to comment on the Draft Transition Plan, which would automatically enroll full benefit Medicare and Medi-Cal dual eligible beneficiaries into managed care health plans in eight selected California counties. The COA supports any attempt to improve the quality of beneficiaries' care, while at the same time reducing costs; however, we have concerns with the latest proposal. COA believes that the disruption to patient care that will result from the automatic enrollment in the proposal will be harmful to beneficiaries given the fact that the population is comprised of the most vulnerable seniors and disabled. A "passive" enrollment process, in which a beneficiary is automatically enrolled, limits patient choice, disrupts current patient directed provider relationships, all without providing a reasonable alternative for beneficiaries to maintain and actively participate in their own healthcare. Patients and providers already have difficult time navigating the complex healthcare system, and California's proposal will only add to that difficulty. Furthermore, managed care does not always correlate with coordinated care due to many health plans having inadequate provider networks. Because these plans usually have network requirements, beneficiaries who have been moved to Medicare Advantage plans from fee-for-service arrangements in the past have had to change providers, which interrupts longstanding relationships and treatments. This is particularly disruptive to dual eligible beneficiaries, who often have multiple, complicated medical conditions. Additionally, coordination of care will also be interrupted because managed care plans also often use prior authorization and other utilization management techniques that beneficiaries will have difficulty navigating, which will limit access to needed care. In addition to our opposition to the "passive" enrollment process, COA believes that a beneficiary should have the right to opt out of their assigned managed care plan at any time, instead of the six-month stable enrollment period included in the proposal. Since the beneficiary will not have chosen the health plan in the first instance, we do not believe that it is fair to require them to remain in that plan if they are dissatisfied prior to expiration of the six-month period. At a minimum, should the proposal be approved, COA requests that the six-month stable enrollment period be removed and allow beneficiary to move to different plan, or opt out of the demonstration project entirely, at any given time. We respectfully ask that DHCS consider the impact that California's proposal will have o Medicare and Medi-Cal dual eligible beneficiaries, as we believe that the proposal will be harmful to the beneficiaries that are automatically enrolled. While we understand that the state is looking for ways to save health care costs, we do not agree that disrupting beneficiaries' care is the solution.

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California Podiatric Medical Association Comments September 6, 2012

Regarding: Programmatic Transition Plan
Coordinated Care Initiative Beneficiary Protections
Submitted by the Department of Health Care Services
In Partial Fulfillment of Requirements of Senate Bill 1008
(Chapter 33, Statutes of 2012)

Thank you for the opportunity to comment on the latest CCI transition plan. We have quoted the DHCS document and posted our comment below each quoted section.

> *"Executive Summary: In addition, during the fall of 2012 the State and CMS will jointly assess each health plan's readiness using a jointly developed tool to ensure the plans will meet the operational requirements. Oversight of the health plans to ensure contract compliance for the demonstration will be carried out by a joint CMS-State contract management team."*

We appreciate that assessment of readiness and ongoing oversight are included in this transition plan. The results of ongoing oversight should be available to beneficiaries and providers so that informed choices as to ongoing participation can be made.

> *"Part A: Note that DHCS and DMHC are collaborating to determine the applicability of state standards to services funded by the federal government."*

It is very important that providers are aware of any deviation under the CCI from expected service and funding coverage under Medicare. Clear understanding by patients and providers will help to ensure proper access and benefit patients.

> *"To further strengthen provider access, DHCS and CDPH are conducting a provider outreach workgroup and related activities to ensure that health care providers receive information about the CCI, and to document and address any concerns that they may have. Provider engagement and participation in health plan networks is a key component of maintaining access for beneficiaries."*

We agree that all providers should have information about all aspects of the CCI. Participation by the California Podiatric Medical Association, representing physician providers of foot and ankle care under Medicare, would benefit this provider workgroup. We are specifically expert in timeliness and access issues, and how those affect patient outcomes and healthcare costs.

> *"Part B: Enrollment and Notification Strategy"*

It is important that options and beneficiary rights be included in the informing and reminder notices.

"(3) Primary Care Physician Assignment

This section of SB 1008 addresses primary care physician assignment for dual eligible beneficiaries not enrolled in the demonstration, by requiring Medi-Cal health plans to:

1) Not interfere with a beneficiary's primary care physician choice under Medicare;

2) Not assign a full-benefit dual-eligible beneficiary to a primary care physician except for specified circumstances"

These beneficiary rights and options should also be clearly stated on any enrollment notices or materials.

"DHCS is working with the enrollment contractor, Maximus, to clarify the process for authorizing legal representatives, such as a caregiver, family member, conservator, or a legal services advocate, to communicate with the contractor on enrollment issues and make elections on the beneficiary's behalf when necessary and appropriate."

Whenever a beneficiary is enrolled by a legal representative or primary care provider, there should be an exception to any (if any) stable enrollment period authorized by CMS. There are numerous documented instances of misunderstanding on behalf of beneficiaries in these cases. Patients would be protected by allowing immediate disenrollment in the case that they were enrolled against their wishes.

We applaud the ongoing development of outreach plans, communication plans and oversight plans. We look forward to working with DHCS and DMHC to achieve the best final product.

We remain concerned about the proposed implementation timeline considering that the joint CMS/State of California assessments have not yet been completed, the communication plans are not completed, and the in depth assessment of each beneficiary which is required. We believe further serious consideration to a delay in implementation is warranted.

"PART C – PROCESS FOR ADDRESSING CONSUMER COMPLAINTS"

In the interest of beneficiaries, CPMA urges a requirement that the 24 hour hotline for patient treatment issues and complaints be adequately staffed and consist of multilingual services.

In conclusion, we remain concerned about the proposed implementation timeline considering that the joint CMS/State of California assessments have not yet been completed, the communication plans are not yet completed, and the time it will take for the in depth assessment of each beneficiary which is required. We believe further serious consideration to a delay in implementation is warranted.

We look forward to ongoing participation in clarifying this CCI initiative.

Sincerely,

Karen L. Wrubel, DPM
President, California Podiatric Medical Association
drkw@cox.net
(310) 702-8447

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: California Primary Care Association
Contact Name: Vanessa R. Saavedra
E-Mail: vsaavedra@cpca.org

Page	Section Title	Existing Text	Comment or Suggested Edit
15	(3) Primary Care Physician Assignment	"DHCS will ensure that [the provisions of SB 100 related to primary care physician assignment for partial-benefit dual eligible beneficiaries] are incorporated into the contracts… and will monitor and enforce these contract provisions."	It is critical for continuity of care that the plan not inadvertently assign beneficiaries to physicians or clinics that d not provide the kinds of services required by the patients (e.g., assigning an adult beneficiary to pediatric clinic), as occurred with auto-assignment of the SPD population in that demonstration. DHCS should specifically include in its contracts a requirement that plans must have a way of ensuring appropriateness of assignments.
18	Behavioral Health Care Coordination	"…the readiness review process will require health plans to provide policies and procedures for joint care coordination between health plans and behavioral health agencies and providers."	Coordination of behavioral health care, especially at lower levels, requires the inclusion of primary care providers, as well. The readiness review process should also require health plans to provide policies and procedures for integrating behavioral health care into overall care management.
18	(5) Network Adequacy	"Provider networks will be subject to confirmation through Demonstration plan readiness reviews in October and November 2012, including the following…"	Omitted from the listed network confirmation reviews is safety net provider contracting, required by W&I Code Sec. 14182.17(d)(5)(E). Pursuant to that section, plans "shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area. Suggest including language as follows: "Safety Net providers: Demonstration plans must contract with and assign patients to willing safety net providers in the covered zip code areas and, to the extent possible, in the adjacent zip code areas."
21	(8) Monitor Health Plan Performance and Accountability…	"The State and CMS will jointly: 1) review the health plan's provider network to ensure an adequate number of providers are available to beneficiaries"	Fails to specify that provider network must include safety net providers. Suggest language as follows: "The State and CMS will jointly: 1) review the health plan's provider network to ensure an adequate number of providers, *including safety net providers,* are available to beneficiaries"

Comment Template for CCI Transition Plan
Due September 7, 201

Organization: CA Rural Health Association
Contact Name: Al Hernandez-Santana
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Page	Section Title	Existing Text	Comment or Suggested Edit
p. 16	The Interdisciplinary Care Team	In keeping with the goals of the Demonstration, plans will promote and encourage a ICT that is both sustainable and person- and family-centered. This means getting the member, to the extent possible, directly involved in their care delivery. If the member agrees, immediate family or authorized representatives can also be members of the ICT.	In keeping with the goals of the Demonstration, plans will promote and encourage a ICT that is both sustainable, culturally competent, and person- and family-centered. This means getting the member, to the extent possible, directly involved in their care delivery. If the member agrees, immediate family or authorized representatives (including, but not limited to language interpreters) can also be members of the ICT.
p. 16	Composition and leadership of the ICT	To coordinate the care of members residing in the community, ICTs will include trained care managers or health navigators, and other health care professionals such as RNs and Licensed Social Workers, and the members' primary care physicians as the core team members.	ADD sentence: To the extent feasible, if the member is identified as deaf or limited-English speaker, health navigators or care managers certified in sign language and with proficiency in the relevant non-English language will be matched with the member's dominant language. [Comment - The addition of the lic social worker is a new essential component of the team composition. In the past social services were seen outside of health focused care coordination and are here an essential member, just like they have been added to the primary care patient centered health home concept for preventative care.]
p. 20		For the demonstration, the grievance and	COMMENT: This paragraph remains vague and

Page	Section Title	Existing Text	Comment or Suggested Edit
	(7) Grievance and Appeal Process	appeals process is jointly managed by the State of California, County Social Services Agencies, and the Center for Medicare and Medicaid Services (CMS). The unified process will not be more restrictive than the current Medi-Cal process, and might initially be combined with the Medi-Cal and Medicare process for health plan review of appeals, while maintaining the beneficiary option to use other current federal and state avenues for appeals. The unified process will be reviewed with stakeholders and will be communicated to beneficiaries and providers.	may cause more confusion than clarity.
pp. 14 and 42	Initial Assessment Process and Appendix F	Bottom of p. 14, The multi-tiered process will begin with a health risk assessment of each beneficiary *conducted upon enrollment.* On p. 42, para. (2)(A): The risk assessment process shall be performed in accordance with all applicable federal and state laws.	The text is silent on whether the Medicare 90-day requirement to conduct assessments will remain. Or whether the alternate std. discussed on the call, 45 days for high risk beneficiaries and 105 days for low risk, will be the new benchmark. The Plan ought to specify whichever standard applies, or at the very least state that it will be completed "in accordance with time limits set by the department or MOU."
pp. 18 and 43	Behavioral Health Care Coordination	Top of p. 18, ...the readiness review process will require health plans to provide policies and procedures for joint care coordination between health plans and behavioral health agencies & providers.	The statutory protection referenced here and other parts demands close coordination with county mental health. Therefore more detail should be included in the lone paragraph on page 18. We've heard complaints from health

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Organization: CA Rural Health Association
Contact Name: Al Hernandez-Santana
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	and Appendix F	On paragraph (G), Assesses each new enrollees behavioral health needs and historical utilization, including mental health and substance use disorder treatment services.	plans under the SPD transition, that although department(s) have utilization data on drugs and MH services, often times it is not forwarded to the plan in a timely way or is lost due to no-match or system's errors. This information is crucial for competent assessment, and therefore it calls for a more in-depth discussion in the Initial Assessment section, or instead allow for safeguards or corrective action before nailing down final Care Coordination. For instance, ADD on page 18: Policies and procedures for joint care coordination shall include the authentication of up-to-date utilization data of substance abuse and mental health services received in the 12 months prior to enrollment.
p. 43	Appendix F	On paragraph (H), Follows timeframes for reassessment and, if necessary... conditions that require redetermination of risk level, which shall be set by the department.	The statutory CCI beneficiary protection necessitates that the Plan include some mention or explanation of redetermination procedures. INSERT new section after end of (4) Care Coordination on p. 18, or after (2) Initial Assessment on pp. 14-15.

Page	Section Title	Existing Text	Comment or Suggested Edit
7	Transparency	"…will require proof of on-going stakeholder involvement at the local level that includes, at a minimum: a process for gathering ongoing feedback from beneficiaries…	Add language here about engaging members directly when we don't have "plan" or "marketing" approval from CMS
8	Health Plan Selection, Readiness, Contracts and Oversight	"In addition, Medi-Cal contracts between the state and health plans will be amended to reflect the LTSS and other provisions of SB 1008 for dual eligible beneficiaries that do not participate in the demonstration and Medi-Cal only beneficiaries."	Add any required activities and contract amendment timing to the Major Milestones and Timelines for 2012 – 2013 document. Provide draft language as soon as possible.
11	Access and Quality of Service	"Medicare Continuity of Care: Beneficiaries will have access to out-of-network providers for the first six months of enrollment."	Please clarify if and how this provision will be impacted if CMS does not approve the six month stable enrollment period. Additionally, please identify any other components of the CCI that will be impacted if the six month stable enrollment period is not approved.
11	Access and Quality of Service	"For Medi-Cal LTSS benefits, DHCS will review health plan networks in fall of 2012, as part of the readiness process, to ensure plans met the State's newly established LTSS network adequacy standards."	Please specify the network adequacy standards for DME and non-emergency medical transportation providers.
12	Access and Quality of Services	DHCS will develop descriptions of continuity of care rights in all threshold languages…	Confirm which languages will be considered threshold for Long Term Services and Supports (LTSS) integration and for Duals (are they different)?

Page	Section Title	Existing Text	Comment or Suggested Edit
13	Enrollment and Notification Strategy	"The standard notification process will be based on a 12 month enrollment schedule for the two-plan and GMC plan types."	Please provide guidance on the notification process for both the transition of additional LTSS into Medi-Cal managed care and enrollment into the Demonstration in County Organized Health System (COHS) counties.
19	Community Based Adult Services (CBAS)	"Demonstration plans must contract with all willing, licensed, and certified CBAS centers, with encumbering citations that are located in the covered zip code areas and in adjacent zip code areas, not more than 60 minutes driving time away from the eligible individual's residence."	Does this apply to all CBAS facilities in zip codes adjacent to Orange County, which are not more than 60 minute drive from beneficiary residence or only those facilities currently serving members?
24	Key Milestones and Timelines	"Draft enrollment process and timelines (Completed July 2012)	Confirm whether eligibility files will be consolidated and made available through DHCS or separately available through CMS for Medicare and DHCS for Medi-Cal.
25	Key Milestones and Timelines	"By February 2013, implement fully executed Managed Care Health Plan Contracts."	Please clarify which contract DHCS is referring to in this statements; the Medi-Cal managed care contract or the three-way contract for the Duals Demonstration. If the latter, this is two months later than the date communicated to health plans by DHCS. Please clarify the impact this date change will have on the timing of the readiness assessment.
26	Key Milestones and Timelines	"Ensure health plan and county MOUs are in place prior to initial enrollment."	Please clarify timing for execution of LTSS/IHSS MOU; as draft readiness assessment tool requires MOU. (Also, same question with respect to any changes to other LTSS contracts)

Page	Section Title	Existing Text	Comment or Suggested Edit
27	Key Milestones and Timelines	"Develop draft qualify withhold measures and unified quality metrics (August 10, 2012"	Please provide the draft measures and metrics for review.
28	Part C Process for Addressing Consumer Complaints	For complaints concerning services delivered by IHSS provider, county social services offices or public authority are responsible for responding to the beneficiary	What is the complaint resolution process for hours authorized by plan beyond those authorized by SSA? If plan contracts with a qualified agency, rather than a provider hired by beneficiary through the IHSS registry, to provide emergency services, what is the complaint resolution process?
33	Appendix A, CCI Timeline	N/A	The dates in this timeline are not consistent with the dates provided in the transition plan. Please update the timeline, and ensure that the most recent is posted on calduals.org, to reflect the proposed dates. -- Confirm eligibility confirmed only through DHCS. We had previously understood that we would have to validate eligibility through both CMS and DHCS

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Due September 7, 2012

Organization:
Contact Name:
E-Mail:

Page	Section Title	Existing Text	Comment or Suggested Edit
Page 11	Part A – Access and Quality of Service	SB 100 requirement: A description of how access and quality of service shall be maintained during and immediately after implementation of these provisions, in order to prevent unnecessary disruption of services to beneficiaries. The provisions below will allow beneficiaries to maintain continued access to providers and services during and after implementation of the CCI.	The Coalition for Compassionate Care of California (CCCC) encourages DHSC and DMHC to go beyond thinking about how to maintain the status quo. The CCI presents an opportunity to bring the care that this population receives up to state of the art. Part of the state of art for this medically complex population is palliative care. Research demonstrates that palliative care improves symptom distress, quality of life, and patient and family well-being. Palliative care has been shown by some studies to even lengthen life. Palliative care is most effective when it is provided early in the disease process. Palliative care is specialized medical care for people with serious illnesses. It is focused on relieving suffering and providing the best possible quality of life for patients and their loved ones. It provides patients with relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.
Page 16	(4) Care Coordination	DHCS is currently developing care coordination standards for the health plans.	Care coordination is a fundamental part of palliative care. Anyone providing palliative care to a beneficiary should be providing care coordination as a part of palliative care.

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Organization:
Contact Name:
E-Mail:

Page	Section Title	Existing Text	Comment or Suggested Edit
Page 18	(5) Network Adequacy	Entire section	CCC strongly encourages the inclusion of access to palliative services – early in the disease process and concurrently with curative treatment – as core part of network adequacy. Palliative care is fundamental to achieving the goals of SB 1008, including care coordination, person-centered care, maximizing beneficiaries ability to stay in their homes, improving quality of care, and attaining/maintaining personal goals.

Comment Template for CCI Transition Plan

Organization: **County of San Diego, Aging & Independence Services**
Contact Name: **Brenda Schmitthenner**
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Page	Section Title	Existing Text	Comment or Suggested Edit
6	Introduction	The current fair hearing process for IHSS will remain in effect in the initial years of the demonstration.	This is ambiguous. What is meant by initial years? It is only a 3-year demonstration. What happened then?
6 and 13	Introduction and Enrollment and Notification Strategy:	Beneficiaries will be informed about their enrollment rights and options, plan benefits and rules, and care plan elements with sufficient time to make informed choices. Beneficiaries will be sent an informing notice at least 90 days prior to the health plan enrollment effective date, followed by 60-day notice with plan information and selection materials and a 30-day reminder notice.	This process was not successful for SPDs. Why is it anticipated to be effective with duals?
7	Health Plan Selection, Readiness, Contracts, and Oversight	In addition, during the fall of 2012 the State and CMS will jointly assess each health plan's readiness using a jointly developed tool to ensure the plans will meet the operational requirements.	Counties should have the opportunity to review these plans and provide feedback.
8	Health Plan Selection, Readiness, Contracts, and Oversight	Provide timely access to medical care to beneficiaries, and measure the adequacy of the provider networks for medical, long-term care, and behavioral health services.	How can you assess adequacy of long-term care network without data to project current and future population needs?
14	Enrollment and Notification Strategy:	This plan will include contracting with community-based, nonprofit consumer or health insurance assistance organizations	This will be essential and if not funded, should be reason to not proceed with demonstration.

Comment Template for CCI Transition Plan

Organization: **County of San Diego, Aging & Independence Services**
Contact Name: **Brenda Schmitthenner**
E-Mail: **brenda.schmitthenner@sdcounty.ca.gov**

Page	Section Title	Existing Text	Comment or Suggested Edit
		with expertise and experience in assisting beneficiaries in understanding their health care coverage options.	
16	The Interdisciplinary Care Team	The ICT will also be responsible for care transitions between community and institutional settings (hospital and nursing facilities). In keeping with the goals of the Demonstration, plans will promote	This is restrictive. Other evidence-based care transitions programs may be more effective and timelier than relying on an ICT for this function.
20	Medical and Social Needs	Health plans will be required to incorporate referrals to community resources into their Models of Care and to provide other activities or services needed to assist beneficiaries in optimizing their health status. These services will be specified in the health plan contract requirements.	These referrals should be documented and monitored to ensure appropriate utilization of HCBS for members.
29	Process for Addressing Consumer Complaints	In the MOUs between the health pan and the county social services agency and/or public authority.	typo

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: County Welfare Directors Association
Contact Name: Diana Boyer
E-Mail: dboyer@cwda.org

Page	Section Title	Existing Text	Comment or Suggested Edit
12	**PART A - ACCESS AND QUALITY OF SERVICE**	DHCS will develop descriptions of continuity of care rights in all threshold languages and alternative, accessible formats, and distribute these materials to beneficiaries through plans and providers.	This only speaks to DHCS and not DSS informing materials for IHSS consumers. Will IHSS consumers receive information about their IHSS benefits under the demonstration? This is an area that should be discussed with county agencies. Also, historically we have had problems with timely notices to IHSS consumers in their native language. DSS will only translate notices into three threshold languages, and requires counties to translate into all other local threshold languages, which is both an unfunded workload and also does not give adequate time to notify consumers.
13	Enrollment and Notification Strategy:	All notices will be released for stakeholder review at least 60 days prior to mailing to the beneficiaries. DHCS will collect comments and update the material as appropriate. The release of notices will be scheduled by population groups. The standard notification process will be based on a 12-month enrollment schedule for the two-plan and GMC plan types.	Again, this may provide adequate time to translate notices into the required languages.
17	Composition and leadership of the ICT	For members in nursing facilities, ICT will involve nurse practitioners, physician assistants or primary care physicians to work with NF staff to manage medical	This only addresses the medical needs of the consumers and often nursing home clients often have behavioral and functional needs to make transitioning to home care safe and possible for

Organization: County Welfare Directors Association
Contact Name: Diana Boyer
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Page	Section Title	Existing Text	Comment or Suggested Edit
		conditions in nursing facilities and to facilitate nursing facility-hospital transitions. Health plans will also develop care plans to successfully transition beneficiaries into the community to the extent possible without jeopardizing the safety, health and welfare of the beneficiary.	the client. We suggest revising this ICT to include behavioral health and social services (IHSS and MSSP) representatives who can consult on these cases as well, through a process that is locally determined between health plans and local providers of these services (i.e. county agencies, MSSP).
20	(6) Medical and Social Needs	Dental, Vision and Home- and Community-Based (HCBS) Plan Benefits might be required benefits, depending upon rate development. Health plans will be required to incorporate referrals to community resources into their Models of Care and to provide other activities or services needed to assist beneficiaries in optimizing their health status. These services will be specified in the health plan contract requirements.	How is the State defining "Home- and Community-Based (HCBS) Plan Benefits" ? Are not IHSS, MSSP and CBAS types of benefits? Is the intent in this statement to indicate that the amount of HCBS benefits will be determined by the rate? Referrals to community resources will be inadequate if there are waiting lists for some of these services, such as meals on wheels. There should be a requirement that health plans assess local community services likely to be needed by their clients and to create a plan to coordinate with community agencies to bolster these services for the dual population. An since referrals do not translate into access, there needs to be monitoring and assessment if the services were actually utilized, in order to determine effectiveness of the intervention.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: County Welfare Directors Association
Contact Name: Diana Boyer
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Page	Section Title	Existing Text	Comment or Suggested Edit
21	**(9) Local Stakeholder Advisory Groups Established by Health Plans**	With CMS, DHCS is developing joint readiness review standards for health plans, which will include requirements for local stakeholder advisory groups.	Health plans are already planning locally and not necessarily including broader consumer stakeholder input. These standards need to be released soon so that planning with consumer input is not done too late and consumers feel that their input is an after-thought.
26	18. Plan and Complete IT System Changes	DSS CMIPS II Transition– (Complete in eight counties by May 1, 2013)	Additional changes will be necessary to the CMIPS II System after the eight counties transition to this system. Demonstration counties will need to have functionality built to the system to differentiate between IHSS hours authorized by the county worker, and any additional hours authorized by the health plan. In addition, Notices of Action will need to be automatically generated to inform the client when additional hours are provided by health plans and the appeal rights of the consumer with respect to those additional benefits. DSS has informed the demonstration counties that this process will need to be manually tracked until such time that CMIPS II can be modified.
26	19. Implement IHSS Managed Care Coordination	Develop Template MOUs between health plans and county social service organizations, and local public authorities. (August 31, 2012)	The date should be changed because we have only seen a draft and a final template MOU has not yet been provided to counties.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Health Net
Contact Name: Diane Sargent
E-Mail: Diane.Sargent@healthnet.com

Page	Section Title	Existing Text	Comment or Suggested Edit
7	INTRODUCTION- Health Plan Selection, Readiness, Contracts, and Oversight	The readiness review process demonstrates the health plan's ability to: • Provide timely access to medical care to beneficiaries, and measure the adequacy of the provider networks for medical, long-term care, and behavioral health services.	Please specify if Long-Term Care network readiness standards require having contracts in place in time for the readiness review. Please share with the health plans any additional requirements against which they will be evaluated. The implementation plan states network adequacy will be monitored using Medicare Network Adequacy standards – statement that plans will be monitored through the HSD tables would help to clarify. We recommend adding the specific network adequacy standards and access to care standards for all medical, long-term care and behavioral health services that the plan will be monitored against.
8	INTRODUCTION- Health Plan Selection, Readiness, Contracts, and Oversight	The health plan readiness reviews are instrumental to the ongoing monitoring and oversight activity of the health plans that will be coordinated by the Department of Health Care Services (DHCS), involving the Department of Managed Health Care (DMHC) and other state departments and county agencies to ensure beneficiary care is being coordinated effectively.	We suggest adding the Centers for Medicare and Medicaid Services (CMS) as an agency participating in the readiness review.
11	PART A - ACCESS AND QUALITY OF SERVICE	Note that DHCS and DMHC are collaborating to determine the applicability of the state standards to services funded by the federal government.	The final implementation plan should include the access standards the health plans will be monitored against and the expectations for monitoring access to medical care (primary and specialty). We request that this question be resolved and the

Organization: Health Net
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Page	Section Title	Existing Text	Comment or Suggested Edit
			access standards communicated to health plans no later than the issuance date of the Readiness Review tool.
11	PART A - ACCESS AND QUALITY OF SERVICE	DHCS will review health plan networks in the fall of 2012, as part of the readiness review process.	Please note that this will be challenging (if not impossible) if rates, as well as LTSS guidelines and standards, are not known within reasonable time before the review.
11	PART A - ACCESS AND QUALITY OF SERVICE	For Medi-Cal LTSS benefits, DHCS will review health plan networks in the fall of 2012, as part of the readiness review process, to ensure the plans meet the State's newly established LTSS network adequacy standards.	The draft Long-Term Care network readiness standards available on the CalDuals website seem to require health plans to have contracts in place, and referrals take place based on need. Will this be the requirement for health plans to monitor network adequacy? We request that the final transition plan clarifies this process and specifies what the standards for LTSS the health plans will need to have in place to demonstrate readiness.
12	PART A - ACCESS AND QUALITY OF SERVICE	Provider Physical Accessibility: Health Plans will contract with providers that meet physical accessibility requirements. (W&I §14182.17(d)(5)(c))	The W&I code specifies that the plans "Monitor an appropriate provider network that includes an adequate number of accessible facilities within each service area." Please clarify how the state will define "an adequate number of accessible facilities" (e.g., is there a designated proportion of the health plan's contracted provider network that must meet the physical accessibility requirements, or will another standard be used).
12	PART A - ACCESS AND QUALITY OF SERVICE	DHCS will develop descriptions of continuity of care rights in all threshold languages …	Please define what the threshold languages are and confirm if these are State-wide or specific to a population within each demonstration county. Also, please communicate if the threshold is determined

Organization: Health Net
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			by the languages of the dual eligible population or will reflect those used for the Medi-Cal-only population.
12	PART A - ACCESS AND QUALITY OF SERVICE	Alternative Format: Health plans will provide information in alternative formats. (W&I §14182.17 (d)(5)(A))	Please provide a clear description of which documents are required to be provided in alternative formats. For example, CMS currently has list for Medicare Part D of which documents must be translated. What are the specific requirements for the Duals Demonstration?
12	PART A - ACCESS AND QUALITY OF SERVICE	DHCS, CHS and DMHC are currently reviewing responsibility for monitoring compliance with state and federal timely-access provisions. DMHC recently promulgated regulations regarding Timely Access to Non-Emergency Health Care Services (California Code of Regulations Section 1300.67.2.2). DHCS and DMHC are reviewing the applicability of the regulation to the Duals Demonstration Project.	It is important to clarify that health plans have no oversight rights of Medicare FFS providers.
13	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (1) Ensure timely and appropriate communication with beneficiaries- Enrollment and Notification Strategy:	All beneficiary notices and enrollment materials will require a reading proficiency no higher than sixth grade level and will be available in all the Medi-Cal threshold languages required under current state law, as well as in alternative formats, all of which are culturally, linguistically, and physically appropriate.	Please define what the threshold languages are and confirm if these are State-wide or specific to a population within each demonstration county. Also, please communicate if the threshold is determined by the languages of the dual eligible population or will reflect those used for the Medi-Cal-only population. Will Part D communications have to be made available in all Medi-Cal threshold languages?
14	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR	DHCS is working with the enrollment contractor, Maximus, to clarify the process for authorizing legal representatives, such as a	We request that this process be developed and communicated to health plans no later than the issuance date of the Readiness Review tool.

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	BENEFICIARY PROTECTION PROVISIONS OF CCI- (1) Ensure timely and appropriate communication with beneficiaries- Enrollment and Notification Strategy:	caregiver, family member, conservator, or a legal services advocate, to communicate with the contractor on enrollment issues and make elections on the beneficiary's behalf when necessary and appropriate.	
14	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (1) Ensure timely and appropriate communication with beneficiaries- Health Plan Oversight for Enrollment Communication:	DHCS will ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures. Communication and services will be available in alternative formats that are culturally, linguistically, and physically appropriate through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language and written translations.	Please provide the health plans with specific requirements for membership cards and beneficiary correspondence.
15	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (2) Initial Assessment Process	Health plans will use the assessment information for risk stratification of members, using a mechanism or algorithm developed by the health plan and reviewed and approved by DHCS. This will serve as a triage for further assessment needs in variety of areas including, but not limited to, mental health concerns, substance abuse concerns, chronic physical conditions, and potential needs related to key activities of daily living, dementia, cognitive status and the capacity to make informed decisions.	Please provide details of DHCS's review and approval of the risk stratification adopted by the health plans.

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15	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (2) Initial Assessment Process	Building o what was learned from the transition of the Medi-Cal-only SPD population into Medi-Cal managed care, the State will work with plans and providers to ensure necessary processes and procedures are in place to support timely health risk assessments. In addition, California's health plans will use promising practices, such as repeated attempts to gather assessment information via various modes (phone, mail, interactive voice by phone) and web-based care planning tools that allow providers and beneficiaries to view and add to the care plan.	Please provide additional information regarding the anticipated policies and procedures for HRA to ensure that health plans have effectively scaling resources based on requirements and member volume.
15	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (2) Initial Assessment Process	<Time frame not specified>	DHCS has stated that the timeline for HRA completion will be 45-days for high risk and 105-days for low risk. There has also been commentary regarding the 90 day Medicare requirement. It was stated on the 9/4 stakeholder call that for dual eligible members the 90-day Medicare requirement would be the standard to follow. Please provide written confirmation and clarify the time frame expectations in the final transition plan.
15	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (3) Primary Care Physician Assignment	Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-Cal managed care plan	Please provide additional information about partial-benefit dual eligible beneficiaries, including how health plans identify them and know that they are receiving primary or specialty care through Medi-Cal.

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16	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (4) Care Coordination	DHCS is currently developing care coordination standards for the health plans.	We request that these standards be developed and communicated to plans no later than the issuance date of the Readiness Review tool.
17	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (4) Care Coordination- Composition and leadership of the ICT	…when possible the member will be a major factor when deciding the make-up and direction of the ICT.	Is this language stating the member will be able to determine who is o the ICT? Medicare has specific roles/individuals that are required to be included. Please clarify if it is the member's conditions and needs that determine the makeup of the ICT, or if the member themselves determine the makeup of the ICT.
17	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (4) Care Coordination- Identifying beneficiaries requiring an ICT	Specific criteria will be established by the plans and approved by DHCS.	Medicare currently requires that all beneficiaries are assigned to an ICT. Please confirm if the expectation is to follow the Medicare guideline or if only specific beneficiaries will be required to have an ICT.
18	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (5) Network Adequacy	State Medicaid network standards shall be utilized for LTSS and the prescription drugs covered by Medicaid which are excluded from Medicare Part D. Medicare network standards shall be used for Medicare prescription drugs and other services for which Medicare is the primary coverage. Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage	We recommend that the requirements be stated as: • State Medicaid network standards shall be utilized for LTSS. • Medicare network standards shall be used for Medicare prescription drugs, prescription (and non-prescription) drugs covered by Medicaid which are excluded from Medicare Part D, and other services for

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		overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards.	which Medicare primary. • Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards. Reasons for suggested changes: • Recognize that some OTC (non-prescription) drugs are covered by Medicaid (and not covered by Medicare Part D). • Suggest using same access standard for all prescription drugs (which seems to be supported in the CCI Fact Sheet on Beneficiary Protections issued by DHCS on August 30th, 2012).
18	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (5) Network Adequacy	State Medicaid network standards shall be utilized for LTSS and the prescription drugs covered by Medicaid which are excluded from Medicare Part D. Medicare network standards shall be used for Medicare prescription drugs and other services for which Medicare is the primary coverage. Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare	Please clarify if the network standards for LTSS are the demonstration of MOUs or contracts with the respective county social services agencies to provide IHSS, contracts with licensed and certified Nursing Facilities, and CBAS organizations/centers, and contracts with MSSP organizations in good standing with CDA. For DME, home health services, and other services for which Medicaid and Medicare coverage overlap it states to use the Medicaid standards so long as the State can show that such standards are as stringent as Medicare standards. How will health

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		standards. Provider networks will be subject to confirmation through Demonstration plan readiness reviews in October and November 2012, including the following:…et.al	plans know what the State has proven to be applicable and which will be required to use Medicare standards? Recommend the Transition plan describes exactly what network standards for these benefits are to be used by the health plans with the regulation(s) used to determine such.
18	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (5) Network Adequacy	Provider networks will be subject to confirmation through Demonstration plan readiness reviews in October and November 2012…	Please note that this will be challenging (if not impossible) if rates are not known within a reasonable time before Oct/Nov 2012
19	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (5) Network Adequacy	Nursing facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care.	Please define “encumbering citations”. Does encumbering citations not allow for prior authorization of services?
19	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (5) Network Adequacy - Nursing facility:	Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility.	We recommend that the requirements be stated as: Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities at prevailing Medi-Cal rates until a safe transfer can be made to an in-network facility.
19	PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI- (5) Network Adequacy -	Health plans must allocate to the MSSP providers the same level of funding they would have otherwise received under their MSSP contract with CDA.	On the 9/4 stakeholder call it was stated that MSSP services will remain “as is” for year one. Does this mean that the waiver will remain in place and the state will pay the MSSPs directly and a pass-through payment will be paid to the state by the health plans? Or does this mean that the health plans must

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	Multipurpose Senior Services Program (MSSP):		pay the MSSPs directly year one and ensure that the same level of funding remains in place? If the later, how will each plans' contribution to the MSSPs be determined in Counties in which there is more than one health plan? How are an MSSPs administrative costs covered in this arrangement?
20	(7) Grievance and Appeals Process	The In-Home Supportive Services (IHSS) grievance and appeals process will remain as it currently is, …	On the 9/4 stakeholder call it was stated the IHSS grievance and appeals process would "follow the money" that whoever had approved the IHSS hours, the health plan or DPSS, the member would follow that grievance or appeal process. It is not clear where a request from a beneficiary would be submitted for additional IHSS hours. If a member has been denied additional hours by the DPSS, would the member have to exhaust that grievance/appeal process and then request additional hours through the health plan and also have access to that grievance/appeal process?
23	Key Milestones and Timeline	…continue tobe posted…	…continue to be posted…(add a space between "to" and "be")
23	Key Milestones and Timeline	3. Develop, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices. (Expected by October 2012)	Will there be a state review of all beneficiary documents in coordination with CMS or will there be separate review process by both the state and CMS for document? When will this be determined?
27	Key Milestones and Timeline	• Develop thresholds for quality measures for health plan contracts (Fall 2012)	Receiving the thresholds for quality measures later than the receipt of the quality measures themselves can delay the progress of the Quality Management program and impact the ability to convey expectations to the provider community that we are aiming to contract with for the Demonstration. We

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			recommend that the thresholds be developed and distributed with the quality measures.
32	PART D – STAKEHOLDER ENGAGEMENT[2] – Working with Stakeholders after the Transition is Underway	…issues that worthy of further examination…	…issues that are worthy of further examination… (add the word "are")
36	APPENDIX D	California Department of Consumer Affairs (CDA)	(DCA) – reverse the C and D
37	APPENDIX D	California Department of State Hospitals (DSH)	More information would provide greater clarity. Recommend mentioning that this department was formerly DMH (Department of Mental Health) or update the link to the DSH link

The IHSS Consumers Union experience of the work group process was that it was a waste of our time and an insult to our intelligence. We felt that it was a lesson in futility because we felt that those who were asking for our input were not sincere about hearing it or developing systemic solutions to the very serious issues and concerns expressed by stakeholders. Forgive the coarseness but we felt that the department of health care services was "covering their xxxxx" and in no way making efforts to solve the egregious problems of discontinuity of care that had already happened to seniors and people with disabilities in the Medi-Cal managed-care program they implemented last year, which were essentially the same medical programs with the same health plans. And although people on both MediCal and Medicare could opt out of the program, it was clear the administration was banking on people being captured in the program by default and locking us in and chuckling about the name -- into the very programs that they knew were harming people and refused to correct.

Our worries about consumers having real protections and a genuine mechanism to have their life threatening medical mismanagement and civil rights protected in the managed-care plans were ignored. Our concerns with the ombudsman program were that they were not helping people who were not getting appropriate treatments and medications. All of our input was met with absolutely no commitment from the Department of Health Services to design solutions for the systemic problems that have been documented.

The workgroup designed by Harbage Consulting was excellent --the way things are broken down into topics will give people the opportunity to talk. We feel we had the opportunity to speak but absolutely no opportunity to be really heard by the California Department of Healthcare services. We told them and they heard in legislative testimony that they were seriously harming some Seniors and People with Disabilities in MediCal managed care, and they were as deaf to those cries as they were to stakeholder input.

When we asked where the consumer mechanism that had teeth in it would be, we received a surly reply. We never heard back from the hosts about any steps they were taking to resolve these issues of not being harmed by these Medicare “F” rated plans. There are problems with people showing up to the hospital without their records; one woman mentioned that the only medication she was able to get from her plan was one she was allergic to; when someone said that people with Cancer and Hepatitus C were having their treatments interrupted risking their cures and their lives;

that people were losing their places on transplant lists; that people going to dialysis were losing their transportation; and people were being cut 100 hrs of IHSS services we felt no compassion and heard no attempts to rectify threatening the lives of our people.

In a genuine work group process, when a stakeholder brings up a serious issue, the host would say words to the effect: "that's terrible: we'll get on that right away," and then at a subsequent meeting report back on the solutions the administration developed to repair that systemic problem. We don't remember hearing anything like that ever! What we did hear were panel discussions comprised mostly of people from the state plan who we felt were pushing the program on stakeholders and not answering the grave issues that we brought to their attention. We felt we were being handled, manipulated, and unheard. We felt that the issues we brought up were being lobbed back to us like tennis balls in a game. To summarize you can have the greatest telephone in the world but it doesn't matter if no one is listening on the other end.

Most Sincerely,
Nancy Becker Kennedy, Susan Chandler, Larry Buchalter, Joey Riley and Michael Condon, Ben Rockwell and Ellyn Kearny
on behalf of the IHSS Consumers Union

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Imperial Care Center
Contact Name: Gemma Bellatuoni
E-Mail: leah.savadian@yahoo.com

Page	Section Title	Existing Text	Comment or Suggested Edit
11	Part A- Access and Quality of Service	"Medicare Part D Continuity of Care: The department and CMS will implement and enforce Medicare Part D transition of care provisions, to ensure that health plans provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Part D drugs that are not on the health plan's formulary."	Please describe the process for covering non-formulary drugs if a patient needs to obtain them for personal needs/wants.
14	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"Outreach Plan: DHCS is developing an outreach and education program informing beneficiaries of their enrollment options and rights, including specific steps for working with consumer and beneficiary community groups."	Please also develop an education program for providers, such as skilled nursing facilities.
15	Primary Care Physician Assignment	"This section of SB 1008 addresses primary care physician assignment for dual eligible beneficiaries not enrolled in the demonstration, by requiring Medi-Cal health plans to: Not interfere with a beneficiary's primary care physician choice under Medicare."	Under the duration of CCI, dual eligible beneficiaries should be able to continue to see their primary care physician.
16	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"The Interdisciplinary Care Team: An Interdisciplinary Care Team (ICT) is formed for the care management of medical, LTSS and behavioral services. For individuals identified as needing such care management, the ICT functions will include assessment, care	Please outline the extent to which skilled nursing facilities will be utilized for care management of patients.

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Due September 7, 2012

Organization: Imperial Care Center
Contact Name: Gemma Bellatuoni
E-Mail: leah.savadian@yahoo.com

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		planning, service authorization, coordinating delivery of needed services, monitoring health status and service delivery. The ICT will also be responsible for care transitions between community and institutional settings (hospital and nursing facilities). “	

Comment Template for CCI Transition Plan Organization: Infocrossing, a Wipro company

Due September 7, 2012 Contact Name: Shannon Glasscock

E-Mail: Shannon.glasscock@wipro.com

Page	Section Title	Existing Text	Comment or Suggested Edit
	Passive Enrollment	General comment	There are many concern about the "passive" enrollment. Seems like better approach would be to let the market drive consumer choice. This would prevent many complaints to the department and would allow consumers to feel empowered. This would also challenge the health care plans to provide optimal service so that consumers stay engaged. Overall, this free market approach may cost the state more money (better service may mean higher capitation payments initially), but would result in a more meaningful demonstration - (i.e. we'd really know if CCI worked or not). Over the long term, a voluntary coordinated care demonstration will most likely save money, if indeed care is better coordinated. A "forced" coordinated care model may feel more like a prison, and less like coordinated care and won't be a true test of the demonstration. I fear that the state is setting themselves up for a failed demonstration, further exacerbating already hard feelings about state run health programs. Let's set this program up so that the market "likes" it (borrowing a Facebook term).

We participated in many of the workgroups etc... We feel that most Consumers & IP's were not really listened to. DHCS had its own agenda & preconceived notions & the stakeholder process was reduced to a rubber stamp .It was clear from the get go that the DHCS is looking for cost savings not quality of care. The cost savings language has been cleaned up, but the intent is still the same -to cut costs. From the beginning those that receive or provide IHSS begged for IHSS to be a carve out, to our dismay Mr. Toby Douglas testified that IHSS was an essential component in the Duals Demo. Yet, IHSS & LTSS will not be measured & evaluated because "there is no time to develop the metrics. It would take years to develop the metrics to do that." Please do not implement until DHCS has developed the metrics to evaluate IHSS & LTSS.

1. Delay implementation time of the Duals Demo Pilot by 3 years in CA. The DHCS, the MCO's and the consumers/beneficiaries are not ready. The "Stakeholder Process" has been a rubber stamp. The vast majority of questions & concerns from consumers, Individual Providers (caregivers/IP's) and advocates have not been answered or addressed.
2. Reduce the scale. Los Angeles is 1/3 of the State. San Diego is the 2nd largest county. A true "Duals Demo Pilot" should be small for a test of better care & cost savings. Therefore, L.A. should be taken out of the mix and only 4 not 8 counties should be part of the Duals Pilot. There should be a 3 year time period and evaluations before adding other counties.
3. IHSS & other LTSS should also be measured & evaluated. Consumer surveys & satisfaction should be measured. Morbidity, mortality rates, E.R. visits and institutionalization rates should be studied with the reason why it occurred.
4. MCO's & CA DHCS and their agents must not be immune from litigation.
5. Consumers must not lose their State Fair Hearing Rights.
6. Cap MCO's admin. & profits to 15%.
7. Any savings realized, i.e. reduced institutionalizations, should be invested in the IHSS direct care services of the Duals Demo.
8. A true"Emergency Back up System" (other than 911) for consumers in 90% of the counties does not exist. CFCO requires that it does. This needs to be remedied.
9. ALL IP training should be optional & paid.
10. IP's (not Union reps.) should have a voice at the table and be included on all Advisory boards as well as Consumers.
11. If there is a sincere desire to move and keep folks out of institutions, then accessible, affordable housing, durable medical equipment and accessible transportation must be made available.
12. Strong consistent enforcement of MCO's noncompliance must be rigorous if consumers needs are not met (DHCS is very lax regarding enforcement so we need CMS to step up to the plate).
13. Consumers & IP's need dental care.
14. A Public website (like calduals.org) should be made available to post MCO's reports & evaluations and for consumer/beneficiaries, IP's, family members and advocates to post experiences, comments & concerns.
15. FFS physicians should be paid by both medicare & MEDI-CAL funds not just medicare.
16. If 8 counties are chosen - then there should be 8 advisory boards made up of Consumer/IP majority in each county respectively.

Comment Template for CCI Transition Plan Organization: Keiro Senior HealthCare
Due September 7, 2012 Contact Name: Shawn Miyake
E-Mail: smiyake@keiro.org

Page	Section Title	Existing Text	Comment or Suggested Edit
19	Nursing Facility	Nursing facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care.	Nursing facility: Demonstration plans must contract with all willing licensed and certified nursing facilities without encumbering citations to access all levels of care.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Dept. of Public Social Services - LA County
Contact Name: Gail Washington
E-Mail: gailwashington@dpss.lacounty.gov

Page	Section Title	Existing Text	Comment or Suggested Edit
12	Part A – Access and Quality of Services	DHCS will develop descriptions of continuity of care rights in all threshold languages and alternative, accessible formats, and distribute these materials to beneficiaries through plans and providers.	What are the threshold languages? And who will be responsible to translate the description of continuity of care rights in the other languages served in the county? Will the managed care plans be responsible to translate the forms? For example in Los Angeles County, we have 9 threshold languages (Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Spanish, Tagalog and Vietnamese). We recommend including the county required threshold languages in which the continuity of care rights will be translated and provide a statement regarding translating this form in other languages.
13	Part B – Operation Steps, Timeliness and Key Milestones for Beneficiary Protection Provisions of CCI Enrollment and Notification Strategy:	All beneficiary notices and enrollment materials will require a reading proficiency no higher than sixth grade level and will be available in all the Medi-Cal threshold languages required under current state law, as well as in alternative formats, all of which are culturally, linguistically, and physically appropriate.	We recommend including a statement on who will be responsible for translating the beneficiary notices and the enrollment material in the pilot counties required threshold languages as described above.
14	Enrollment and Notification Strategy:	Beneficiary notices will be made available for public view through the website www.CalDuals.org and made available to providers before they are mailed to beneficiaries.	We recommend including the notices in the pilot counties threshold languages on the website.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Dept. of Public Social Services - LA County
Contact Name: Gail Washington
E-Mail: gailwashington@dpss.lacounty.gov

Page	Section Title	Existing Text	Comment or Suggested Edit
16	Composition and Leadership of the ICT	To coordinate the care of members residing in the community, ICTs will include trained care managers or health navigators, and other health care professionals such as RNs and Licensed Social Workers, and the members' primary care physicians as the core team members. Based on the assessed need of the members, the core ICT will involve IHSS social workers, CBAS' Interdisciplinary team, behavioral health specialists, pharmacists, and other specialty providers in the development of comprehensive care plans, when appropriate.	We understand that there is clean-up legislation pending (AB 1471) that provides information regarding the ICT composition. Specifically, it changes IHSS social workers to Social Services Agency. Will this change be reflected in the transition plan if the bill gets approved?
17	Composition and Leadership of the ICT	ICTs will be under the oversight of the plan's medical leadership or Medical Director.	We recommend clarifying this sentence. Does this mean that the medical leadership will be responsible for the ICT members and work directly for the Medical Director?

CA Dual Managed Care true "stakeholders", those who will be put into managed care, commentors seem to voice opinions which fall on deaf ears. This is so disheartening after giving countless hours of my time and that of many other interested consumers to what I had hoped would be a true sharing and development of "managed care" as the law requires.

Protections for consumers is *not* evident as this effort to move far too many people into a poorly conceived and planned "managed care". As clearly moving mass numbers of people who are straight Medi-Cal into a managed care system was frought with horrible mistakes, missteps and horror stories of cancer, kidney treatments ending inappropriately, not to mention horror stories of magnitude shocking even the Department and now...admission of same by the Department is a clear message, the Dual Managed Care MUST BE STOPPED until **all** problems with the SPD Managed Care is resolved! We are not being heard therefore, the requirement that CMS insists on is participation with **stakeholders**...not an ignoring from concept to oversight. This is neither evident or being practiced.

I see this whole process as being an ADA infringment on my rights as a beneficiary. The push to involved 8 counties rather than 4, taking careful steps from education of consumers, to transitioning, consumer civil rights and strong protections, violation penalities for those health care plans who do not do as promised (they are all so poorly rated by CMS), Opt-out questions which have gone unanswered such as, "What penalties will there be for those who choose to "opt-out" will be levied on those who opt-out their Medicare; such as restrictions for IHSS? MSSP? Who pays for 20% that Medicare does not cover? Housing? Transporation? Food Stamps? CBAS, WPCS waivers and other waivers, Voc. Rehab? Another serious question gone unanswered: "How does this managed care concept virtually violate the ADA?

Another question I feel important...why doesn't CA offer a Medigap plan to pay the 20% that Medicare does not cover? A plan that does not penalize the consumer, allows for physician of choice, civil rights protections and an active role consumers play chosen by their peers NOT appointed and who have authority--NOT AN ADVISORY capacity?
Margaret Dowling

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Molina Healthcare of California
Contact Name: Yunkyung Kim
E-Mail: Yunkyung.kim@molinahealthcare.com

Page	Section Title	Existing Text	Comment or Suggested Edit
16	Care Coordination – Composition an leadership of the ICT	To coordinate the care of members residing in the community, ICTs will include trained care managers or health navigators, and other health care professionals such as RNs and Licensed Social Workers, and the members' primary care physicians as the core team members.	To coordinate the care of members residing in the community, ICTs will include trained care managers or health navigators, and other health care professionals such as RNs, gerontologists, and ~~Licensed~~ Social Workers, and the members' primary care physicians as the core team members.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Northridge Care Center
Contact Name: Amy Velasquez
E-Mail: fac56bus3@longwoodmgmt.com

Page	Section Title	Existing Text	Comment or Suggested Edit
11	Part A- Access and Quality of Service	"Medicare Part D Continuity of Care: The department and CMS will implement and enforce Medicare Part D transition of care provisions, to ensure that health plans provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Part D drugs that are not on the health plan's formulary."	If the patient desires to obtain a non-formulary drug, the process for covering non-formulary drugs is not mentioned.
14	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"Outreach Plan: DHCS is developing an outreach and education program informing beneficiaries of their enrollment options and rights, including specific steps for working with consumer and beneficiary community groups."	It is essential for DHCS to also develop an education program for providers, such as skilled nursing facilities. Providers must know the instructions and regulations to make sure that services are delivered appropriately.
15	Primary Care Physician Assignment	"This section of SB 1008 addresses primary care physician assignment for dual eligible beneficiaries not enrolled in the demonstration, by requiring Medi-Cal health plans to: Not interfere with a beneficiary's primary care physician choice under Medicare."	All dual eligible beneficiaries should be able to continue to see their primary care physician, even after the first six months of enrollment in the CCI.
16	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"The Interdisciplinary Care Team: An Interdisciplinary Care Team (ICT) is formed for the care management of medical, LTSS and behavioral services. For individuals identified as needing such care management, the ICT functions will include assessment, care	The extent to which skilled nursing facilities will be utilized for care management is not discussed.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Northridge Care Center
Contact Name: Amy Velasquez
E-Mail: fac56bus3@longwoodmgmt.com

Page	Section Title	Existing Text	Comment or Suggested Edit
		planning, service authorization, coordinating delivery of needed services, monitoring health status and service delivery. The ICT will also be responsible for care transitions between community and institutional settings (hospital and nursing facilities). "	
19	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"Nursing Facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care. Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility. Demonstration plan's contracted facilities will be located in zip code areas covered by the Demonstration, and, to the extent possible, in adjacent zip code areas."	How do skilled nursing facilities initiate contracting with demonstration plans?

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: National Senior Citizens Law Center
Contact Name: Kevin Prindiville
E-Mail: KPrindiville@nsclc.org

Page	Section Title	Existing Text	Comment or Suggested Edit
4	**Introduction**	Mandatory Medi-Cal managed care enrollment for dual eligible beneficiaries.	The paper does not discuss the federal approval process for mandatory Medi-Cal managed care for duals or for integrating LTSS into the current plan benefit package for SPDs.
6	**"**	Specific terms of the demonstration will be established in the Memorandum of Understanding (MOU) between the Centers for Medicare and Medicaid Services (CMS) and the State.	Again, n discussion of waiver review by CMS. MMCO has told advocates that waivers related to mandatory Medicaid managed care will be subject to the usual required CMS waiver review, and will not be handled or coordinated by MMCO.
	Health Plan Selection, Readiness, Contracts, and Oversight	The State held a rigorous joint selection process with the Centers for Medicare and Medicaid Services (CMS) to identify health plans with the requisite qualifications and resources best suited to provide beneficiaries seamless access to an integrated set of benefits for the initial eight counties.	When will CMS make its determination re which plans it will approve for participation in the demonstration?
7	"	In addition, during the fall of 2012 the State and CMS will jointly assess each health plan's readiness using a jointly developed tool to ensure the plans will meet the operational requirements.	We question whether all aspects of the readiness review can take place in the fall. Written readiness review criteria have not yet been shared with stakeholders for comment. It also is unclear how the state's readiness review will coordinate with the review that CMS is hiring a contractor to undertake.
10	**State Administrative Background**	CDSS provides state-level oversight and fiscal services for the county-administered In-Home Supportive	Doesn't CDSS also handle fair hearings for IHSS?

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: National Senior Citizens Law Center
Contact Name: Kevin Prindiville
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		Services Program.	
11	**PART A - ACCESS AND QUALITY OF SERVICE**	Note that DHCS and DMHC are collaborating to determine the applicability of state standards to services funded by the federal government.	What does this mean?
11	"	For Medicare benefits, CMS has reviewed health plan networks and ensured they meet Medicare Advantage adequacy standards.	Has this review been completed?
11	"	Medi-Cal Continuity of Care: Beneficiaries may, under specified conditions, have access to out-of-network Medi-Cal providers for up to 12 months after enrollment. (W&I §14182.17 (d)(5)(G)).	The referenced statute excludes "ancillary services." Where are "ancillary services" defined? It is important that beneficiaries have some care continuity rights for all services they use. Also, does this apply to both people in the demonstration and those only in Medi-Cal managed care?
11	"	Medi-Cal Continuity of Care for Nursing Facility Care: For nursing facility care, managed care health plans will recognize any prior treatment authorization made by DHCS for at least six months after enrollment into the health plan. (W&I §14186.6 (c) (3))	The plan should also be required to provide aid paid pending beyond a current treatment authorization period if the individual appeals timely. IN other words, the plan should not be allowed to stop aid paid pending when a previous authorization period ends before the appeal is resolved. Also, does this apply to both people in the demonstration and those only in Medi-Cal managed care?

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Organization: National Senior Citizens Law Center
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11	"	Medicare Continuity of Care: Beneficiaries will have access to out-of-network Medicare providers for the first six months of enrollment. (W&I §14132.275 (l)(2)(A)	Was this meant to be a separate bullet? Also, this does not state that these protections only apply to individuals in the duals demonstration. Finally, we note that having separate transition periods for Medicare services and Medi-Cal services is neither integrated nor easy to explain to beneficiaries.
11	"	Medicare Part D Continuity of Care:	Does not state whether this applies only to the duals demonstration. What will the continuity of care policy be for Medicaid drug coverage?
12	"	Health plans will maintain liaisons to coordinate access for out of network Medi-Cal providers, and to coordinate with regional centers. The continuity of care liaison will ensure provider access and a smooth transition for each beneficiary into the demonstration. (W&I §14182.17 (5)(F) and (G))	How many liaisons? Sounds like only one per plan?
12	"	DHCS will develop descriptions of continuity of care rights in all threshold languages and alternative, accessible formats, and distribute these materials to beneficiaries through plans and providers.	What is the timing for developing descriptions?
12	"	To further strengthen provider access,	We note that extensive efforts are critically important, and were far too late in CBAS.

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Organization: National Senior Citizens Law Center
Contact Name: Kevin Prindiville
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Page	Section Title	Existing Text	Comment or Suggested Edit
		DHCS and CDPH are conducting a provider outreach workgroup and related activities to ensure that health care providers receive information about the CCI, and to document and address any concerns that they may have.	
13	**PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI**	The key operational steps to implement these provisions are listed below.	There is no reference here to getting Medicaid waiver approval as one of the operational steps. CMS plan approval is also not mentioned. Further it appears to us that Step (3) the Readiness Review process should follow Step (4), the three-way contract.
13	**(1) Ensure timely and appropriate communication with beneficiaries.**		Clarify what is CCI and what is duals demonstration. What notices will SPDs get re MLTSS?
13	"	All notices will be released for stakeholder review at least 60 days prior to mailing to the beneficiaries.	Is this enough time to collect comments, then translate, print and mail?
13	"	All beneficiary notices and enrollment materials will require a reading proficiency no higher than sixth grade level and will be available in all the Medi-Cal threshold languages required under current state law, as well as in alternative formats, all of which are culturally, linguistically, and	Suggest clarifying that, in addition to just being available, alternate format/language mailings will send to individuals whom Medi-Cal has already been identified as wanting particular languages or formats. In addition, the availability of alternate versions should be highlighted through prominent statements on the material and multilingual inserts.

Organization: National Senior Citizens Law Center
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		physically appropriate.	
		For in-person enrollment, disability accommodation such as assistive listening systems, sign language interpreters, captioning, and written communication will be available.	Add: and interpreter services will be provided without charge. Also, who will be handling?
15	**(3) Primary Care Physician Assignment**	Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-Cal managed care plan;	As we understand it, the state's definition of a "partial benefit dual" for purposes of this section is one that either does not have Part A or does not have Part B. But if dual is Medi-Cal eligible, the state must pay his Part premiums. We cannot think of circumstances where a dual would not have Medicare as primary for Part B services and thus not have Medicare freedom of choice with respect to a primary care physician.
14	Transition of Care for Part D Benefits	Through the readiness review process, CMS and the State will ensure that health plans have policies and procedures to address the effective transition of beneficiaries from Medicare Part D plans not participating in the demonstration.	Will these policies be any different than those currently required under Part D?
14	Outreach Plan:	Contingent o available funding, this plan will include contracting with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting beneficiaries in understanding their	Suggest adding reference to ADRC and SHIP funding opportunity and intention to apply.

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Organization: National Senior Citizens Law Center
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Page	Section Title	Existing Text	Comment or Suggested Edit
		health care coverage options.	
14	Communication Plan:	DHCS is developing, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices, including the enrollment notice time frame, alternative formats, accessible formats, and ensuring the materials are culturally and linguistically appropriate.	Mentions consumers and beneficiaries. Is there difference?
14	Health Plan Oversight for Enrollment Communication:	DHCS will ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures.	Change to : DHCS and CMS will ensure that managed care health plans have prepared materials to inform beneficiaries enrolled in the demonstration of how to obtain all their benefits, including grievance and appeals procedures. DHCS will also insure that plans have prepared separate materials for those beneficiaries who are only enrolled for Medi-Cal services.
14	"	Communication and services will be available in alternative formats that are culturally, linguistically, and physically appropriate through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language and written translations.	Add: Plans will be required to have measures in place to identify individuals wishing alternate materials and ensure that those individuals routinely receive materials in the formats they request.
14	Initial Assessment Process		What is meant by "initial"?
14	"	The multi-tiered process will begin with a health risk assessment of each	What is meant by "upon enrollment?"

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		beneficiary conducted upon enrollment.	
15	"	Care plans will be developed for beneficiaries that include member goals and preferences, measurable objectives and timetables to meet his or her medical, psychosocial and long-term support needs that are identified in a comprehensive risk assessment.	When will the comprehensive assessment b e done?
15	**(3) Primary Care Physician Assignment**	Not assign a full-benefit dual-eligible beneficiary to a primary care physician except for specified circumstances;	What are "specified circumstances?"
16	**"**	Some of these provisions will be incorporated into existing Medi-Cal managed care health plan contracts as early as October 1, 2012.	Which ones?
16	The Interdisciplinary Care Team	For individuals identified as needing such care management, the ICT functions will include assessment, care planning, service authorization, coordinating delivery of needed services (plan covered Medicare/Medi-Cal benefits or other community resources), monitoring health status and service delivery.	This section seems to say that only individuals with high needs will have access to ICTs. California's proposal to CMS appears broader and seems to imply that an ICT could be available to anyone who wished to have one.
17	Composition and leadership of the ICT	In keeping with the "person-centered" goals of the demonstration, when possible the member will be a major	Change to:" . . . when possible the member will decide the make-up and direction of the ICT."

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		factor when deciding the make-up and direction of the ICT.	
17	"	For members in nursing facilities, ICT will involve nurse practitioners, physician assistants or primary care physicians to work with NF staff to manage medical conditions in nursing facilities and to facilitate nursing facility-hospital transitions.	How will this work?
17	"	The State expects plans to designate individuals with experience working with seniors and persons with disabilities to lead the care management effort.	Emphasis on experience with LTSS is missing.
18	**(5) Network Adequacy**	State Medicaid network standards shall be utilized for LTSS and the prescription drugs covered by Medicaid which are excluded from Medicare Part D. Medicare network standards shall be used for Medicare prescription drugs and other services for which Medicare is the primary coverage. Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards.	Add at the start: Plans will be required to develop provider networks that are adequate to provide the services covered, taking into account the needs of the enrollee population, including needs for language and cultural competence and for accessible facilities. As a floor, state . . .

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Page	Section Title	Existing Text	Comment or Suggested Edit
18	"	Provider networks will be subject to confirmation through Demonstration plan readiness reviews in October and November 2012,	How does this coordinate with national readiness tools being developed by CMS? Also need opportunity for stakeholder review of tool.
19	In-Home Supportive Services	Demonstration plans may contract with other agencies to provide emergency backup personal care services, or in cases where a beneficiary cannot find a provider, for so long as such agencies are certified by the California Department of Social Services.	This contracting for back up services should be required, not optional.
19	Nursing facility:	Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility.	Although the Department at a listening session provided assurances that plans had n intention to move long-term nursing home residents, even if their facility did not join a network, these assurances should be spelled out as requirements. Add a sentence as follows: If a beneficiary wishes to continue to reside in an out-of-network facility, the plan must make provisions, such a single-case agreement, that allows the beneficiary to stay in place, absent documented health or safety concerns.
19	"	Demonstration plan's contracted facilities will be located in zip code areas covered by the Demonstration and, to the extent possible, in adjacent zip code areas.	Clarify "to the extent possible."
19	Multipurpose Senior Services Program (MSSP):	Demonstration plans must contract with MSSP organizations in good standing with the California Department of Aging (CDA) in the covered zip code areas included in	Change to: "Demonstration plans must contract with all MSSP organizations . . ." Clarify "to the extent possible."

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		the Demonstration, and to the extent possible, in the adjacent zip code areas.	
20	DME	The state will require that health plans contract with a sufficient number of providers of durable medical equipment.	Clarify "sufficient."
20	**Medical and Social Needs**	Dental, Vision and Home- and Community-Based (HCBS) Plan Benefits might be required benefits, depending upon rate development.	Is this sentence really saying that HCBS benefits may not be required? Also this is another place where the distinctions between the CCI and the demonstration, if any, are unclear.
20	**(7) Grievance and Appeals Process**	The unified process will not be more restrictive than the current Medi-Cal process, and might initially be combined with the Medi-Cal and Medicare process for health plan review of appeals, while maintaining the beneficiary option to use other current federal and state avenues for appeals.	There is no reference to the availability of aid paid pending during the first level of appeal.
21	**(8) Monitor Health Plan Performance and Accountability Through Performance Measures, Quality Requirements, Joint Reports, and Utilization Results**	DHCS, DMHC, and CDSS will implement the monitoring requirements of this subdivision by doing the following:	How is the CMS role different for demonstration plans v. CCI?
21	"	DMHC and DHCS will submit an annual joint report on financial audits performed on health plans.	To whom will the reports be submitted? Will they be public?

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21	"	In conjunction with the demonstration evaluation efforts, DHCS and CDSS will monitor the utilization of medical services and LTSS (including IHSS), and will identify and share any significant changes in aggregate or average utilization among beneficiaries participating in the demonstration or the CCI	This is a very important and useful element. Add CMS? Also, with whom will changes be shared? Will the info be public? Missing from this list is a mechanism for real time identification of problems in service delivery.
21	**(9) Local Stakeholder Advisory Groups Established by Health Plans**	As noted below, all health plans have already met with local stakeholders, and most have established ongoing stakeholder advisory groups.	Which plans do not yet have advisory groups?
22	Hospital and Provider Groups:	Health plans throughout the state have convened advisory committee and town hall meetings with hospitals and provider groups.	All health plans?
22	Stakeholder Workgroups	Health plans have conducted workgroup meetings with a broad spectrum of community advocates and LTSS providers to engage them in the duals planning process.	All health plans? An what about meeting with consumers?
22	County Collaboration	Health plans have ongoing meetings with county social service agencies	All health plans?

Organization: National Senior Citizens Law Center
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		and local public authorities.	
22	LTC Facility Outreach	Health plans have been meeting with the California Association of Health Facilities, as well as individual facilities, to further establish a dialogue on long-term services and supports for dual eligible and Medi-Cal only beneficiaries.	All health plans?
24	6. Review Health Plans' Models of Care and Plans Benefits Packages	Review plan benefit package, identify deficiencies, and confirm that deficiencies have been corrected (Completed on August 31, 2012)	How can this have been completed if rates have not yet been set? Also, CMS participation not noted. Also, no distinction between CCI and demonstration review.
24	8. Develop Enrollment Process	Finalize enrollment phase-in process and timeline (August 30, 2012)	Has this been released? What is the process?
24	9. Develop Beneficiary notices	All	This timeline appears very aggressive, given the need for translation, printing, etc.
25	10. Prepare Beneficiary and Provider Outreach and Education Plan:	• Conduct outreach activities (webinars, forums, presentations, etc.) (November 2012 – June 2013)	Outreach will need to continue well past June 2013

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Organization: National Senior Citizens Law Center
Contact Name: Kevin Prindiville
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Page	Section Title	Existing Text	Comment or Suggested Edit
25	11. Develop LTSS Provider Network Adequacy Standards:	All	No mention of CMS role.
25	12. Complete Readiness Reviews	All	No mention of CMS role.
25	13. Determine Supplemental Benefits Policy	Develop draft guidelines for the scope, duration, and intensity of HCBS Plan Benefits and share with stakeholders (August - September 2012)	Has this happened?
25	14. Amend 1115 Waiver	DHCS will determine which changes are necessary to the Waiver (August 2012)	Has this happened? When will the information be public? Has DHCS submitted a waiver request? Begun waiver negotiations with CMS?
26	18. Plan and Complete IT System Changes	All	Does this schedule allow adequate time to test the systems?
26	19. Implement IHSS Managed Care Coordination	Develop Template MOUs between health plans and county social service organizations, and local public authorities. (August 31, 2012)	Have these been completed? We have not seen them.

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Organization: National Senior Citizens Law Center
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Page	Section Title	Existing Text	Comment or Suggested Edit
27	23. Develop and Implement Quality Measurement and Evaluation Plan	• Publish dashboard measure results (July 2013 and ongoing) · Review and verify data, and publish results (January 2014 and ongoing)	Where will these be published? On DHCS website?
27-28	**PART C – PROCESS FOR ADDRESSING CONSUMER COMPLAINTS**	The State currently has several avenues for receiving beneficiary complaints about managed care health plans.	This section does not respond to the requirement of SB 1008. It does not describe the ombudsman function envisioned for the demonstration and it does not describe how the roles and responsibilities of existing complaint mechanisms will be coordinated. Further, it does not discuss how the state will respond to the statutory requirement for "a 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints."

September 7, 2012

Jane Ogle, Deputy Director
California Department of Health Care Services
150 Capitol Mall, M.S. 0000
P.O. Box 997413
Sacramento, CA 95899-7413
Delivered via e-mail to: info@CalDuals.org

RE: Programmatic Transition Plan for the Coordinated Care Initiative (CCI).

Dear Ms Ogle,

Thank you for providing the opportunity to comment on the draft Programmatic Transition Plan for the Coordinated Care Initiative (CCI).

In addition to more detailed comments that will be provided separately, the undersigned organizations want to highlight three general reactions to the transition plan. Our line-by-line comments are set out on the enclosed comment form. Please note that our comments are limited to the transition plan itself. We have repeatedly shared with DHCS our broader substantive concerns with specific elements of the CCI and did not reiterate those concerns here.

1. The plan does not allow enough time to accomplish important activities like readiness reviews, developing and expanding networks, contracting with providers, and conducting outreach and education campaigns with beneficiaries, community based organizations and providers.

2. The plan is still missing important details like when enrollment will begin and what benefits will be included. Instead of providing much in the way of new details o the

plan, the plan seems to simply summarize the governing state statutes and repeat the duals demonstration proposal that was submitted to CMS. We were struck by the sheer number of places where the plan reports that the Department is still developing policies, documents or procedures.

3. The plan fails to distinguish between the steps that need to be taken to implement the dual eligible demonstration from needed to implement the rest of the CCI. For example, there is no discussion of how notice materials will differ for dual eligibles and Seniors and Persons with Disabilities (SPDs) newly eligible for Medicaid, or of the type of notice regarding the integration of long term services and supports (LTSS) will be provided to SPDs already in managed care. It also does not include discussion of what type of waiver authority is being sought from the CMS to implement the integration of long term services and supports into Medi-Cal managed care for SPDs or for mandating the enrollment of dual eligibles into Medi-Cal managed care.

These concerns highlight once again the complexity of the CCI and the many elements that need to be in place before launch. It reinforces our concerns about the aggressive timetable and huge enrollment proposed by the Department in the first year of the demonstration.

Thank you for the opportunity to submit these and our more detailed comments.

Sincerely,

Kevin Prindiville
Deputy Director
National Senior Citizens Law Canter

Kim Lewis
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Directing Attorney
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Vanessa Cajina
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Stephanie Lee
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Anne Donnelly
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Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: CalPACE
Contact Name: Peter Hansel
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Page	Section Title	Existing Text	Comment or Suggested Edit
Page 13	Enrollment Notifications Strategy	Additional text suggested.	We recognize that the draft CCI transition plan is intended as a report to the Legislature o key provisions of the trailer bill. We believe the PACE related provisions in the trailer bill are important and are provisions the Legislature and administration devoted some time to. We appreciate the Department's development of fact sheets with more detailed information about PACE which have been added to the Cal Duals website. We suggest that the transition plan include information o the department's approach to implementing the PACE provisions, consistent with the fact sheets and other materials that the department has developed.

September 7, 2012

Toby Douglas
Director, Department of Health Care Services
1500 Capitol Avenue
P.O. Box 997413, MS 2000
Sacramento, CA 95899-7413

SUBJECT: August 27, 2012 Draft Coordinated Care Initiative Beneficiary Protections Transition Plan

Dear Mr. Douglas:

I am writing on behalf of Private Essential Access Community Hospitals (PEACH), representing California's community safety net hospitals, in response to the August 27, 2012 Draft Transition Plan for California's Dual Eligible Demonstration, and to express our ongoing concerns about the demonstration as it is currently planned.

We strongly support the intent of the joint state and federal effort to provide California's diverse and vulnerable dual eligible population with higher quality, coordinated, and more cost-effective care. All patient populations deserve better health outcomes and costs must be controlled to ensure the viability of Medicare and Medi-Cal programs. However, we have concerns about key elements of the demonstration, which we outline below, which could negatively affect continuity of care and patient access to community disproportionate share hospitals, their physicians, and other traditional safety net providers that serve this population.

On average, nearly 70 percent of the care provided by PEACH hospitals is for patients who rely on Medicare, Medicaid or are uninsured. ***Community safety net hospitals also provide more than one-third of the state's hospital-based care to California's 1.1 million dual eligible individuals***. Given the important role community safety net hospitals serve in the state's safety net, we are seeking further details and clarification from DHCS about how the provisions in the program's authorizing legislation (SB 1008, Chapter 33, Statutes of 2012) will be implemented to ensure that demonstration savings will be achieved by improved care coordination resulting in better health outcomes and reduced utilization, and not through provider rate reductions, redirection of patients away from their community safety net hospitals, denial of days or other mechanisms that will adversely impact the ability of these safety net providers to continue caring for all residents in their communities.

We appreciate DHCS' commitment to the Dual Eligible Demonstration stakeholder process and respectfully ask for clarification and additional details regarding the following issues in the August 27, 2012 transition plan:

I. Demonstration Size & Geographic Service Area (Page 4 of the Draft Transition Plan)

We remain very concerned about the large scope of the demonstration which will include eight counties and is now anticipated to serve about 540,000 dual eligible individuals– covering 49 percent of the total dual eligible population in California. The demonstration doubles the number of counties in the original dual eligible demonstration authorized by the California Legislature (SB 208 Steinberg/Alquist 2010). SB 1008 gives the department the option of establishing demonstration sites in "up to 8 counties not sooner than March 1, 2013." We urge the department to exercise its authority to limit the scope of the demonstration and to consider delaying and phase-in the demonstration in the larger counties.

PEACH INC
Private Essential Access Community Hospitals, Inc.
1107 9th Street, Suite 1001 • Sacramento, California 95814 916-446-6000 Fax 916-446-6266 • www.peachinc.org

We continue to share the concerns of the Medicare Payment Advisory Commission (MEDPAC) in its June 15, 2012 "Medicare and the Health Care Delivery System" Congressional report, cautioning that "…varied and complex needs of many of these individuals leads us to question whether care management models should be tested on large numbers of dual eligible beneficiaries or entire subgroups within a state. In addition, the large scope also makes the demonstrations appear to be large-scale program changes rather than true demonstrations." We also share the concern expressed in the June 2012 MEDPAC report regarding the short implementation time frame of dual demonstrations starting in early 2013, which is likely an inadequate timeframe for states to address all outstanding issues.

Additionally, we remain greatly concerned about the inclusion of Los Angeles County in the demonstration. Los Angeles County represents more than one-third of the state's dual eligible beneficiaries and any unintended enrollment problems, disruptions in care, provider network inadequacy or care transition deficiencies would present real and extensive dangers to this large segment of California's most medically vulnerable citizens.

PEACH Recommendations:

1. We urge DHCS to limit the demonstration to four counties, and to give serious consideration to limiting the inclusion of densely populated counties, so that the proposed models can be tested, evaluated and any problems corrected without widespread disruption if enrollment, access, or networks prove to be inadequate.

2. We also encourage DHCS to withdraw L.A. County from the group of counties participating in the demonstration project. Once the scaled down pilot projects have been implemented, tested, evaluated and best practices determined, PEACH would support the expansion of the demonstration projects to additional counties, to the extent the programs are replicable and scalable to the target county population.

II. Enrollment Concerns:

a) Passive Enrollment and Six-month Stable Enrollment Period (Page 6 of the Draft Transition Plan)

The demonstration transition plan indicates DHCS is continuing to propose a passive enrollment process with a six-month mandatory enrollment period for beneficiaries who do not affirmatively opt out. As proposed, beneficiaries would have at least 90 days to choose to enroll in a demonstration health plan or opt out for their Medicare benefits (all non-excluded dual eligible individuals in a demonstration county will be enrolled on a mandatory basis for their Medicaid covered benefits).

While we understand the desire of DHCS, health plans and providers to have the necessary time to make improvements in patient outcomes and cost reduction, we believe a six-month mandatory enrollment violates Medicare patients' rights to health care options that are in their best interest. Additionally, other recently approved state demonstration projects, such as the Massachusetts demonstration project, do not require the six-month mandatory enrollment, instead allowing individuals to opt out at any time in the process effective the first day of the next month. These patients are among the sickest and poorest, and the State estimates that more than 40 percent of the dual eligible population has multiple co-morbidities that include Alzheimer's disease, dementia-related cognitive disorders, behavioral and/or other mental health conditions.

We believe the passive enrollment/six-month lock-in framework could result in a widespread pattern of patients being inappropriately dislocated from their regular providers of care with a potentially difficult and confusing reunification process. We do, however, support DHCS's plan to work closely with stakeholders to develop timely beneficiary notices in all threshold languages, materials in alternative

formats, as well as communications in multiple settings. These efforts will be critical to helping avoid interruption of care and confusion about benefits.

b) Intelligent Assignment of Beneficiaries to Plans (Not addressed in the Transition Plan)

We are also concerned that the draft transition plan does not address the method of intelligent assignment of beneficiaries to plans for those who neither choose to opt out of the demonstration nor choose a health plan. This intelligent assignment process must ensure continuity of care and access to traditional safety net providers who are providing care to those beneficiaries. The June 15, 2012 MEDPAC report raises concerns about how beneficiaries will be matched to care delivery organizations that are appropriate to meet their needs under passive enrollment models, and if the opt-out enrollment policy will be structured to accommodate beneficiaries with cognitive and other limitations. We believe it is critical that these concerns are addressed in a transparent manner as the intelligent assignment process is finalized.

Further, intelligent assignment will require that Medicare claims and other data be made available to the plans so that customary providers, medical conditions, treatment modalities, and other critical information can be used in the "intelligent assignment process," the provider outreach process, as well as the clinical risk assessment that will lead to individual care plans for the most vulnerable patients.

PEACH Recommendation:

We urge DHCS to require that the intelligent assignment process is developed in a transparent manner and ensures continuity of care and access to traditional safety net providers who are providing a disproportionate share of care to dual eligible beneficiaries.

III. Network Adequacy (Pages 18-20 of the Draft Transition Plan)

The transition plan indicates that provider networks will be subject to confirmation through demonstration plan readiness reviews in October and November 2012. However, the plan does not indicate how it will monitor health plans inclusion and utilization of safety net and traditional providers, such as community safety net hospitals, in their networks.

SB 1008 [WIC 14182.(a)(2)(B)(22)(c)(7)] requires that the demonstration contract with safety net and traditional providers to ensure access to care and services and that managed care health plans "establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area." PEACH requests that DHCS further address this issue in the transition plan and indicate how it will measure this critical provision to ensure network adequacy and continuity of care.

Default Enrollment Algorithm

We are also concerned that the demonstration transition plan does not indicate which algorithm will be used in the default enrollment process. Community safety net hospitals provide one-third of the care to the state's dual eligible beneficiaries, and most primary and specialty care is provided by solo and small physician practices in the communities where the patients reside. These providers have long-standing relationships with their dual eligible patients, and must be included in the provider networks in the demonstration default enrollment process.

Currently, the state's default enrollment process for Medi-Cal Two Plan Model Counties and Geographic Managed Care Counties under a State Plan Amendment that provides an algorithm based on eight categories–six of which are Healthcare Effectiveness Data and Information Set (HEDIS) performance scores and the remaining two of which are based on plans contracting with the greatest volume of safety

net providers. Plans performing well under these measures are granted a greater volume of individuals under the state's algorithm.

It is estimated that sixty percent of all Medi-Cal enrollees are auto-assigned to a primary care physician or clinic because they do not affirmatively identify their current provider. Ensuring the state's definition of safety net providers encompasses all safety net providers in the auto assignment algorithm will help ensure greater network adequacy and continuity of care for not only the dual eligible population but those expected to enroll in Medi-Cal when the health care reform expansions occur in 2014.

Under current guidance directives to the plans, the California Department of Health Care Services has defined "safety net provider" in (a) through (f) below:

a) A federally qualified health center.
b) A federally designated rural health clinic.
c) A nonprofit community or free clinic that is licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.
d) A satellite or intermittent site of a nonprofit community or free clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.
e) An Indian or tribal clinic exempt from licensure pursuant to subdivision (c) of Section 1206 of the Health and Safety Code.
f) A freestanding county clinic or clinic associated with a publicly owned disproportionate share hospital.

In order to meet the intent of SB 1008, we recommend the department amend this definition to include three additional categories of safety net providers who serve more of the dual eligible beneficiaries in the state than those entities stated in (a) through (f) above:

1. Clinics associated with private disproportionate share (DSH) hospitals (in addition to the regulatory category of clinics associated with publicly owned DSH hospitals);

2. A medical group, independent practice association, physician office, or clinic with more than 10 physicians that has a Medi-Cal or medically indigent encounter rate of at least 50 percent of total patients served in a calendar year; and

3. A medical practice of 10 or fewer physicians in which at least 30 percent of patients served in a calendar year are enrolled in Medi-Cal.

PEACH Recommendations:

1. We recommend DHCS adopt a definition of safety net provider that amends the state's current default algorithm and includes the three additional safety net provider categories as defined in the above section.

2. We recommend the DHCS transition plan indicate how it will monitor health plan inclusion and utilization of safety net providers, including community safety net hospitals, in their networks.

IV. Other Concerns not Addressed in the August 27, 2012 Transition Plan

The Proposed Model of Care

The demonstration proposal states that California "will work closely with CMS and health plans during the MOU and three-way contracting processes to fully coordinate the Medicare and Medi-Cal Models of Care and benefit delivery to create a truly seamless experience for enrolled beneficiaries."

The demonstration project also proposes to utilize a delegated group model, in which "health plans may delegate certain responsibilities, such as utilization management, chronic disease management and the credentialing of providers, to another health plan and/or a group of physicians…"

The demonstration would rely on the delegated group model to control costs and achieve higher quality care through a variety of means, including broad, diverse provider networks; timely appointments, coordinated, person centered care; evidence based medicine; pay-for-performance networks that use information technology; innovative management and treatment of chronic conditions; and language assistance for beneficiaries.

While we support delegated group model goals, we are greatly concerned that safety net providers, as defined by our recommended definition for the enrollment default algorithm, are able to continue serving their traditional patient base. As noted above, a large proportion of the care to the dual eligible population is provided by solo and small group physician practices. These physicians–the historical and traditional providers of care to low-income patients in the selected counties–must be brought into the networks of care outside of the delegated group model. The default algorithm noted above is one measurable process to ensure that the dual eligible population will continue to have access to their traditional providers in their own communities and to ensure network adequacy and continuity of care.

We are also greatly concerned that there may be a perverse incentive built into the system that would encourage physicians to admit at non-Medicare DSH, non-teaching hospitals so that they can retain the DSH and IME payment equivalency or share in cost savings associated with admissions at lower cost hospitals. If this occurred, it may appear that networks are broad and adequate, but access would be severely limited and safety net providers would be harmed.

PEACH Recommendation:

PEACH greatly appreciates that the demonstration will require plans to ensure access and network adequacy by requiring that plans include traditional and safety net providers in their networks, including all public and private Medicaid DSH hospitals, *and* show full utilization of safety net providers in communities where patients reside. The proposed revised default algorithm outlined in this comment letter is one approach that should be employed.

V. Continuity of Care: Access to Out-of-Network Providers (Page 11 of the Transition Plan)

We appreciate that the draft transition reflects that department's plans to develop materials that clearly and appropriately describe beneficiaries' continuity of care rights under the SB 1008 requirement [WIC 14182.17(d)(1)(I)(5)(G)] that health plans are required to provide access to out-of-network providers Medi-Cal services for up to 12 months–if the provider meets applicable professional standards, has no disqualifying quality of care issues, and will accept the health plan's rate the applicable Medi-Cal fee-for-service rate, whichever is higher.

We also appreciate the demonstration requirement [WIC 14132.275(l)(2)(A)] that a beneficiary may continue receiving Medicare services from an out-of-network Medicare provider for primary and specialty care services for six months, if: (1) the beneficiary has an existing relationship with the provider; (2) the provider accepts payment from the health plan based upon the current Medicare fee schedule; and (3) the health plan would not otherwise exclude the provider due to documented quality of care concerns.

The ability of beneficiaries to access out-of-network providers will be critical to ensure continuity of care for beneficiaries whose traditional providers are not in the demonstration plan's network.

Continuity of Care Teams

The transition plan and subsequent DHCS "Beneficiaries Protections and the Coordinated Care Initiative" fact sheet indicate that health plans will conduct care coordination and management activities that reflect a member-centered, outcome-based approach, and provide seamless access to the full continuum of necessary services [WIC 14182.17(d)(1)(I)(4)].

PEACH recommends that as part of the care coordination and management activities that DHCS require plans to develop care coordination teams that are inclusive of safety net hospital clinical personnel and other hospital providers in this important aspect of the demonstration. This will help ensure that care transitions, especially from emergency room visits or the acute care setting into appropriate step-down levels of care, are standardized, timely and do not result in prolonged periods of hospitalization due to communication failures between clinicians, facilities and plans or as a result of network deficiencies where there is no receiving entity authorized.

PEACH Recommendation:

We ask that DHCS require the health plans to provide an enforceable process for engagement with hospitals so that all Medicare and/or Medicaid plan benefits and processes will be understood by physicians and appropriate hospital personnel upon patient admission, discharge and during care transitions.

V. *Financing & Payment*

PEACH greatly appreciates the SB 1008 requirements that managed care plans pay physicians and other health care providers for Medicare-covered services according to the current Medicare fee schedule and full Medi-Cal rates for benefits covered by Medi-Cal. We are also greatly appreciative of the requirement that health plans continue making supplemental payments such as DSH and IME, and bad debt reimbursement inclusive in the state capitation payment to qualifying hospitals.

However, we have some concerns about the capitated model of reimbursement to the demonstration health plans. While a capitation model limits risk for all partners, very few hospitals in the state, especially community safety net hospitals, are well positioned to accept full risk at this time for this population.

If the California experience with capitation models is a basis for the dual eligible demonstration projects, we must anticipate that plans and the major medical groups will seek to derive shared savings from the creation of risk pools. In order for risk pools to yield the desired financial incentives, "efficient provider networks" or "premier tier networks" will be established. Physicians will then be incentivized to admit patients to the lowest cost hospital in a region regardless of whether this is the hospital in the patient's community or the hospital of record for that patient. For safety net hospitals such as those represented by PEACH, loss of Medicare patients will pose a very significant threat. Medi-Cal is the primary source of coverage for our patients and is, sadly, among the worst payers of all Medicaid programs in the country; community DSH hospitals face consistent underfunding from caring for disproportionately high volumes of this patient population. With a range of 5 to 20 percent commercial payers, these hospitals do not have the ability that other hospitals do to cost-shift government payer shortfalls to commercial contracts, nor do they have the reserves to accept significant financial risk.

Instead, our hospitals are deeply reliant on a solid Medicare patient base that, with the supplemental add-on payments such as DSH, IME and Capital pass-through, begins to cover their costs of providing care to high-cost dual eligible patients that often present in the emergency room. It is critical that community safety net hospitals remain accessible to their significant dual eligible population and that plans and groups are prohibited from employing mechanisms that redirect patients from their community hospitals because of their more costly commitment to low-income populations and/or teaching missions. There may be lower cost hospitals nearby, but entire communities of mostly low-income and ethnically diverse residents may be

jeopardized if community safety net hospitals are underutilized for care to their historic dual eligible populations and are forced to reduce services and departments.

As noted above, to ensure continuity of care and network adequacy, plans must be required to offer contracts to traditional and community safety net hospital providers, and engage in full utilization of these providers. Payments must be fair and cost savings must result from decreased utilization and admissions, not from reduced provider payments.

Given their high volume of low-income and uninsured patients, community safety net hospitals are already in a very vulnerable position. Medicare DSH, bad debt reimbursements, and IME supplemental payments are essential to the survival of these hospitals and must be directed solely to the hospitals providing the services.

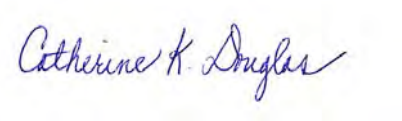
PEACH Recommendations:

1. Requiring financial protections from denial of days for hospitals when participating patients no longer require hospitalization but post-acute-care services are unavailable and such patients must temporarily remain hospitalized; and

2. Incentivizing plans and medical groups to fully utilize community safety net hospitals and traditional physicians by modifying the state's current algorithm to include all Medicaid DSH hospitals, clinics associated with them and high volume Medi-Cal physician practices.

PEACH appreciates the opportunity to submit these comments DHCS. We are committed to ensuring that the Coordinated Care Initiative Demonstration Project is successful and meets the goals of improving health care access and health care outcomes, and ensuring that care is delivered in the appropriate setting. We recognize that reduced utilization will produce significant cost savings and appreciate DHCS's commitment to require utilization reduction as the basis for achieving cost savings and to prohibit reduced provider payments in order to achieve those savings.

Sincerely,



Catherine K. Douglas
President and CEO

CC: Diana Dooley, Secretary, California Health and Human Services Agency
Jane Ogle, Deputy Director, Health Care Delivery Systems,
Department of Health Care Services

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Pico Rivera Healthcare
Contact Name: Rubie Let Esguerra
E-Mail: fac56admit@longwoodmgmt.com

Page	Section Title	Existing Text	Comment or Suggested Edit
15	Primary Care Physician Assignment	"This section of SB 1008 addresses primary care physician assignment for dual eligible beneficiaries not enrolled in the demonstration, by requiring Medi-Cal health plans to: Not interfere with a beneficiary's primary care physician choice under Medicare."	All dual eligible beneficiaries should be able to continue to see their primary care physician, even after the first six months of enrollment in the CCI. Some primary care physicians have served the beneficiaries for many years, it would not be fair to cut them off.
11	Part A- Access and Quality of Service	"Medicare Part D Continuity of Care: The department and CMS will implement and enforce Medicare Part D transition of care provisions, to ensure that health plans provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Part D drugs that are not o the health plan's formulary."	In the case that the patient needs a drug important to their personal need which is not on the formulary, the process for covering non-formulary drugs and the way in which these costs will be transferred to the plan participant is not mentioned.
14	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"Outreach Plan: DHCS is developing an outreach and education program informing beneficiaries of their enrollment options and rights, including specific steps for working with consumer and beneficiary community groups."	DHCS should not only develop an education program for beneficiaries, but also for providers such as skilled nursing facilities. This would ensure that services are delivered appropriately and that claims are paid on timely manner.
16	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"The Interdisciplinary Care Team: An Interdisciplinary Care Team (ICT) is formed for the care management of medical, LTSS and behavioral services. For individuals identified as needing such care management, the ICT functions will include assessment, care planning, service authorization, coordinating delivery of needed services, monitoring health status and service delivery. The ICT will also be	For patients with extreme behavioral or mental issues, the extent to which skilled nursing facilities be utilized is not discussed.

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Due September 7, 2012

Organization: Pico Rivera Healthcare
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Page	Section Title	Existing Text	Comment or Suggested Edit
		responsible for care transitions between community and institutional settings (hospital and nursing facilities). "	
19	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"Nursing Facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care. Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility. Demonstration plan's contracted facilities will be located in zip code areas covered by the Demonstration, and, to the extent possible, in adjacent zip code areas."	It is stated that demonstration plan's contracted facilities will be located in zip code areas covered by the demonstration; however, the process for skilled nursing facilities to contract with the demonstration plans is not explained. Is it randomized or is there a sign up process?

Comment Template for CCI Transition Plan Organization: Aging & Independence Services
Due September 7, 2012 Contact Name: Ellen Schmeding
E-Mail: Ellen.Schmeding@sdcounty.ca.gov

Page	Section Title	Existing Text	Comment or Suggested Edit
15	Enrollment & Notification		Suggest adding in the ability to leverage current communication channels to notify individuals (e.g., current community based organizations, provider networks, Area Agencies on Aging, community networks), in addition to contracting with identified parties to get the word out.
18	Network adequacy	Demonstration plans are required to have an MOU or contract with their respective county social services agencies to provide IHSS for their beneficiaries.	..respective county social services agencies and Public Authorities to provide IHSS and related tasks for their beneficiaries.
20	Medical and social needs	Dental, Vision and Home- and Community-Based (HCBS) Plan Benefits might be required benefits, depending upon rate development.	Need to spell out the difference between those benefits that could be part of the required benefit package (dental and vision) and additional HCBC services like home modification, transportation, counseling, money management, etc.) that could be purchased by plans to benefit specific clients (other states call these "cost effective alternatives" – MA calls them 'supplemental services'). This section does not differentiate

Comments on CCI Transition Plan

Organization: Sharp HealthCare
Contact Name: Sara Steinhoffer
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Page	Section Title	Existing Text	Comment or Suggested Edit
11	Part A: Network Adequacy Reviews	"For Medicare benefits, CMS has reviewed health plan networks and ensured they meet Medicare Advantage adequacy standards."	**Sharp HealthCare (Sharp) agrees with the California Hospital Association (CHA) that CMS and DHCS should provide documentation in support of the conclusion noted to the left that finds that current networks are adequate. Network adequacy should be broken down by health plan and county. In particular, as a full service behavioral healthcare provider, Sharp is very concerned that a lack of appropriate care options for these patients will mean they cannot achieve their best health outcomes** Sharp is concerned that narrow networks will be implemented and beneficiaries will lose access to their primary and specialty providers after the continuity of care provisions are no longer in place. Furthermore, DHCS and CMS should ensure that health plan networks are adequate for services that may not be addressed in existing Medicare Advantage (MA) standards, such as standards for long term care services and supports (LTSS) and services for mental health and substance use disorders. For example, long term residential care in a skilled nursing facility is presently reimbursed on a fee-for-service basis ; MA and Medi-Cal managed care plans have not needed to have extended networks of skilled nursing facilities. While we support the general guidelines included in the draft standard for LTSS, we note that they do not include clear benchmarks for assessing the number of providers relative to the population served, or to ensure that the network includes the various types of providers that will be required (i.e., suabacute care, availability of dialysis, etc) to care for this medically complex and vulnerable population.
12	Part A	To further strengthen provider access, DHCS and CDPH are conducting a provider outreach workgroup and related activities to ensure that health care providers receive information about the CCI, and to document and address any concerns that they may have. Provider engagement and participation in health plan networks is a key component of maintaining access for beneficiaries.	**DHCS and CMS should more actively engage hospitals and health systems in joint conversations with health plans regarding enrollment and outreach as well as network adequacy and beneficiary protections and these conversations should take place before the Memorandum of Understanding is finalized.**
12	Part A	DHCS, CHS and DMHC are currently	As part of the transition plan, DHCS should provide a timeline for evaluation and

Organization: Sharp HealthCare
Contact Name: Sara Steinhoffer
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Page	Section Title	Existing Text	Comment or Suggested Edit
		reviewing responsibility for monitoring compliance with state and federal timely-access provisions. DMHC recently promulgated regulations regarding Timely Access to Non-Emergency Health Care Services (California Code of Regulations Section 1300.67.2.2). DHCS and DMHC are reviewing the applicability of the regulation to the Duals Demonstration Project.	discussion of these provisions so that the current transition plan has a set of concrete follow up steps and a timeline in which additional information will be provided.
13	Enrollment and Notification Strategy	NA	This section does not address how enrollment and communication will occur with beneficiaries currently housed in institutions such as hospital based skilled nursing facilities or long term acute care hospitals in which a patient may exceed any 90 day period. Further, there is no detailed plan for hospital and other provider education and engagement. **DHCS should move quickly to add language to the transition plan that addresses these critical issues.**
16	Care Coordination	DHCS is currently developing care coordination standards for the health plans	**Sharp is proud to be participating in one, and expects to be part of a county-wide Affordable Care Act care transitions demonstration. Additionally, hospitals have clear incentives to ensure effective care transitions. As a result, hospitals should be able to provide input and to comment on the care coordination standards as they are developed.** This process is not outlined as part of the current transition plan timeline. This should be a high priority for DHCS and we look forward to work to craft those guidelines.
18	5) Network Adequacy	Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as	We ask that DHCS provide the standards for review and public comment and to demonstrate how it plans to show each standard meets the appropriate criteria. The level of specificity in this document should be strengthened so that there is clear understanding of the metrics used to make the network adequacy determinations across the board. Further, if the plan fails on those specified metrics DHCS should also document what corrective actions must be undertaken and in what timeline to address these failures. T**his level of detail should be provided in the transition plan for greater clarity.**

Organization: Sharp HealthCare
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Page	Section Title	Existing Text	Comment or Suggested Edit
		stringent and beneficiary-friendly as Medicare standards.	
19	Nursing Facility	Nursing facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care. Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility. Demonstration plan's contracted facilities will be located in zip code areas covered by the Demonstration and, to the extent possible, in adjacent zip code areas.	**Many SNF providers do not currently contract under managed care and additional work must be done to ensure that these services remain available to Medicare beneficiaries.** In particular, the critical role of the hospital based SNF should not be overlooked when reviewing the network of providers. These providers are currently caring for the most complex patients and are essential to the fabric of a coordinated care system. The current Medi-Cal rate structure recognizes the unique role of hospital based skilled nursing providers, and consequently reimburses hospital based distinct part SNFs at higher levels than free-standing nursing facilities. While present DP/NF rates are already well below the cost of care provided, we urge DHCS and CMs to ensure that rates for care provided in hospital based skilled nursing facilities continue to support the unique role these facilities serve in the continuum of care, and do not erode further.
20	(7) Grievance and Appeals Process	The unified process will not be more restrictive than the current Medi-Cal process, and might initially be combined with the Medi-Cal and Medicare process for health plan review of appeals, while maintaining the beneficiary option to use other current federal and state avenues for appeals. The unified process will be reviewed with stakeholders and will be communicated to beneficiaries and providers.	Please provide in the transition plan the timeline for when this discussion will occur with stakeholders as it is critical for maintain access to Medicare benefits for Medicare beneficiaries. This is not noted in any of the timeline information
28	PART C – PROCESS FOR ADDRESSING CONSUMER COMPLAINTS	NA	This section does not currently reflect provider and stakeholder input regarding patient complaints and appeals and we urge DHCS and CMS to go back to this section and make several revisions including but not limited to the following. 1) **DHCS and CMS must ensure that dual eligible beneficiaries have access to an effective "real-time" appeals process to resolve care denials.** The appeals

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			process for hospital discharge/transition to a post-acute setting should be completed **within 48 hours**. The current 3 day timeline specified in the transition document is not sufficient and must be revised. The ability to access the appropriate level of care in the days and weeks following an acute hospitalization is an important factor in beneficiaries' ultimate success in transitioning back to home and community. Additionally, appropriate post-acute care will reduce readmissions and reduce health care costs. **2) Health plans should be prohibited from transferring the patient until an appeal decision is rendered, and should be required to continue to be financially responsible for the patient's care pending the results of the appeal.** **3) Providers should not be prohibited from assisting beneficiaries with appeals and should be able to advocate on their behalf in particular in a situation where the patient is unable to take action due to physical or cognitive impairments.** **On page 28 it notes, "**In certain cases, beneficiaries may request an independent medical review as part of their complaint filing process." DHCS has not detailed what would allow for an independent review and further has not shared who would be the independent reviewer. Sharp shares CHA's concern that the plan will be incentivized to provide the lowest level of care at the lowest cost, which may not result in the best outcomes. Without adequate, timely and clear processes for care denials to be addressed by an independent reviewer, Medicare beneficiaries will have limited access and providers will remain financially responsible for providing the right care at the right time.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: Shield HealthCare
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Page	Section Title	Existing Text	Comment or Suggested Edit
4	Introduction	"…while achieving substantial savings from rebalancing service delivery away from institutional care and into the home and community."	The Plan does not address how the resulting increased expenditures in home care will be compared to the expected reductions in institutional care. The State should be able to quantify and report on what is meant by achieving substantial savings in real dollars.
5	Introduction	"…IHSS is a prized program rooted in consumers' right to self-direct their care by hiring, firing and managing their IHSS provider.	Self-direction and managed care conflict with one another. Consumers have ultimate self-direction under FFS and will have much less under managed care.
6	Introduction	"The principles of consumer-direction and continuity of care are and will remain key aspects of the beneficiary protections."	For this statement to hold true health plans must not be able to override beneficiary choice. What specific time frame is DHCS judging is "sufficient time to make informed" choices for beneficiaries impacted by this program?
6	Introduction	"Pending CMS approval, those who do not opt out will be enrolled in the demonstration for an initial six-month stable enrollment period, during which they will remain in the same health plan."	CMS has previously indicated that it would not support an enrollment lock-in period. The State should take the necessary steps to ensure that continuity-of-care provisions shall apply during the stable enrollment period should CMS decide to change its mind.
7	Introduction	"Transparency and meaningful involvement of external stakeholders, including beneficiaries, has been a cornerstone in the development of the CCI and will remain so throughout its implementation. "	The State needs to define what meaningful external involvement will look like. Under the SPD transition input was sought but routinely ignored. There is real concern amongst providers and beneficiaries that the same thing will happen as this program is implemented.
8	Introduction	"Following a successful health plan readiness review, DHCS and CMS will execute a three-way contract with the health plan for the demonstration that will reflect the MOU and the provisions of SB 1008."	The Plan does not indicate when or if readiness review results will be published or made available to the public. It also fails to explain what is included in LTSS.
8	Introduction	"The Contract Management team will be responsible for day-to-day monitoring of each	The Plan should explain who makes up this team and how beneficiaries or providers can access them.

Comment Template for CCI Transition Plan
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Organization: Shield HealthCare
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Page	Section Title	Existing Text	Comment or Suggested Edit
		health plan."	
8	Introduction	"…State agencies will conduct similar oversight activities for the CCI Medi-Cal contracts…"	The State agencies responsible for CCI oversight activities are not specified in this Plan and really need to be.
9	Introduction	"Within DHCS, primary responsibility for the CCI lies within the Health Care Delivery Systems program."	The Plan should identify who the head of this health care delivery systems program will be so there is visibility and accountability and how responsibility will be divided between various DHCS departments.
10	Introduction	"Note that while this Transition Plan mentions a select grouping of stakeholder comments, DHCS has carefully reviewed all submitted comments and will give each suggestion consideration in the process of implementing the components of the CCI."	In the interest of transparency, the State should explain how it addressed comments submitted and how it prioritized and incorporated external feedback into the development of this transition plan.
11	Part A – Access and Quality of Service	"Note that DHCS and DMHC are collaborating to determine the applicability of state standards to services funded by the federal government."	The Plan should indicate when this determination will be made and how it will be externally communicated.
11	Part A – Access and Quality of Service	"…to ensure the plans meet the State's newly established LTSS network adequacy standards."	Providers and beneficiaries would like to know where these newly established standards can be found.
11	Part A – Access and Quality of Service	"DHCS, CMS, and DMHC will monitor and enforce these provisions as part of the readiness review process, throughout implementation, and on an ongoing basis."	The Plan lacks specific details on how the State will monitor and enforce the continuity of care and network adequacy provisions of the CCI.
12	Part A – Access and Quality of Service	"Health plans will maintain liaisons to coordinate access for out of network Medi-Cal providers, and to coordinate with regional centers."	The Plan should explain what kind of regional center coordination is needed and how it will be handled.
12	Part A – Access and Quality of Service	"DHCS will develop descriptions of continuity of care rights in all threshold languages and alternative, accessible formats, and distribute these materials to beneficiaries through plans and providers."	The Plan does not indicate when the development of descriptions will be complete. These items should be complete well before implementation in order to ensure beneficiaries are well informed of their rights.
12	Part A – Access and Quality of Service	"…DHCS and CDPH are conducting a provider outreach workgroup and related activities to	The State should list out the various providers and provider types that have been involved in the

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Page	Section Title	Existing Text	Comment or Suggested Edit
		ensure that health care providers receive information about the CCI, and to document and address any concerns that they may have."	stakeholder process thus far and what continued involvement will look like in the future. The documents developed about provider concerns and what has been done to address them should be publicly available.
12	Part A – Access and Quality of Service	"DHCS, CHS and DMHC are currently reviewing responsibility for monitoring compliance with state and federal timely-access provisions."	The Plan fails to specify when the responsible agency(ies) will be identified and how compliance will be decided and how results will be communicated to providers and beneficiaries.
13	Part B – Enrollment and Notification Strategy	"…The release of notices will be scheduled by population groups."	The Plan should clearly identify the various population groups and time frame for release of notices.
14	Part B – Outreach Plan	"Contingent on available funding, this plan will include contracting with community-based, nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting beneficiaries in understanding their health care coverage options."	The Plan should address what sort of outreach efforts will occur should funding not be available. This statement appears to confirm beneficiary and provider concerns that DHCS continues to ignore concerns raised about ensuring appropriate beneficiary education and outreach should be a priority.
14	Part B – Communication Plan	"This communications plan will build on the experience gained during the Medi-Cal-only Seniors and Persons with Disabilities (SPD) program transition process."	The SPD transition provided many learning opportunities for this project and yet the Plan does not address what, if anything will be done differently this time around.
14 & 15	Part B – Initial Assessment Process	"…the State will work with plans and providers to ensure necessary processes and procedures are in place to support timely health risk assessments…DHCS is developing data files for health plans for this purpose."	The Plan should define what "timely" means and when exactly the development of HP data files will be complete. Risk assessments and data sharing were marked trouble spots for DHCS during the SPD transition. The plan should also provide additional information regarding the initial assessment process, including the time frame in which health plans will be required to perform an initial assessment.
15 & 16	Part B – PCP Assignment	"…Not assign a full-benefit dual-eligible beneficiary to a primary care physician except for specified circumstances…Assign a primary	The Plan should explain the specific circumstances in which a full-benefit dual-eligible will be assigned to a primary care physician. It is unclear what constitutes

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Organization: Shield HealthCare
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		care physician to a partial-benefit dual eligible beneficiary…Some of these provisions will be incorporated into existing Medi-Cal managed care health plan contracts as early as October 1, 2012."	a partial-benefit dual eligible beneficiary and additional info on that is needed. The Plan should also specify which provisions will be incorporated into existing MMC contracts.
16	Part B – Care Coordination	"…DHCS is currently developing care coordination standards for the health plans."	There is no indication as to when care coordination standards for the health plans will be complete and this info is important.
16	Part B - ICT	"…For individuals identified as needing such care management…"	It is unclear how individuals will be identified as needing care management under an ICT.
16	Part B – ICT Composition and Leadership	"…ICTs will include trained care managers or health navigators, and other health care professionals such as RNs and Licensed Social Workers…"	The Plan does not explain whether these individuals will be employed by the health plans, the State or both.
17	Part B – ICT Composition and Leadership	"…Health plans will also develop care plans to successfully transition beneficiaries into the community to the extent possible without jeopardizing the safety, health and welfare of the beneficiary."	There are no details or specifics given on how beneficiaries will transition into the community. This plan should include some guideline on types of methods to transition beneficiaries into the community will or will not be acceptable.
17	Part B - Frequency of ICT Meetings	"…Plans will need to establish policies and procedures guiding assessments and reassessments according to the approach and intensity of care management…"	It is clear that plans will be required to establish policies and procedures, however there is no indication when this needs to happen by.
17	Part B – ID'ing Beneficiaries for an ICT	"Specific criteria will be established by the plans and approved by DHCS."	The Plan calls for the establishment of specific criteria but it does not indicate when this project must be complete.
18	Part B – Network Adequacy	"…Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards."	The State should indicate when the comparison will be made and how it will be documented externally. This plan must not allow limitation of Medi-Cal benefits to the Medicare standard. This plan must not circumvent the Charpentier vs. Belsche [Coye/Kizer] injunction allowing dual eligible beneficiaries access to the same level of care as a Medi-Cal only beneficiary.

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20	Part B – Network Adequacy	"…individuals have timely access to scheduled and unscheduled medical care appointments…The state will require that health plans contract with a sufficient number of providers of durable medical equipment.	The State should clearly define what constitutes timely access so providers and beneficiaries have appropriate expectations. Additionally, it is unclear what a sufficient number of DME providers will be. Providers struggled mightily to get health plans to open up their network panels during the SPD transition and there remains great concern in this area today. It is unlikely that the existing provider networks have enough excess capacity to meet the needs of a largely expanded population and the Plan should indicate expansion of provider networks will be required.
20	Part B – Medical & Social Needs	"Dental, Vision and Home- and Community-Based (HCBS) Plan Benefits might be required benefits, depending upon rate development."	The Plan should indicate when it will be known whether or not these benefits will be required.
20	Part B – Medical & Social Needs	"Health plans will be required to use the most recent common procedure terminology (CPT) codes, modifiers, and correct coding initiative edits."	Please add HCPCS codes to the required list for health plans to use. HCPCS codes are used for DME and medical supplies.
20	Part B – Grievances and Appeals Process	"For the demonstration, the grievance and appeals process is jointly managed by the State of California, County Social Services Agencies, and the Center for Medicare and Medicaid Services (CMS)."	The Plan fails to explain how beneficiaries access their rights in this process or how they know they are interfacing with the appropriate agency to handle their issue. The plan states it "might initially be combined" with the Medi-Cal and Medicare process. This is not reasonable language to include in a transition plan document. There clearly is no plan.
21	Part B – Monitoring Health Plan Performance	"DMHC and DHCS will submit an annual joint report on financial audits performed on health plans."	The Plan does not indicate to whom this report will be submitted and whether or not it will be made available to the public and how to access it.
21	Part B – Monitoring Health Plan Performance	"DHCS will continue to work with stakeholders and CMS to develop ongoing quality measures for health plans for the demonstration…"	The Plan should already have quality measures in place. When they are available, they should be available for public review.
21	Part B – Monitoring Health Plan Performance	"…to audit health plans for quality measures…"	The Plan should indicate how often audits will occur and make results available for public review.

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21	Part B – Monitoring Health Plan Performance	"…and will identify and share any significant changes in aggregate or average utilization among beneficiaries…"	This language is unacceptable. Terms such as "significant changes" are ambiguous and allow varying interpretations. The State should provide clear and measurable guidelines as to what constitutes a "significant change" and explain who the info will be shared with.
23	Part B – Key Milestones and Timeline	"DHCS has developed and is maintaining a stakeholder list…This list currently has over 2,000 participants. "	It is extremely concerning that DHCS has only identified 2,000 stakeholders thus far. DHCS clearly has not accomplished a key milestone if a combined list of beneficiaries, advocates, health plan representatives and other interested parties only add up to 2,000 parties. This project is expected to impact more than 500,000 beneficiaries alone. The pool of potential stakeholders is likely in the millions. A list that includes a mere 2,000 members is more demonstrative of DHCS lack of commitment to ensuring beneficiary education and protections and making transparency a cornerstone of the Plan. DHCS has been planning for this project for months. It is imperative that the DHCS be required to communicate to stakeholders through a variety of channels (e.g. list serves, bulletins, and website) and ensure the communication is effective.
23	Part B – Key Milestones and Timeline	"…Ongoing communications: Continuous consultation with stakeholders…"	The Plan should include specific schedules of this process and whether it is DHCS or stakeholder initiated.
26	Part B – Key Milestones and Timeline	"Develop Interagency Agreement between DHCS and DMHC."	It is unclear if this will be complete in September or at some later point.
27	Part B – Key Milestones and Timeline	"Review and verify data, and publish results (January 2014 and ongoing)"	Stakeholders will want and need data on quality and evaluation results much sooner than 9 months after implementation.
28	Part C – Process for Addressing Complaints	"…DHCS will work with DMHC, other departments, health plans, and stakeholders to develop a tracking mechanism for complaints…"	The Plan should include a finalized tracking mechanism for complaints, rather than a note that one will be developed. This plan should be rejected if

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			it does not clearly indicate when this mechanism for tracking complaints will be completed. Stakeholders want and need ready access to a measurable and understandable mechanism for receipt and tracking of complaints.
29	Part C – Process for Addressing Complaints	"The following state agencies currently provide consumer assistance and complaint processing for covered medical services administered by the State of California…"	It is unclear from the Plan whether these agencies are expected to continue in their role of a resource to consumers instead of or in addition to the health plans. If consumer assistance will be limited in some manner (earlier indication states they will have to work with the assigned health plan), beneficiaries must be informed. Some clarification on this would be helpful.
31	Part D – Stakeholder Engagement	"DHCS staff members review the inbox daily and refer comments to the appropriate person for response."	Stakeholders want transparency and access to information. There should be a tracking mechanism and communication of information and comments received by DHCS. The Plan merely states that someone will review them daily and refer them elsewhere for a response. When comments are submitted to DHCS and responses are given this information should be shared with other stakeholders via the website or some kind of FAQs sheets.
32	Part D – Stakeholder Engagement	:"some of the recommendations represent efforts that DHCS cannot immediately implement and must address in future phases"…. "…bringing to light concepts and issues that worthy of further examination…"	The State should provide a complete accounting of recommendations received by stakeholders and that will be "addressed in future phases" or that are "worthy of further examination". It is unclear from this Plan and throughout the stakeholder process which specific concepts and issues DHCS has committed to examine further or in more detail and those they have unilaterally decided are without merit. In addition, we recommend that all responses to comments or recommendations be made available to the public in a consolidated document.

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33	CCI Timeline	(SEE CHART IN APPENDIX A)	This compressed timeline is too aggressive given the large number of beneficiaries impacted, the inherent complexities associated with implementing new demonstration projects and the large number of significant items included in this Plan that are "to be decided" or are "in development". The proposed timeline negates the State's opportunity to take advantage of any lessons learned (both bad & good) from the SPD transition.
34	Operational Readiness Principles	"The joint readiness standards for demonstration health plans are currently being developed, and will be shared with stakeholders when available."	The Plan should indicate when the readiness standards will be complete.
11	Part A – Access and Quality of Service	"Network adequacy reviews, conducted by the Centers for Medicare and Medicaid Services (CMS) and DHCS, are a key process…Beneficiaries may, under specified conditions, have access to out-of-network Medi-Cal providers for up to 12 months after enrollment…"	The Plan is clear that beneficiaries will have a choice of providers from a broad network of providers including primary care, behavioral health, specialists, ancillary, hospitals, pharmacists and LTSS providers. The State further requires health plans to follow all continuity of care requirements under current law. This is important because with the SPD transition the concept of care continuity changed more than once. The final MMCD All Plan Letter (11-019) came out two and a half months after the transition began and specifically excluded ancillary providers like DMEs and medical product suppliers. Dual eligible beneficiaries have a right to maintain relationships with their long-standing care providers and the out-of-network provision should apply to all provider types referenced in this section.
6, 8, 11, 12, 13, 15, 16, 17, 20, 21, 25, 27, 28, 34	(Introduction), (Health Plan Selection, Readiness, Contracts and Oversight),	"Pending CMS approval…" "Following a successful health plan readiness review, DHCS and CMS will execute three-way contract with the	The Plan document has significant number of items that are pending, in development, are noted as planned to be done and under review, either by DHCS alone or multiple agencies.

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		health plan."	The reviews are related to determining which agency is responsible or if state standards and regulations are applicable. Questions remain as to what benefits will or will not be included. These comments found throughout the document indicate a lack of readiness by DHCS to implement this plan. The timeline should be adjusted to allow all of these items to be complete before any part of the program is implemented. This list of remaining open items should cause DHCS, the legislature and all stakeholders significant concern.
	(Transition Plan Components),	"Note that DHCS and DMHC are collaborating to determine the applicability of state standards…"	
	(Access and Quality of Service),	"DHCS will develop descriptions of continuity of care rights…" "DHCS, CHS and DMHC are currently reviewing responsibility for monitoring compliance with state and federal timely-access provisions. "DHCS and DMHC are reviewing the applicability of the regulation to the Duals Demonstration Project"	
	Part B Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI (1)	"DHCS is developing and outreach and education program…" "DHCS is developing, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan…" "DHCS is developing data files for health plans for this purpose."	
	Part B Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI (3)	"DHCS is currently developing care coordination standards…"	
	Part B Operational Steps,	"Plans will need to establish policies and	

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	Timelines and Key Milestones for Beneficiary Protection Provisions of CCI (4)	procedures guiding assessments…" "Specific criteria will be established by the plans and approved by DHCS."	
	Part B Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI (6)	"Dental, Vision and Home- and Community-Based (HCBS) Plan Benefits might be required benefits…"	
	Part B Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI (7)	"The unified process will not be more restrictive than the current Medi-Cal process, and might initially be combined with…"	
	Part B Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI (9)	"With CMS, DHCS is developing joint readiness review standards…"	
	Key Milestones and Timelines (item 14)	"DHCS will determine which changes are necessary to the Waiver"	
	Key Milestones and Timelines (item 17)	"Develop Technical Assistance Guidelines for surveys"	
	Key Milestones and Timelines (Item 23)	"Finalize quality withhold measures for MOU" "Develop thresholds for quality measures for health plan contracts" "Develop Rapid-Cycle Quality Improvement Process for CCI"	

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		"Develop Process Indicators Dashboard for CCI" "Develop Evaluation Plan with CMS, and stakeholder input"	
	Process for Addressing Consumer Complaints	"DHCS will work with DMHC, other departments, health plans, and stakeholders to develop a tracking mechanism for complaints…"	
	Operational Readiness Principles	"The joint readiness standards for demonstration health plans are currently being developed…"	

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Organization: Silicon Valley Independent Living Center
Contact Name: Sarah Triano
E-Mail: saraht@svilc.org

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4	Introduction	The eight counties for 2013 implementation are: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.	These are all large urban counties. Los Angeles County alone contains one-quarter of all the dual eligibles in the state. This feels less like a demonstration than an attempt to use the 1115 waiver to get as many people into managed care as fast as possible.
5	Introduction	The CCI will protect and improve the nation's largest personal care services program, IHSS, which serves over 430,000 individuals. IHSS is a prized program rooted in consumers' right to self-direct their care by hiring, firing and managing their IHSS provider.	How in the world is interposing a health plan between IHSS consumers and caregivers supposed to "protect and improve" the program? And, how are health plans, which are used to delivering services in a clinical setting, supposed to suddenly branch out into home- and community-based services?
6	Introduction	The current fair hearing process for IHSS will remain in effect in the initial years of the demonstration.	"in the initial years of the demonstration" suggests that the fair hearing process may be phased out in coming years.
6	Introduction	For the demonstration, the State will use a passive enrollment process through which dual-eligible beneficiaries may choose to opt out of the demonstration.	On the August 29 stakeholder call, one of the speakers stated that the opt-out provision applied to Medicare only, and that managed care enrollment for Medi-Cal would be mandatory in the eight affected counties. This is contrary not only to the statement referenced but to similar information contained in the plan submitted to CMS.
7	Introduction	The State held a rigorous joint selection process with the Centers for Medicare and Medicaid Services (CMS) to identify health plans with	There have been complaints that the plans selected for the demonstration, as well as those already serving Medi-Cal-only eligibles, score poorly o performance measures as compared

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		the requisite qualifications and resources best suited to provide beneficiaries seamless access to an integrated set of benefits for the initial eight counties.	to those serving the general population.
11	Part A – Access and Quality of Service	Medi-Cal Continuity of Care: Beneficiaries may, under specified conditions, have access to out-of-network Medi-Cal providers for up to 12 months after enrollment.	What are the conditions? Where are they specified?
20	(7) Grievance and Appeals Process	The In-Home Supportive Services (IHSS) grievance and appeals process will remain as it currently is,	This is contradictory to the statement on page 6, which says the process will remain in effect "in the initial years of the demonstration".
22	Key Milestones and Timelines	Enrollment in CCI will occur no sooner than March 1, 2013.	Santa Clara County officials have indicated they are not prepared to make the transition so soon. As far as our plans go, 46,347 people in Santa Clara County are dually eligible for Medicare and Medi-cal; approximately 13,000 receive IHSS. Santa Clara Family Health Plan estimates that approximately 27,000 will enroll or be assigned to them. They are currently managing care for 6,308 dual eligible members. That's a 400% increase over a 1 year period (or approximately 3,000 new enrolees/month). Anthem estimates that approximately 15,000 – 22,500 will enroll or be assigned to them. They are currently managing care for 16,000 duals.

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Organization: Silicon Valley Independent Living Center
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31	Part D – Stakeholder Engagement	DHCS created two dedicated email addresses and inboxes to receive written stakeholder comments on the duals demonstration: duals@dhcs.ca.gov and info@calduals.org.	I submitted a question regarding the issues identified above on Page 6 to info@calduals.org on August 29. As of September 4 I have received no response.

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Organization: The SCAN Foundation
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7	Introduction	*Transparency.* Transparency and meaningful involvement of external stakeholders, including beneficiaries, has been a cornerstone in the development of the CCI and will remain so throughout its implementation. California has embarked on stakeholder workgroup process and will require proof of ongoing stakeholder involvement at the local level that includes, at a minimum: a process for gathering ongoing feedback from beneficiaries and other external stakeholders o program operations, benefits, access to services, adequacy of grievance processes, and other consumer protections.	**We recommend that the state adopt a standard 30-day comment period for stakeholder input o all planning documents, such as the CCI Transition Plan, in order to increase meaningful involvement of external stakeholders, including beneficiaries. Furthermore, we recommend that the state continue to engage local and state-level stakeholders in meaningful ways after the implementation of the Demonstration has begun.**
11	Part A – Access and Quality of Service, first bullet	Network adequacy reviews, conducted by the Centers for Medicare and Medicaid Services (CMS) and DHCS, are key process to ensure that health plans have sufficient providers in their network to meet the needs of members and provide sufficient access to care. For Medicare benefits, CMS has reviewed health plan networks and ensured they meet Medicare Advantage adequacy standards. For Medi-Cal LTSS benefits, DHCS will review health plan networks in the fall of 2012, as part of the readiness review process, to ensure the plans meet the State's newly established LTSS network adequacy standards. Further details regarding network adequacy and the readiness review process are provided in Part B, paragraph 5 of this report.	**We recommend that the health plan readiness review process include the full range of LTSS. In addition to those services specifically described in the Transition Plan in the Demonstration, we also recommend that the readiness review consider accessibility to home modification, caregiver support, supportive housing, transportation, Older Americans Act, and Independent Living Center services. The readiness review should also incorporate the specifications and standards for coordinating and funding all LTSS.**

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Organization: The SCAN Foundation
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14-15	Initial Assessment Process	Health plans will be responsible for an in-depth risk assessment process capable of timely identification of primary, acute, LTSS and behavioral health and functional needs. The multi-tiered process will begin with a health risk assessment of each beneficiary conducted upon enrollment. Health plans will use the assessment information for risk stratification of members, using a mechanism or algorithm developed by the health plan and reviewed and approved by DHCS. This will serve as a triage for further assessment needs in a variety of areas including, but not limited to, mental health concerns, substance abuse concerns, chronic physical conditions, and potential needs related to key activities of daily living, dementia, cognitive status and the capacity to make informed decisions. This assessment will help inform the interdisciplinary care team to assist in creating an appropriate individual care plan, and beneficiaries in accessing all necessary resources. Individual care plans will be used to address risk factors, prevent health disparities, and reduce the effect of multiple co-morbidities. Care plans will be developed for beneficiaries that include member goals and preferences, measurable objectives and timetables to meet his or her medical, psychosocial and long-term support needs that are identified in a comprehensive risk assessment.	**We recommend that the state be more prescriptive on the content of the health risk assessment to ensure that the information generated is more consistent across plans and populations. Furthermore, we recommend that the state provide more guidance about what constitutes "risk" for long-term services and supports needs and behavioral health needs, which would trigger more in-depth health and functional assessment for care planning purposes.** **We also recommend that the state specify what will be expected of plans around more in-depth assessment prior to implementation of the universal assessment tool, given that the universal assessment tool will not b piloted until 201 at the soonest, and only piloted in up to four of the eight Demonstration counties. Guidance is needed on how the LTSS assessment process will work in the near term and how to ensure consistency in implementation across health plans.**

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15	Care Coordination	DHCS is currently developing care coordination standards for the health plans.	**We recommend that the care coordination standards be released in draft form for public comment prior to finalizing with health plans.**
16	Identifying beneficiaries requiring an ICT	Individual plan members who require complex care coordination or case management are those who have multiple acute and chronic diagnoses, functional impairments (vision, hearing, upper/lower extremities, bowel and bladder), cognitive impairments, behavioral problems, ADL/IADL needing human assistance, and/or high utilization of medical, behavioral health and LTSS resources. Specific criteria will be established by the plans and approved by DHCS. The beneficiary's medical conditions will be assessed and ranked as low, medium or high complexity, each requiring a different approach and intensity of care management. Beneficiaries with ICTs could range from disabled individuals who are able to direct their own care to individuals with highly complex conditions needing intensive case management. Each ICT team will reflect the complexity and intensity of care management appropriate to the individual case.	**We recommend that the state provide clear guidance on who should be offered ICT support for care planning. This should be guided by information gathered through comprehensive health risk assessment process as defined by the state (see previous recommendation on assessment above).**
17	Composition and Leadership of the ICT	For members in nursing facilities, ICT will involve nurse practitioners, physician assistants or primary care physicians to work with NF staff to manage medical conditions in nursing facilities and to	**We recommend that the state require health plans to identify individuals who wish to transition from institutions to community settings and provide appropriate support through the California Community Transitions/Money Follows the Person**

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		facilitate nursing facility-hospital transitions. Health plans will also develop care plans to successfully transition beneficiaries into the community to the extent possible without jeopardizing the safety, health and welfare of the beneficiary.	**(CCT/MFP) program, where possible. If not already available to the health plans, the state/CMS should facilitate data sharing so that health plans may have access to the Minimum Data Set 3.0 Section Q information in which the resident indicates their wishes to return to the community. We also recommend that the state examine the cost-effectiveness of making available a transition allowance to plans both inside and outside of the CCT/MFP program.**

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Organization: UDW/AFSCME Local 3930
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16	Composition and leadership of the ICT	Based o the assessed need of the members, the core ICT will involve IHSS social workers, CBAS' Interdisciplinary team, behavioral health specialists, pharmacists, and other specialty providers in the development of comprehensive care plans, when appropriate. If the member agrees, immediate family or authorized representatives can also be members of the ICT.	IHSS providers need to be included in the list of potential members of the ICT. The following paragraph should be revised as follows: Based o the assessed need of the members, the core ICT will involve IHSS social workers, CBAS' Interdisciplinary team, behavioral health specialists, pharmacists, IHSS providers and other specialty providers in the development of comprehensive care plans, when appropriate. If the member agrees, immediate family or authorized representatives, including IHSS providers can also be members of the ICT.
18	Case follow-up and monitoring	The health plans will develop policies and procedures to implement an array of methods for follow-up and monitoring of cases. These may include face to face visits, telephone calls or direct e-mail contact as appropriate.	Members of the ICT, including IHSS providers, should be included in the follow-up and monitoring of members' cases. Frequently, IHSS providers are the only service providers to see a member on a daily basis, and thus are critical to both the care team and case follow-up and monitoring.
20	Medical and Social Needs	Dental, Vision and Home- and Community-Based (HCBS) Plan Benefits might be required benefits, depending upon rate development.	This sentence implies that HCBS might not be a guaranteed benefit covered by the managed care plan. This sentence needs to be clarified.
20	(7) Grievance and appeals process	The unified process will not be more restrictive than the current Medi-Cal process, and might initially be combined with the Medi-Cal and Medicare process for health plan review of appeals, while maintaining the beneficiary option to use other current federal and state avenues for appeals.	We support the development of a unified Medi-Cal Medicare grievance and appeals process and the preservation of the current grievance and appeals process available to IHSS consumers. We ask that aid paid pending and other benefits covered under the existing IHSS appeals and grievance process be explicitly laid out.

Comments submitted by Western Center on Law & Poverty and the National Health Law Program			
Page	**Section Title**	**Existing Text**	**Comment or Suggested Edit**
4	**Introduction**	Mandatory Medi-Cal managed care enrollment for dual eligible beneficiaries.	The paper should be amended to add the federal approval process for mandatory Medi-Cal managed care.
6	**"**	For the demonstration, the State will use a passive enrollment process…	Edit to read: "For the demonstration, the State has requested to implement a passive enrollment process through which dual-eligible beneficiaries may choose to opt out of the demonstrations for their Medicare benefits."
7	**Health Plan Selection, Readiness, Contracts, and Oversight**	The State held a rigorous joint selection process with the Centers for Medicare and Medicaid Services (CMS) to identify health plans with the requisite qualifications and resources best suited to provide beneficiaries seamless access to an integrated set of benefits for the initial eight counties.	The plan should add the timing of when CMS make its determination re which plans it will approve for participation in the demonstration
7	"	In addition, during the fall of 2012 the State and CMS will jointly assess each health plan's readiness using a jointly developed tool to ensure the plans will meet the operational requirements.	We d not believe all aspects of the readiness review can take place in the fall. There are not specific readiness review criteria that have been developed (or at least not yet shared with stakeholders for comment). It also is unclear how the state's readiness review will coordinate with the review that CMS is hiring a contractor to undertake.
11	**PART A - ACCESS AND QUALITY OF SERVICE**	Note that DHCS and DMHC are collaborating to determine the applicability of state standards to services funded by the federal government.	More clarification is needed here. What state standards are you considering not applying to access and quality (and how can these be waived if they are Medicaid standards)

Comments submitted by Western Center on Law & Poverty and the National Health Law Program			
Page	**Section Title**	**Existing Text**	**Comment or Suggested Edit**
11	"	For Medicare benefits, CMS has reviewed health plan networks and ensured they meet Medicare Advantage adequacy standards.	Has this review been completed? If so, what tool was used to determine that and what are the result?
11	"	Medi-Cal Continuity of Care: Beneficiaries may, under specified conditions, have access to out-of-network Medi-Cal providers for up to 12 months after enrollment. (W&I §14182.17 (d)(5)(G)).	The referenced statute excludes "ancillary services." Where are "ancillary services" defined? It is important that beneficiaries have care continuity rights for all services they use. Also, does this apply to both people in the demonstration and those only in Medi-Cal managed care? We not believe that would be allowed so it should be clarified.
11	"	Medi-Cal Continuity of Care for Nursing Facility Care: For nursing facility care, managed care health plans will recognize any prior treatment authorization made by DHCS for at least six months after enrollment into the health plan. (W&I §14186.6 (c) (3))	The plan should also be required to provide aid paid pending if the individual appeals a denial of continued treatment after the prior treatment authorization period. Also, this should apply to both people in the demonstration and those only in Medi-Cal managed care. Can that be clarified?
11	"	Medicare Continuity of Care: Beneficiaries will have access to out-of-network Medicare providers for the first six months of enrollment. (W&I §14132.275 (l)(2)(A)	Was this meant to be a separate bullet? Also, this does not state that these protections only apply to individuals in the duals demonstration. Finally, we note that having separate transition periods for Medicare services and Medi-Cal services is neither integrated nor easy to explain to beneficiaries. We have stated repeatedly that

Comments submitted by Western Center on Law & Poverty and the National Health Law Program			
Page	**Section Title**	**Existing Text**	**Comment or Suggested Edit**
			this should be integrated and happen in the same time frame.
11	"	Medicare Part D Continuity of Care:	It does not state whether this applies only to the duals demonstration. Please clarify.
12	"	Health plans will maintain liaisons to coordinate access for out of network Medi-Cal providers, and to coordinate with regional centers. The continuity of care liaison will ensure provider access and a smooth transition for each beneficiary into the demonstration. (W&I §14182.17 (5)(F) and (G))	How many liaisons? Sounds like only one per plan? Liaisons should be able to meet cultural and linguistic competency standards, have an understanding of the disabilities they are dealing with, and refer consumers to with independent and qualified consumer assistance organizations (to ensure consumers experience smooth transition into a new plan and see no disruption in their care).
12	"	To further strengthen provider access, DHCS and CDPH are conducting a provider outreach workgroup and related activities to ensure that health care providers receive information about the CCI, and to document and address any concerns that they may have.	We note that extensive efforts are critically important, and were far too late in CBAS and with the SPD transition. This process must be robust and meaningful.
13	**PART B - OPERATIONAL STEPS, TIMELINES AND KEY MILESTONES FOR BENEFICIARY PROTECTION PROVISIONS OF CCI**	The key operational steps to implement these provisions are listed below.	There is no reference here to getting Medicaid waiver approval as one of the operational steps. What steps are necessary for federal approval?

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Page	**Section Title**	**Existing Text**	**Comment or Suggested Edit**
13	**(1) Ensure timely and appropriate communication with beneficiaries.**		Clarify what is CCI and what is Duals Demonstration.
13	"	All notices will be released for stakeholder review at least 60 days prior to mailing to the beneficiaries.	More time should be added to obtain comments, then translate, print and mail notices (in addition to seeking any federal approvals)
		For in-person enrollment, disability accommodation such as assistive listening systems, sign language interpreters, captioning, and written communication will be available.	Add: and interpreter services will be provided without charge. Also please indicate who will be providing such services and how such services will be requested or determined to be necessary.
15	**(3) Primary Care Physician Assignment**	Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-Cal managed care plan;	As we understand it, the state's definition of a "partial benefit dual" for purposes of this section is one that either does not have Part A or does not have Part B. But if dual is Medi-Cal eligible, the state must pay his Part premiums. We cannot think of circumstances where a dual would not have Medicare as primary for Part B services and thus not have Medicare freedom of choice with respect to a primary care physician.
14	**Health Plan Oversight for Enrollment Communication:**	DHCS will ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures.	Change to: DHCS and CMS will ensure that managed care health plans have prepared materials to inform beneficiaries enrolled in the demonstration of how to obtain all their benefits, including grievance and appeals procedures. DHCS will also insure that plans

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			have prepared separate materials for those beneficiaries who are only enrolled for Medi-Cal services.
14	"	Communication and services will be available in alternative formats that are culturally, linguistically, and physically appropriate through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language and written translations.	Add: Plans will be required to have measures in place to identify individuals wishing alternate materials and ensure that those individuals routinely receive materials in the formats they request. Provide more details re how these needs will be identified
14	"	The multi-tiered process will begin with a health risk assessment of each beneficiary conducted upon enrollment.	What is meant by "upon enrollment?"
15	"	Care plans will be developed for beneficiaries that include member goals and preferences, measurable objectives and timetables to meet his or her medical, psychosocial and long-term support needs that are identified in a comprehensive risk assessment.	When will the comprehensive assessment be done?
15	**(3) Primary Care Physician Assignment**	Not assign a full-benefit dual-eligible beneficiary to a primary care physician except for specified circumstances;	What are "specified circumstances?"
16	**"**	Some of these provisions will be incorporated into existing Medi-Cal	Which ones, and will these changes to contracts be available to the public prior to incorporation?

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		managed care health plan contracts as early as October 1, 2012.	
18	**(5) Network Adequacy**	State Medicaid network standards shall be utilized for LTSS and the prescription drugs covered by Medicaid which are excluded from Medicare Part D. Medicare network standards shall be used for Medicare prescription drugs and other services for which Medicare is the primary coverage. Durable medical equipment, home health services, and any other services for which Medicaid and Medicare coverage overlap shall be subject to State Medicaid network standards so long as the State can show that such standards are at least as stringent and beneficiary-friendly as Medicare standards.	Ad at the start: Plans will be required to develop provider networks that are adequate to provide the services covered, taking into account the needs of the enrollee population, including needs for language and cultural competence and for accessible facilities. As a floor, state . . .
18	**“**	Provider networks will be subject to confirmation through Demonstration plan readiness reviews in October and November 2012,	How does this coordinate with national readiness tools being developed by CMS? Also need opportunity for stakeholder review of tool.
20	DME	The state will require that health plans contract with a sufficient number of providers of durable medical equipment.	Clarify “sufficient.”
20	**Medical and Social Needs**	Dental, Vision and Home- and Community-Based (HCBS) Plan Benefits might be required benefits, depending upon rate development.	Is this sentence really saying that HCBS benefits may not be required? Also this is another place where the distinctions between the CCI and the demonstration, if any, are unclear.

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20	**(7) Grievance and Appeals Process**	The unified process will not be more restrictive than the current Medi-Cal process, and might initially be combined with the Medi-Cal and Medicare process for health plan review of appeals, while maintaining the beneficiary option to use other current federal and state avenues for appeals.	There is no reference to the availability of aid paid pending during the first level of appeal. This should be added. How will beneficiaries be notified about these changes and what will the timing be for input on notices and approval of any new forms or processes?
21	**(8) Monitor Health Plan Performance and Accountability Through Performance Measures, Quality Requirements, Joint Reports, and Utilization Results**	DHCS, DMHC, and CDSS will implement the monitoring requirements of this subdivision by doing the following:	How is the CMS role different for demonstration plans v. CCI?
21	"	DMHC and DHCS will submit an annual joint report on financial audits performed on health plans.	To whom will the reports be submitted? Will they be public?
24	6. Review Health Plans' Models of Care and Plans Benefits Packages	Review plan benefit package, identify deficiencies, and confirm that deficiencies have been corrected (Completed on August 31, 2012)	What will this entail? Will policies and procedures re benefits be reviewed? CMS' participation in this review process should be included. Also, there is n distinction between CCI and demonstration review.
24	8. Develop Enrollment Process	Finalize enrollment phase-in process and timeline (August 30, 2012)	Has this been released? What is the process?

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24	9. Develop Beneficiary notices	All	This timeline appears very aggressive, given the need for translation, printing, etc.
25	10. Prepare Beneficiary and Provider Outreach and Education Plan:	· Conduct outreach activities (webinars, forums, presentations, etc.) (November 2012 – June 2013)	Outreach will need to continue well past June 2013
25	12. Complete Readiness Reviews	All	CMS' review role should be added.
25	14. Amend 1115 Waiver	DHCS will determine which changes are necessary to the Waiver (August 2012)	Has this happened? When will the information be public? Has DHCS submitted a waiver request? Have waiver negotiations with CMS started?
26	18. Plan and Complete IT System Changes	All	Does this schedule allow adequate time to test the systems?
26	19. Implement IHSS Managed Care Coordination	Develop Template MOUs between health plans and county social service organizations, and local public authorities. (August 31, 2012)	Have these been completed? If so, please share them publicly.
27	23. Develop and	Publish dashboard measure results	What input on the dashboards will be allowed by stakeholders? Where will these be published?

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	Implement Quality Measurement and Evaluation Plan	(July 2013 and ongoing) · Review and verify data, and publish results (January 2014 and ongoing)	On DHCS website?
27-28	**PART C – PROCESS FOR ADDRESSING CONSUMER COMPLAINTS**	The State currently has several avenues for receiving beneficiary complaints about managed care health plans.	This section does not respond to the requirement of SB 1008. It does not describe the ombudsman function envisioned for the demonstration and it does not describe how the roles and responsibilities of existing complaint mechanisms will be coordinated. Further, it does not discuss how the state will respond to the statutory requirement for "a 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints." plan to address that requirement should be added.

Comment Template for CCI Transition Plan
Due September 7, 2012

Organization: West Hills Health & Rehabilitation Center
Contact Name: Michael Seifert
E-Mail: fac56admin@longwoodmgmt.com

Page	Section Title	Existing Text	Comment or Suggested Edit
15	Primary Care Physician Assignment	"This section of SB 1008 addresses primary care physician assignment for dual eligible beneficiaries not enrolled in the demonstration, by requiring Medi-Cal health plans to: Not interfere with a beneficiary's primary care physician choice under Medicare."	All dual eligible beneficiaries should be able to continue to see their primary care physician, even after the first six months of enrollment in the CCI. Some primary care physicians have served the beneficiaries for many years, it would not be fair to cut them off.
11	Part A- Access and Quality of Service	"Medicare Part D Continuity of Care: The department and CMS will implement and enforce Medicare Part D transition of care provisions, to ensure that health plans provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Part D drugs that are not o the health plan's formulary."	In the case that the patient needs a drug important to their personal need which is not on the formulary, the process for covering non-formulary drugs and the way in which these costs will be transferred to the plan participant is not mentioned.
14	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"Outreach Plan: DHCS is developing an outreach and education program informing beneficiaries of their enrollment options and rights, including specific steps for working with consumer and beneficiary community groups."	DHCS should not only develop an education program for beneficiaries, but also for providers such as skilled nursing facilities. This would ensure that services are delivered appropriately and that claims are paid o a timely manner.
16	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"The Interdisciplinary Care Team: A Interdisciplinary Care Team (ICT) is formed for the care management of medical, LTSS and behavioral services. For individuals identified as needing such care management, the ICT functions will include assessment, care planning, service authorization, coordinating delivery of needed services, monitoring health status and service delivery. The ICT will also be responsible for care transitions between community and institutional settings (hospital and nursing facilities). "	For patients with extreme behavioral or mental issues, the extent to which skilled nursing facilities be utilized is not discussed.
19	Part B- Operational Steps, Timelines and Key Milestones for Beneficiary Protection Provisions of CCI	"Nursing Facility: Demonstration plans will contract with licensed and certified nursing facilities without encumbering citations to access all levels of care. Demonstration plans must maintain continuity of care for beneficiaries residing in out-of-network facilities until a safe transfer can be made to an in-network facility. Demonstration plan's contracted facilities will be located in zip code areas covered by the Demonstration, and, to the extent possible, in adjacent zip code areas."	It is stated that demonstration plan's contracted facilities will be located in zip code areas covered by the demonstration; however, the process for skilled nursing facilities to contract with the demonstration plans is not explained. Is it randomized or is there a sign up process?