HCBS Comment Template

Organization: Anthem/CareMore
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Page	Section Title	Existing Text	Comment or Suggested Edit
1	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS): Additional HCBS	Under the Duals Demonstration, the California Department of Health Care Services (DHCS) intends to expand the availability and use of HCBS by allowing demonstration plans to pay for these services out of the monthly payments they receive to provide care to their enrollees.	During the 1/30 HCBS call, stakeholders expressed confusion about the difference between HCBS waiver services and additional HCBS proposed for the duals demonstration. SB 100 refers to these additional HCBS as HCBS plan benefits that may be deemed necessary by the managed care health plan, including its care coordination team. Rather than use the term "additional HCBS" would DHCS consider using a term such as "supplemental benefits", which is defined as HCBS plan benefits deemed necessary by the health plan?
2	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS): Additional HCBS	This particular guidance is focused on the provision of a limited number of additional HBCS that are listed in the authorizing legislation for the duals demonstration, which "may include": 1. Respite care: in home or out-of-home; 2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; 3. Habilitation; 4. Nutrition: Nutritional assessment, supplements and home delivered meals; 5. Home maintenance and minor home or environmental adaptation; and,	Should item state: "beyond those authorized as part of IHSS" SB 100 states "The department, in consultation with stakeholders, may determine whether health plans shall be required to include these benefits in their scope of service, and may establish guidelines for the scope, duration, and intensity of these benefits". Does DHCS intend to propose definitions, for the additional HCBS including scope, duration and intensity for these benefits? If not, who will determine the scope, duration and intensity of additional HCBS? In regard to "other services", we would like the ability to provide any service delivered in HCBS

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		6. Other services (the list provided by legislation is permissive.)	setting that helps members avoid or reduce institutional stays, that is agreed to by the member and at the discretion of the health plan to be available as a supplemental benefit. During the stakeholder call held 1/30, DHCS stated that "habilitation" was a service coordinated by the plan and delivered by Regional Centers. However, this service is listed in SB 1008 as a HCBS benefit. If it is a HCBS plan benefit, is it correct that the plan is responsible for providing this service and could contract with the Regional Centers or other qualified providers to deliver this benefit?
3	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS): Duals Demonstration Vision for HCBS	The demonstration plans' new authority to offer these services will eliminate the need for the waivers for those eligible for the Duals Demonstration.	We disagree that the demonstration plans' authority will necessarily eliminate the need for [HCBS] waivers. The plan's ability to provide additional HCBS is dependent on the capitation rates set by DHCS and CMS as well as the amount, duration and scope of the additional HCBS plan benefits and the plan's ability to set limits on these services. For example, the NF/AH Waiver sets a limit on the cost of HCBS as a condition of waiver enrollment. The limit varies by type of setting in which a person would otherwise have received care, ranging from NF-A to acute hospital (with an annual HCBS cost limit of over $300,000 for persons at hospital level of care). The state has limited its financial exposure for HCBS waiver services by setting the cost limit

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			in each waiver and by imposing a waiting list for these services. We need to better understand the scope of these additional HCBS plan benefits and the methods plan may use to ensure the provision of additional HCBS plan benefits is a cost effective option.
4	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS): Plan Approach to Certain Home- and Community-Based Efforts	As a requirement for participating in the demonstration, and with regard to the six additional HCBS only, plans will: • Coordinate such services for beneficiaries who need them. • Refer beneficiaries to community providers to deliver services and to work with those providers as the plan deems appropriate. • Develop a care plan where the member has input into the services to be provided (for members requiring such a plan.) • Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion. Plans will have the financial incentive to provide these additional HCBS; however, there is no obligation to offer the six additional services.	This section is confusing as written – it is not entirely clear the additional HCBS are plan benefits. Suggested revision: ~~As a requirement for participating in the demonstration, and with regard to the~~ **Plans may authorize** ~~six~~ additional HCBS **plan benefits for member's based upon the plan's determination of the member's nee for on or more of these benefits . The plan will** ~~only, plans will:~~ • **Identify the member's nee for such services in the members ICP;** • Refer ~~beneficiaries~~ **these members** to **contracted** ~~community~~ providers to deliver **these** services; • **Include the provider of additional HCBS plan benefits in the member's ICP meetings, at the member's option** and • ~~and to~~ **Work with and provide** oversight of ~~those~~ **these** providers as the plan deems appropriate. • ~~Develop a care plan where the member has input into the services to be provided (for~~

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			~~members requiring such a plan.)~~ • ~~Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion.~~ ~~Plans will have the financial incentive to provide these additional HCBS; however, there is no obligation to offer the six additional services.~~
4	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS): Plan Approach to Certain Home- and Community-Based Efforts	Since the six additional services are not part of the core Medi-Cal program today, those services will not be subject to Medi-Cal grievance and appeals procedures if a plan chooses to offer them.	We believe these services will be subject to the grievance and appeals process because of language in the enabling legislation and related law that states: 14186.1.(c) "Home- and community-based services (HCBS) plan benefits" may include in-home and out-of-home respite, nutritional assessment, counseling, and supplements, minor home or environmental adaptations, habilitation, and other services that may be deemed necessary by the managed care health plan, including its care coordination team. The department, in consultation with stakeholders, may determine whether health plans shall be required to include these benefits in their scope of service, and may establish guidelines for the scope, duration, and intensity of these benefits. **Th grievance process for these benefits shall b the same process as used for other benefits authorized by managed care health plans** and shall comply with Section 14450, and Sections 136 and 1368.1 of the Health and Safety Code. If these services are subject to the same grievance process as other benefits, we need a

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			better understanding of the scope of these benefits, and the limitations plans may place on these benefits.
4	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS): Readiness and Compliance	The provision of these certain HCBS will be a new function for many demonstration plans. As such, the state will require that plans take number of steps to prepare for implementation. More specifically, for the services discussed in this document, demonstration plans must create: ….. 2. Policies and procedures to identify members that may need HCBS, and to refer members to community-based organizations and other entities that provide these services, such as California Community Transitions organizations, Area Agencies on Aging, Independent Living Centers, or ADRCs where available.	Item 2 as written could be interpreted to mean the plan coordinates these HCBS but does not actually provide (pay) for them. To ensure it is clear the additional HCBS are plan benefits, the suggested revised wording is: More specifically, for the services discussed in this document, demonstration plans must create……Policies and procedures to identify members that may need **additional** HCBS **plan benefits authorize these additional HCBS and arrange for provision of these additional HCBS from** ~~and to refer members to~~ **contracted** community-based organizations and other entities that provide these services, **such as but not limited to** California Community Transitions organizations, Area Agencies o Aging, Independent Living Centers, or ADRCs where available. Similar revisions should also be made to the language in the section entitled “Readiness and Compliance”.
6	Appendix A	Table of waivers Relevant to CCI	The inclusion of this table is confusing without additional explanation. If this table is necessary, the AL, IHO and NF/AH Waivers should be identified as not included in the demonstration.

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Attachment D	Interaction of Select HCBS Programs with the Coordinated Care Initiative Draft Guidance for Comment January 24, 2013		Stakeholders on the 1/30 HCBS call were very confused about the difference between the demonstration and the mandatory enrollment of dual eligibles not participating in the demonstration into managed care in 8 counties (that includes LTSS). We suggest you develop 2 separate documents or separate the discussion and flow charts into separate sections for the demonstration versus the mandatory managed care enrollment for duals in 8 counties (non demonstration).
Attachment D	Interaction of Select HCBS Programs with the Coordinated Care Initiative Draft Guidance for Comment January 24, 2013 – Attachment D	Green boxes: Waiver slot open; Paid by Medi-Cal FFS; Waiver waiting list applies Plan provides care management and plan benefits; Waiver slots are closed.	• The term "waiver slot open" is unclear especially because waiting list may/does exist. Suggested wording: Enrolled into waiver and paid by Med-Cal FFS or placed on waiver waiting list. • Waiver slots are closed could be interpreted to mean the NF/AH or AL Waiver is part of the Duals Demonstration. Suggested wording: Plan provides care management and plan benefits; Waiver not open to Duals Demonstration participants ~~slots are closed~~.
Attachments and F	Interaction of Select HCBS Programs with the Coordinated Care Initiative Draft Guidance for Comment January 24, 2013 – Attachments E and F	Green box: Plan provides care management and plan benefits; Waiver slots are closed White and green box: Plan may contract with CCT	• Waiver slots are closed could be interpreted to mean the NF/AH or AL Waiver is part of the Duals Demonstration. Suggested wording: Plan provides care management and plan benefits; Waiver not open to Duals Demonstration participants ~~slots are closed~~. • If the health plan contract with a CCT is optional, should this slide instead be entitled

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			"Beneficiary Seeks Transition from NF to Community"? The boxes would then include: Beneficiary would like to use CCT to transition out of a nursing home – Plan contracts with CCT – YE or NO. Additional boxes would show the difference between the CCT versus health plan transition process. If contracting with a CCT is required, the box "Plan may contract with CCT" should be eliminated and the green box revised. Suggested revision: Plan provides care management and plan benefits; CCT provides transition supports; Waiver not open to Duals Demonstration participants
Attachment G	Interaction of Select HCBS Programs with the Coordinated Care Initiative Draft Guidance for Comment January 24, 2013 – Attachments G	Under "Waiver" white box, green box states "Stays in waiver"	Suggested revision: Plan provides care management and plan benefits; Stays in waiver.

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DOCUMENT: "Interaction of Select HCBS Programs with the CCI"

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Attachment B	Not Enrolled: Beneficiary Seeks MSSP	Right side of page – "Excluded or exempt from MLTSS **or** demonstration"	"Excluded or exempt from MLTSS **and** demonstration" – an individual needs to be excluded from both MLTSS & DDP in order to receive MSSP services via Medi-Cal FFS i.e. ESRD as previous diagnosis – excluded from the DDP, included in MLTSS, therefore will be receiving MSSP services through health plan.
Attachment B	Not Enrolled: Beneficiary Seeks MSSP	Bottom right box – "Plan contracts for services."	"Plan provides services. May contract with MSSP agencies." Plans may choose to provide these services in-house through care management departments, or could contract it out to an MSSP agency or other resource.
Attachment B	Not Enrolled: Beneficiary Seeks MSSP	Bottom left box – "Enrolled when slot open; paid by Health Plan."	Question: what is the obligation of the health plan to provide commensurate services when a member is eligible for MSSP but no slots are available? Please clarify if plans must provide MSSP-equivalent services to these opt-out individuals. Note that it would be extremely complicated to do for a dual eligible person who is only enrolled in a health plan for their Medi-Cal benefits.
Attachments - G		Question	How will the health plan notify the state that a member has been newly identified for needing HCBS and/or MLTSS? Imperative for an aid code and actuarial rate to appropriately reflect the status of the member.
Attachment D	Not Enrolled: Beneficiary	Beneficiary would like to be in NF/AH, ALW	Does this mean that NF/AH , ALW waivers (and

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	seeks NF/AH, ALW Waiver	waiver, completed CCI enrollment & mandatorily enrolled in MLTSS, eligible for, but not enrolled in Demonstration (opt-out), Waiver slot open and *paid for by Medi-Cal FFS*	other waivers administered through Medi-Cal FFS) are carved-out of the health plan? Will the health plan be required to coordinate care with agencies that provide these services? Is the health plan responsible for everything else, but the waiver services?
Attachment D	Not Enrolled: Beneficiary seeks NF/AH, ALW Waiver	"Joins the Demonstration"	"Joins the Demonstration – must disenroll from waiver program". We suggest making this explicitly clear in the flow chart that people must choose between continuing in these waiver programs or joining the DDP
Attachment D	Not Enrolled: Beneficiary seeks NF/AH, ALW Waiver	Question	How will DHCS notify plans that a member is currently receiving waiver services through a carved-out waiver program? This is imperative to the care management process. Applies to the opt-outs as well as beneficiaries with Medi-Cal only who are enrolled in Medi-Cal managed care.
Attachment F	Not Enrolled: Beneficiary seeks CCT	Bottom right and left of flow chart: currently reads "Waiver slot and IHSS open; paid by Medi-Cal FFS)"	Recommendation: "Waiver slot open, waiver and IHSS paid for by Medi-Cal FFS" – IHSS never closes.
Attachment F	Not Enrolled: Beneficiary seeks CCT	"Beneficiary would like to use CCT to transition out of nursing home"	"Beneficiary would like to transition out of a nursing home" - this flow chart is not just about CCT, it is about transitions with CCT being one option for transition services
Attachment F	Not Enrolled: Beneficiary seeks CCT	"Plan may contract with CCT"	Suggest deleting this box as it is repeated in the box underneath (see following comment)
Attachment F	Not Enrolled: Beneficiary seeks CCT	Bottom middle box - "Plan provides care management and plan benefits; May contract with CCT; Waiver slots are closed"	"Plan provides transition services. May contract with CCT agency." Delete "waiver slots are closed" because this process is for people who

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			did not already have a waiver slot.
Attachment F	Not Enrolled: Beneficiary seeks CCT	"IHHS open"	Recommend deleting IHSS everywhere it appears in this document. May be confusing. Suggest separate flow chart for how people will get their IHSS.
Attachments F & G	Not Enrolled: Beneficiary seeks CCT and Post-Transition CCT	Question	For beneficiaries who are pending health plan enrollment and are enrolled in CCT while they await their health plan effective date, will the health plan be required to contract with the existing CCT vendor once the member joins and assume the remainder of the CCT contract, or can health plans at their discretion take over the transition services? (which could include contracting with the existing CCT agency)
Attachment G	Post-Transition: CCT Beneficiary	Bottom middle box – "Plan provider care management and plan benefits; IHSS continues"	"Plan provides post-transition services and health plan benefits." Recommend deleting IHSS from this box and everywhere else on this chart, and creating separate IHSS flow chart.
Attachments B-G		Question	Please similar provide flow charts for the AIDS waiver program, IHSS, and IHO. While the numbers statewide for the AIDS and IHO waiver programs are relatively small, there are six AIDS waiver agencies in L.A. County and we are working closely with them to determine how we will coordinate care and services. The majority of recipients of all of these waivers reside in L.A. County and it's crucial we all understand the process flows.

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Attachments B-G		Question	How will people with Medi-Cal only be affected by these processes? If these flow charts only apply to dual eligibles, please specify that, and please provide alternate flows for people with Medi-Cal only who will be impacted by the transition of LTSS into managed care.
2	CCI Participating Populations Chart – Duals Demo	American Indian Medi-Cal Beneficiaries – Included, but may opt out of Medi-Cal any month	"Included, but may opt out any month"
2	CCI Participating Populations Chart – Duals Demo	Beneficiaries with HIV/AIDS – "Included, but may opt out of Medi-Cal any month"	"Included, but may opt out any month"
3	Appendix A.2 CCI Populations for MLTSS	Question	There are some TANF beneficiaries who receive LTSS – recommend listing them as an included population. Examples: 1) today we have CBAS members in TANF aid codes 2) a TANF member may require long-term care and would remain in a TANF aid code until the system catches up and changes the aid code to an LTC code or the member changes to an SSI beneficiary , and 3) TANF beneficiaries can and do receive IHSS today (we confirmed this with DPSS)
3	Appendix A.2 CCI Populations for MLTSS	"Beneficiaries with Share of Cost – in community and not continuously certified"	We recommend this be an excluded population.
3	Appendix A.2 CCI Populations for MLTSS	"Medicare Advantage and Special Needs Plan members – Exempt in 2013"	"Exempt from passive enrollment in 2013"
2	CCI Participating Populations Chart for the Duals Demonstration	Beneficiaries with a Share of Cost – in skilled nursing facility, MSSP, or IHSS and continuously certified to meet share of cost - included	All SOC beneficiaries with MSSP and/or IHSS should be excluded. Other docs issued by the state define a SOC that is continuously met, as one that is met at the beginning of the month. Most IHSS recipients with a SOC do not meet it

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			until the later part of the month, after their homecare worker has turned in their first timesheet for the month. In addition, the SOC can be met in different ways and at different times from month to month. This will make it extremely difficult to determine who is meeting their SOC "continuously".
2	CCI Participating Populations Chart for the Duals Demonstration	American Indian Medi-Cal beneficiaries - Included, but may opt out of Medi-Cal any month	The comment of opting out of Medi-Cal is irrelevant on the chart for the duals pilot.
2	CCI Participating Populations Chart for the Duals Demonstration	Beneficiaries with HIV/AIDS - Included, but may opt out of Medi-Cal any month	The comment of opting out of Medi-Cal is irrelevant on the chart for the duals pilot.
2	CCI Participating Populations Chart for the Duals Demonstration	Program of All-Inclusive Care for the Elderly (PACE) and AIDS Healthcare Foundation enrollees - Exempt from passive enrollment (may enroll in Demonstration if first disenrolls from PACE/AHF)	Should simply say "Excluded".
3	CCI Participating Populations Chart for Managed Long Term Services and Supports	Beneficiaries with a Share of Cost – in skilled nursing facility, MSSP, or IHSS and continuously certified to meet share of cost - included	All SOC beneficiaries with MSSP and/or IHSS should be excluded. Other docs issued by the state define a SOC that is continuously met, as one that is met at the beginning of the month. Most IHSS recipients with a SOC do not meet it until the later part of the month, after their homecare worker has turned in their first timesheet for the month. In addition, the SOC can be met in different ways and at different times from month to month. This will make it extremely difficult to determine who is meeting their SOC "continuously".

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DOCUMENT: "Draft Policy for DDP Plans Offering Additonal HCBS"

Page	Section Title	Existing Text	Comment or Suggested Edit
4	Plan Approach to Certain Home- and Community-Based Efforts	"Plans will have the financial incentive to provide these additional HCBS."	Please describe the incentives.
6	Appendix : C HCBS Waivers Relevant to the CCI	Question	Please include the AIDS Waiver Program.
2	Purpose of this Paper	The Coordinate Care Initiative (CCI) legislation also provides specifications for how the Program of All-Inclusive Care for Elderly (PACE) will interact with the CCI.	The Coordinated Care Initiative (CCI) legislation also provides specifications for how the Program of All-Inclusive Care for Elderly (PACE) will interact with the CCI.
2	Background	Out of the 8 million Medi-Cal beneficiaries, approximately 13,000 received HCBS through California's 1915 (c) waivers today that are directly related to the CCI. These waivers each have enrollment caps on a statewide basis and in some cases regionally. (Please see Table A and Appendix A.)	How are these enrollment caps changing, if at all with the implementation of the CCI/DDP?
4	Plan Approach to Certain Home- and Community – Based Efforts	For the LTSS benefits that are required to be offered under Medi-Cal, the grievance and appeals procedures that exist today will continue.	Clarify G&A process for the DDP enrollees, as Medicare and Medi-Cal G&A processes differ.
Appendix A.1	Beneficiary is "Pending Enrollment Process into CCI":	In addition, eligible beneficiaries enrolled in MSSP will be passively enrolled all at the same time in September 2013; this step is	CCI enrollment process phased in vs. eligible beneficiaries enrolled in MSSP passively enrolled all at the same time (?)

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		being taken as a requirement for rate setting.	
Attachment B	Not Enrolled: Beneficiary Seeks Multipurpose Senior Service Program	Eligible beneficiary who would **like** to be in MSSP	Services provided to those who are eligible Physician Referral MSSP Screening Health Plans should not be accountable for all who would "like" to obtain service
Attachment B	Not Enrolled: Beneficiary Seeks Multipurpose Senior Service Program	Enrolled in MSSP **paid by Health Plan**	Describe financial arrangement between Health Plan and MSSP. Direct Payment or indirect (such as proposed by DHCS for IHSS services)
Attachment B	Not Enrolled: Beneficiary Seeks Multipurpose Senior Service Program	BOX1: Enrolled when slot open; paid by Health Plan BOX2: Plan contracts for services	How is access to slots managed when a new slot becomes available? Access for DDP vs. Opt Out? Based or Need?
Attachment B	Not Enrolled: Beneficiary Seeks Multipurpose Senior Service Program	Plan contracts for services	Should be clear that health plan responsibility to provide care coordination and access to HCBS is independent of MSSP role for MSSP members.
Attachment D	Not Enrolled: Beneficiary Seeks NF/AH, ALW Waiver	Beneficiary who would **like** to be in NF/AH, ALW waiver	Se previous comments regarding "Like"
Attachment D	Not Enrolled: Beneficiary Seeks California Community Transition	Beneficiary would **like** to use CCT to transition out of a nursing home	Se previous comments regarding "Like"

Comment Template: Draft Policy for Demonstration Plans Offering HCBS Organization: Alzheimer's Association

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Page	Section Title	Existing Text	Comment or Suggested Edit
1	Introduction	By definition, additional HCBS are available only by waiving federal law, which otherwise does not allow for such services. The notion that these additional HCBS are only available through a waiver creates a situation where such services are trapped in a silo. As a result, the Long Term Services and Supports (LTSS) system is fragmented.	This section appropriately addresses the problems of fragmentation but does not address lack of capacity in the current system, an equally significant issue. Individuals are often placed o long waiting lists before receiving services because of under-funding for each particular HCBS program to appropriately meet the population's need. We recommend that this section be amended to acknowledge the unmet need in the current system and the goal of the demonstrations to use resources more effectively to expand services to meet the population's needs.
3	Preparing for the Demonstration	Offer Technical Assistance to HCBS Community Groups:	Should include training for Demonstration plans that gives them additional insight on the options for care and supervision when their clients have Dementia. Are there ways to include the need to provide added care coordination and communication between services when this is a present reality.?
4	Plan Approach to Certain home and community based efforts	Coordinate Such services for beneficiaries who need them	Coordinate Such services for beneficiaries who need them or for those for whom Dementia or Alzheimer's is a diagnosis, either primary or secondary.
4	Plan Approach to certain home and community based efforts	Develop a care plan where the member has input into the services to be provided(for members requiring such plan)	Include specific requirements that for those with Dementia or Alzheimer's disease, safety and ongoing supervision need to be category of priority. When an appropriate caregiver is

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			present, they should be part of the decision making process, or the individual may need to be assigned someone to help arrange for and coordinate the services they need or are given.
4	Readiness and Compliance	2. Policies and procedures to identify members that may need HCBS, and to refer members to community-based organizations and other entities that provide these services, such as California Community Transitions organizations, Area Agencies on Aging, Independent Living Centers, or ADRCs where available.	Due to variance in geographic capacity, there is potential for member to be referred to a community-based organization (CBO) that must turn that individual away because they lack capacity to provide the service. We recommend that when a service is deemed necessary and included in the care plan and the CBO a plan refers the member to cannot serve the individual, that the state require health plans to purchase the service through other providers or to provide the service itself.

Comment Template: Draft Policy for Demonstration Plans Offering HCBS

Organization:
Alzheimer's Association

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Comment Template – Coordinated Care Initiative Organization: Alzheimer's Associations

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Page	Section Title	Existing Text	Comment or Suggested Edit
General Comments	Coordinated Care Initiative		The Alzheimer's Association has submitted detailed comments o past versions of the Coordinated Care Standards. It is disappointing to see that this current version contains none of our suggested changes. As a result, a number of the suggested changes included in this document have been submitted previously. Then, as now, the suggested changes that follow are designed to both protect and improve care for people with dementia.
General Comments	Coordinated Care Initiative		There are multiple instances in which this draft document references the involvement of caregivers in care consultation, care planning, etc. We believe it is critical that health plans assess these caregivers in order to identify their proficiencies, and also to identify any areas in which they require education and/or support to be an effective component of this process.
4	Health Assessment Process	Higher risk: means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health or functional status if they do not receive their initial contact by the Plan within 45 calendar days of enrollment.	"Individuals with a dementia diagnosis shall be automatically categorized as high-risk."
5	Health Risk Assessment	In 2015, the state will design, develop and test a universal assessment process, including a universal assessment tool, for long-term services and supports.	The Alzheimer's Association has done extensive work to identify best practices for detection of cognitive impairment . Please see: Cordell, C.B.; Borson, S.; Boustani, M.; Chodosh, J.; Reuben, D.; Verghese, J.; Thies, W.; Fried, L.B.; "Alzheimer's Association recommendations for

Comment Template – Coordinated Care Initiative Organization: Alzheimer's Associations

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			operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting". Alzheimer's & Dementia (2013) 1-10.
6	Health Risk Assessment	Including appropriate involvement of caregivers, and obtaining Member consent when the need for such involvement is identified	Plans should clearly state how they will address situations in which, due to cognitive decline, the Member is no longer able to provide this consent.
10	Person-centered planning	4. For Members with significant decline in health or functional status (e.g. Alzheimer's disease and related dementias), Plans will work with the Members, and/or their authorized representatives, as appropriate, to determine their current needs and interest in continuing to self-direct their care.	Individuals with Alzheimer's disease or another form of dementia can be especially vulnerable. Considering that- in some instances- a Member's authorized representative may be an abusive caregiver, we would appreciate some clarity regarding protections or monitoring requirements and/or training to help Plan representatives identify such occurrences.
13	Reassessment and Review	Reassessment may be conducted by phone, email, or in-person for beneficiaries in lower-risk group, and will be conducted in person or in the setting of the Member's choice for higher-risk group and nursing facility residents.	We urge language that explicitly indicates that people with cognitive impairment (including dementia) be considered "high-risk" and automatically qualify for the in person reassessment. We also urge inclusion of the following: c. For members with cognitive impairment, including dementia, the decision-making and planning process will include • The Member , their family, and caregivers; and The use of evidence-based multidisciplinary, transitional care practices for high-risk

Comment Template – Coordinated Care Initiative Organization: Alzheimer's Associations

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			chronically ill older adults.
14	Responsibilities and Qualifications of Care Coordinator	The requirement for the education and experience level of the care coordinator will be determined by the health plan according to the needs of the Member. For Members identified as high risk, care coordinators will have substantial training regarding medical, LTSS, and behavioral health services.	We would urge inclusion of training on cognitive impairment and dementia in the list of training requirements enumerated for care coordinators serving Members who are determined to be high risk.

Comment Template: Interaction of Select HCBS Programs Organization:
Alzheimer's Association

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Page	Section Title	Existing Text	Comment or Suggested Edit
1	Introduction	central goal of the Coordinated Care Initiative (CCI) is to help beneficiaries to stay in their homes and communities for as long as possible	A equally important goal is to ensure that individuals residing in institutional settings have the opportunity to return to the community, in accordance with their needs and preferences. We recommend adding language that acknowledges this goal.
A-1		Flow Charts for each benefit	In each category, especially for CBAS, IHSS, MSSP and ALW, there is a category for those who are eligible for the service, but there is not yet a slot available for the individual. For people with Alzheimer's and Dementia, if the person meets criteria but is not going to be immediately served, what then? People with Dementia or Alzheimer's, if needing this level of service have lost the ability to problem solve and handle any complex daily issues. They almost certainly will not be safe without some type of intervention. What are the Health Plans to do when this is the situation and dementia or alzheimer's is present reality given limited resources? Is a Care Facility of some type an option? How will they remain safe, and not be pushed into the Adult Protective Services arena if we don't find some type of alternate support?

Comment Template: Interaction of Select HCBS Programs

Organization:
Alzheimer's Association

Contact Name:Theresa M. Renken
E-Mail: theresarenken@caalz.org

Page	Section Title	Existing Text	Comment or Suggested Edit

Comment Template: Long-Term Services and Supports Organization:Alzheimer's Association

Contact Name: Theresa M. Renken
E-Mail: theresarenken@caalz.org

Page	Section Title	Existing Text	Comment or Suggested Edit
2	Long Term Services and Supports	2) Maintain the consumer-directed model for IHSS, which allows the member to self direct his or her care by being able to hire, fire and Manage his or her IHSS provider	Added phrase: with care coordination support for people with dementia or Alzheimer's disease. think it is critical to note that an individual meeting the criteria for these services, if Dementia is present, either as a primary or secondary diagnosis, will be unable to supervise, hire and is likely to fire staff even when they desperately need the care. Identifying the individuals with dementia, and providing support appropriately is essential. Driving up risks of high cost care is the almost certain alternative.

Comment Template

Organization: Bet Tzedek Legal Services
Contact Name: Kim Williams
E-Mail: kwilliams@bettzedek.org

Page	Section Title	Existing Text	Comment or Suggested Edit
3	Draft Policy for Demo plans 1-24-13		Add specific language regarding use of institutional deeming rules for married couples : Plans will use the Medi-Cal Long Term Care institutional deeming rules for married individuals who need MSSP services or nursing facility level care and wish to live in the community.

Comment Template: HCBS Policy: Demo Paper

Organization: CAHSAH
Contact Name: Jennifer Gabales, Director of Policy
E-Mail: jgabales@CAHSAH.org

Page	Section Title	Existing Text	Comment or Suggested Edit
1	Introduction	By definition, additional HCBS are available only by waiving federal law, which otherwise does not allow for such services. The notion that these additional HCBS are only available through a waiver creates a situation where such services are trapped in a silo. As a result, the Long Term Services and Supports (LTSS) system is fragmented.	This section appropriately addresses the problems of fragmentation but does not address lack of capacity in the current system. Individuals are often placed on long waiting lists before receiving existing waiver services because of under-funding for each particular HCBS program to appropriately meet the population's need. We recommend that this section be amended to acknowledge the success of existing waiver programs and the need for the services offered in the waiver plans be continued. Additionally, CAHSAH recommends that this section defines and acknowledges what the Olmsted decision is and the the importance of the *Olmstead* Decision and the governance it has over policies regarding access to home and community based care options.
2	Purpose of this Paper	This particular guidance is focused on the provision of a limited number of additional HCBS that are listed in the authorizing legislation for the duals demonstration, which "may include": 1. Respite care: in home or out-of-home; 2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; 3. Habilitation ; 4. Nutrition: Nutritional assessment, supplements and home delivered meals; 5. Home maintenance and minor home or environmental adaptation; and, 6. Other services	We recommend the following services be included in the definition of "Other" services: • Home Health* • Other housing assistance (e.g., restoring utilities, emergency move, non-medical home, temporary lodging;) • Private duty nursing; • Caregiver training and support; and • Supportive services provided in assisted living or publicly-subsidized housing. Home health is an existing Medicare and Medicaid serve has specific eligibility criteria that prohibit the ability to provide home health as a long term care service and support as it is in the existing Assisted Living, AIDS and Nursing Facility A/B and Nursing Subacute wavier programs.

Comment Template: HCBS Policy: Demo Paper

Organization: CAHSAH
Contact Name: Jennifer Gabales, Director of Policy
E-Mail: jgabales@CAHSAH.org

Page	Section Title	Existing Text	Comment or Suggested Edit
			In order for home health services to continue as an LTSS option, it needs to be include as an additional HCBS
3	Duals Demonstration Vision for HCBS	The demonstration plans will be given flexibility to provide supports to enhance a member's care, allowing members to stay in their own homes safely, thereby preventing unnecessary hospitalization and prolonged care in institutional settings. The demonstration plans' new authority to offer these services will eliminate the need for the waivers for those eligible for the Duals Demonstration. At the same time, demonstration plans will have the incentive to offer the six additional HCBS discussed in this paper in order to keep persons in the home and community, resulting in a higher quality of life for their members and avoiding unnecessary and costly institution-based care.	Incentives and Rate Structure: We recommend that the savings accrued from utilizing HCBS and the CCI waiver be invested into developing the HCBD. Need for Waivers: It is unclear how home health, which is an existing Medicare and Medi-Cal service, will be provided as a LTSS service without additional clarifications because the eligibility requirements for Medicare and Medicaid are not appropriate or applicable for waiver services. The waiver programs that utilized home health did not have the same requirements as Medicare and Medi-Cal for home health authorization. **Additional guidance is required to ensure that the plans are permitted to provide services outside of the existing home health eligibility requirements in Medicare and Medi-Cal to allow beneficiaries to receive services in their home**. In absence of this guidance, plans may not be able or willing to utilize home health as a LTSS and miss the savings generated through existing waiver programs.
4	Plan Approach to Certain HCBS	Grievance and Appeals: Since the six additional services are not part of the core Medi-Cal program today, those services will not be subject to Medi-Cal grievance and appeals procedures if plan chooses to offer them. Plans will develop internal procedures as part of developing a care	We recommend that the existing grievance and appeals process apply to all services. There should be an appeal process in place for beneficiaries whose needs, especially their HCBS needs are not met.

Comment Template: HCBS Policy: Demo Paper

Organization: CAHSAH
Contact Name: Jennifer Gabales, Director of Policy
E-Mail: jgabales@CAHSAH.org

Page	Section Title	Existing Text	Comment or Suggested Edit
		plan that is patient-centered.	

Comment Template

Organization: CA Collaborative for Long Term Services and Supports
Contact Name: Jack Hailey
E-Mail: jack@gacinstitute.org

Page	Section Title	Existing Text	Comment or Suggested Edit
n/a	n/a *Timeline for comments*	Cover materials calling for comment by 2/6/13 and cover materials indicating that the period for comment on the LTSS Network Standards and the Care Coordination Standards is closed.	The tight timeline for comments and the difficulty of making comments that reflect the interrelationships among this document, the LTSS Network Standards, the Care Coordination Standards, and the as-yet unknown rate structure limit the Collaborative's ability to provide the kind of assistance we wanted. We hope that there is an opportunity to comment on the entire set of draft documents once the MOU is out. The California Collaborative offers itself or a selection of its members as a working group to conduct a final review of the documents – for clarity and consistency.
2, 4, and *passim*	Purpose and Plan Approach *List of HCBS*	"This particular guidance is focused on the provision of a limited number of additional HBCS that are listed in the authorizing legislation for the duals demonstration, which 'may include': …" page 2; "…there is no obligation to offer the six additional services." page 4; and, *passim*	The Collaborative recommends that Home and Community Based Services (HCBS) not be limited to the six included here, but to a fuller range, including MSSP and those services provided now through waivers. MSSP and that broad set of services available now through waivers should be included in HCBS. Examples include home or environmental adaptions, habilitation, transition assistance, and supplemental home health and personal care.

Comment Template

Organization: CA Collaborative for Long Term Services and Supports
Contact Name: Jack Hailey
E-Mail: jack@gacinstitute.org

Page	Section Title	Existing Text	Comment or Suggested Edit
3	Vision *Waivers and waiver services*	"California's existing LTSS system for providing and funding HCBS is experiencing a number of challenges, including fragmented delivery, isolated data systems and limited access."	The Collaborative believes that the various waiver policies and CCI/Duals opt-in/opt-out policies will increase fragmentation and may limit access – as well as being confusing to consumers, families, providers, and health plans. The CCI/Duals Demonstration seems to be an excellent opportunity to provide a more integrated system instead. Waivers and waiver services, as noted in the comments above and below, should be integrated into the Duals Demonstration and be required of plans.
4	Plan Approach *Assessment*	"As a requirement for participating in the demonstration, and with regard to the six additional HCBS only, plans will: Coordinate such services ... Refer beneficiaries to community … … Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion."	The Collaborative recommends that assessment of clients' needs should be more clearly connected to responsibilities of plans to provide those services. In the draft document, assessment is implied: health plans "coordinate" services, "refer … to community providers," and "deliver additional services … at the plan's discretion." The Collaborative believes that providing these services should be required of health plans when an assessment indicates that the services are needed. By connecting required services to assessed needs, the Collaborative believes that the

Comment Template

Organization: CA Collaborative for Long Term Services and Supports
Contact Name: Jack Hailey
E-Mail: jack@gacinstitute.org

Page	Section Title	Existing Text	Comment or Suggested Edit
			promise of managed care will result in a true integration of services.
4	Plan Approach *Appeals process*	"Since the six additional services are not part of the core Medi-Cal program today, those services will not be subject to Medi-Cal grievance and appeals procedures …."	The Collaborative believes that a grievance and appeal procedure is important to include and to reference for all services, whether required or optional. We learned from the CBAS experience that we need a robust and rapid review process.
1	Introduction *Rates*	"Under the Duals Demonstration, DHCS intends to expand the availability and use of HCBS by allowing demonstration plans to pay for these services out of the monthly payments they receive to provide care to their enrollees. … At the same time, demonstration plans will have the incentive to offer the six additional HCBS discussed in this paper in order to keep persons in the home and community…"	The California Collaborative recognizes that the recommendations above require that the cost for these services must be reflected in the capitation payment. However, the current proposal states that funding will be based on "savings," which may not be adequate to meet the needs of the population if the benefits are mandated. Plus, little if any savings are anticipated in the first year of the Demonstration, so paying for these needed services becomes more problematic. From the outset, rates should reflect payments for anticipated need for all HCBS services.

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National Consumer Voice for Quality Long-Term Care

California Alliance for Retired Americans

Long-Term Care Ombudsman Services of SLO

National Senior Citizens Law Center

Office of the California State Long-Term Care Ombudsman Program

February 6, 2013

Jane Ogle, Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Sacramento, CA

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

Dear Ms. Ogle,

California Consumers for Quality Care, No Matter Where appreciates the opportunity to submit comments regarding California's "Draft Policy for Demonstration Plans Offering Additional Home-and Community-Based Services (HCBS)." *California Consumers for Quality Care, No Matter Where* is an initiative of the National Consumer Voice for Quality Long-Term Care (Consumer Voice), a national non-profit organization that advocates on behalf of long-term care consumers across care settings. The Consumer Voice's membership consists primarily of consumers of long-term care and services, their families, long-term care ombudsmen, individual advocates, and citizen advocacy groups. The Consumer Voice has over 37 years experience advocating for quality care.

California Consumers for Quality Care, No Matter Where consists of California organizations and programs focusing on issues faced by long-term care consumers who receive services and supports in non-nursing home settings and building a strong consumer voice to advocate for well-coordinated, accessible, quality long-term services and supports both at home and in the community.

The primary focus of this initiative to-date has been on nursing home transitions through the California Community Transitions Project, the state's Money follows the Person program. Specifically, we have been looking at ways in which consumers believe the nursing home transition process could be made even better. As part of this research, we interviewed individuals who had successfully transitioned back into the community or who were in the process of transitioning.

Based on the information gathered from these interviews, *California Consumers for Quality Care No Matter Where* urges you to:

- Include community transition services as a mandatory element of the covered benefit package
- Include the additional HCBS benefits currently available through waivers as required elements of the covered benefit package
- Contract with CCT Lead Organization to provide transition services

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1. Include community transition services as a mandatory element of the covered benefit package

Moving out of a nursing home and back into the community completely transformed the lives of these consumers. Individuals told us that they regained privacy, independence and choice. One man said he "has a life again" and feels like he's "alive again." He said that the nursing home "sucked all the life out of him." A woman shared with us that in the nursing home, her whole life was only "three inches beyond the edges of her bed." Once in her own apartment, she had "the power of choice." She could make her own plans and not live her life according to someone else's schedule. She could also choose the type of food she wanted to eat, even if it were just a quick sandwich. This consumer calls this time in her life her "second adulthood" now that she has finally become "officially independent."

California Community Transitions/Money Follows the Person gives privacy, independence and choice back to individuals. It also reduces the number of people who are institutionalized in California, thereby complying with the Americans with Disabilities Act, pursuant to *Olmstead v. LC*, 527 U.S. 581 (1999), and saving the state money.

Given the importance of nursing home transitions, we disagree with the exclusion of community transition services from the covered benefit package of demonstration plans for dual eligibles. Failure to include these services as part of the covered benefit package sends a signal to plans that nursing home transition services are optional rather than mandatory. The National Senior Citizens Law Center (NSCLC) aptly states in its comments, "As a former health plan executive recently explained, the difference between covered and non-covered benefits in managed care is traditionally 'a fairly bright line, and if it is not our service, if the service or product in question is not a benefit, then it is highly unlikely that managed care will provide it.'"[1]

We certainly appreciate the state's commitment to continue to seek Money Follows the Person funding for CCT. By including community transition services as part of the duals demonstration mandatory benefit package, the state can better ensure that eligible individuals who wish to move out of nursing homes receive the services and assistance to do so.

2. Include the additional HCBS benefits currently available through Medi-Cal waivers as required elements of the covered benefit package

In order to successfully return to the community, nursing home residents need a wide range of supports and services. Medi-Cal waivers allow seniors and persons with disabilities to receive more home and community based services than might otherwise be available through the Medi-Cal or IHSS program, such as nutritional assessment, counseling, supplements, home or environmental adaptations, habilitation, supplemental home health and personal care, and other services.

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[1] Bruce Chernof, The SCAN Foundation, "TSF Webinar: Managed Care 101- Presenting the Fundamentals of Integrating Long-Term Services and Supports into a Managed Care Model," Dec. 14, 2012, available at http://www.thescanfoundation.org/tsf-webinar-managed-care-101-presenting-fundamentals-integrating-long-term-services-and-supports.

We object to the failure to include these types of additional HCBS services as part of the covered benefit package for the same reasons expressed in point #1 above. In addition, as noted by NSCLC, "At best, giving complete discretion to plans to decide whether to offer waiver-level HCBS turns these important services into a 'hidden' benefit. Members of a dual demonstration plan may not know that these benefits exist. These beneficiaries will be denied access to the appeals and other due process protections currently available to waiver participants."

Furthermore, California's policy to exclude these benefits runs counter to a national trend among states to include HCBS waiver services in the required benefit package. A review conducted by NSCLC reveals that a significant number of states with existing managed LTSS programs (including Arizona, Minnesota, Tennessee, Texas and Wisconsin) explicitly identify HCBS waiver services as part of the benefit package in their contracts with managed care organizations.

We recommend that additional HCBS services through Medi-Cal waivers be included in the benefit package. This will ensure that plan rates are sufficient to provide the services; that plans establish a network of providers to deliver the services; and that plans actually offer these services to beneficiaries that need them to live in the community.

3. Contract with CCT Lead Organization to provide transition services

The consensus of consumers we interviewed was that the transition process went very well. Here is what individuals who had transitioned said about their coordinators:

- Ms. S: The transition coordinator was great!
- Mr. O: The transition coordinator helped with the entire process. The transition coordinator assisted with the paperwork, interviewed him … and checked their home to see what was needed for Mrs. O when she came home
- Mr. C: The transition team helped with the complete move and arranged for his wife to move out with him.
- Ms. A: The transition team told her they would find her a place to live and help furnish it. Ms. A said she was skeptical, but it happened! … Ms. A said that the transition team was wonderful. They "really bent over backwards" and did "everything perfect."

The assistance and support consumers received from the CCT providers was invaluable in making the transition successful. We heard from consumers that their transition coordinators were involved in every aspect of the move out of the nursing home and back into the community. They helped to find housing, arrange for home modifications, furnish the apartment or house, and pay for the rent and security deposit. They assisted consumers in buying food and medications and obtaining medical equipment. Transition coordinators found caregivers for individuals to interview and when needed, taught people how to interview and select their providers. On moving day they rolled up their sleeves and helped pack boxes and transport individuals. After the move, they continued to provide assistance and support.

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The job of a transition coordinator is complex and challenging. The coordinator must have knowledge about long-term services and supports, housing and payment options; expertise; and familiarity with local resources. He or she must be adept at completing and coordinating an enormous number of tasks. A coordinator must also be very "hands-on" – ready to do whatever it takes from driving people to appointments to decorating apartments. The coordinator is a facilitator, a coach, a mentor, and a counselor.

These statements from consumers indicate that the support they received from their CCT providers was invaluable in making the transition successful.

The current transition coordinators from the CCT lead organizations have this knowledge base, experience, and skills. They know how to successfully transition individuals from a nursing home back into the community. For that reason, the role of CCT lead organizations should be preserved by requiring plans to contract with these organizations. This is the approach the department is taking with IHSS and adult services by proposing that plans contract with county public authorizes and Community-Based Adult Services providers respectively. Community transition services should be handled in the same way.

Thank you for your consideration of these recommendations.

Sincerely,

California Consumers for Quality Care, No Matter Where

Comment Template

Organization: California Medical Association
Contact Name: Lisa Folberg
E-Mail: lfolberg@cmanet.org

Page	Section Title	Existing Text	Comment or Suggested Edit
"HCBS Draft Policy," Page 4	Readiness and Compliance	**1.** Policies and procedures that guide the demonstration plans' care coordinators, Interdisciplinary Care Teams, and primary care physicians in assessing the appropriate authorization of these services and/or benefits, in addition to the required community-based LTSS (i.e. CBAS and IHSS), including but not limited to assessment tools and reassessment cycles.	CMA requests that DHCS clarify the intended role of the primary care physician in assessing the appropriate authorization for the new HCBS services being provided through the plan. The department should clarify such issues as whether the assessment would require a complete history and physical, and whether physicians would need to re-authorize patients o a periodic basis. It is only with that increased level of clarity and specificity that physicians and plans can freely contract for these services.
"CCI Draft Assessment and Care Coordination Standards"; page 15	INTERDISCIPLINARY CARE TEAM (ICT)	Plans will comply with the with following requirements regarding ICTs: 3. The ICT will be led by professionally knowledgeable and credentialed personnel such as physicians, nurses, social workers, restorative therapists, pharmacists, psychologists. (D-SNP) (excerpted)	CMA generally supports the concept of the Interdisciplinary care team (ICT), which is integral to emerging models of care such as the patient-centered medical home. However, CMA asks that DHCS clarify two points: 1) That the personal physician retains the supervisory role in all clinical decision making, in accordance with state scope of practice laws; and 2) That all providers in the ICT should receive additional compensation to account for the extra work involved in increasing care coordination.

Comment Template

Organization: California Medical Association
Contact Name: Lisa Folberg
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Page	Section Title	Existing Text	Comment or Suggested Edit
"LTSS Network Adequacy and Readiness Standards," Page 9	Health Insurance Portability and Accountability Act (HIPAA)	For IHSS, Health Plans shall develop the following policy and procedures to: 1. Ensure consistency with HIPAA to allow IHSS providers to speak on behalf of member, if the member has so authorized.	Physicians, hospitals, and clinics have long history of complying with the HIPAA Privacy and Security Act. However, in most settings including the IHSS provider is a new concept. DHCS, the plans, and others will need to provider additional resources and training to both physicians and IHSS providers to ensure that sensitive personal health information is not inadvertently compromised by bringing new individuals into the system.

California Duals Demonstration
Long-Term Services and Supports Network Adequacy and Readiness Standards
January 22, 2013

These Standards, in conjunction with the companion Care Coordination Standards, are part of the requirements that the Centers for Medicare/Medicaid (CMS) and the California Department of Health Care Services (DHCS) will use to assess Demonstration Health Plan readiness. CMS and the State are currently developing a joint Readiness Review Tool, which will assess whether the Health Plan is compliant with the State/federal criteria for readiness, and able to deliver quality service and coordination.

The State will also require participating Health Plans to meet these standards for their non-Demonstration Medi-Cal managed care for Long-Term Services and Supports (LTSS). LTSS includes:

- In-Home Supportive Services (IHSS);
- Community-Based Adult Services (CBAS);
- Multipurpose Senior Service Programs (MSSP); and
- Nursing Facilities, Sub-Acute Care Facilities (NF/SCF).

Provider Network and Contracting

For IHSS, Health Plans shall develop policies and procedures to:

1. Develop and execute Memorandum of Understanding (MOU) with county agencies that reflects an agreement between the Health Plan and county agency regarding roles and responsibilities for the first year of the Demonstration and Medi-Cal LTSS. Subsequent MOUs for future years will be jointly developed with the Health Plan and stakeholders. The provisions of the MOU shall be consistent with state law, including the provisions of WIC 14186.35. The MOU shall be completed four months prior to the effective date of the Demonstration.

   An MOU shall maintain the role of county social service (or health service) agencies and a separate MOU will explain the ongoing role of the Public Authority in IHSS, as appropriate, for:

   a. Assessing, approving, and authorizing each current and new member's initial and continuing need for services.

   b. Enrolling providers, conducting provider orientation, and retaining enrollment documentation.

   c. Conducting criminal background checks on all potential providers.

d. Providing assistance to IHSS recipients in finding eligible providers through an established provider registry.

e. Until the function transfers to the California In-Home Support Services Authority (the Statewide Public Authority), acting as employer of record, and providing access to trained IHSS providers and backup providers.

f. Performing quality assurance activities.

g. Sharing confidential data as necessary.

h. Appointing an advisory committee.

i. Continuing to perform other functions as necessary, as defined by statute and California Department of Social Services (CDSS) regulation, for the administration of the IHSS program.

2. Maintain the consumer-directed model for IHSS, which allows the member to self direct his or her care by being able to hire, fire, and manage his or her IHSS provider. (WIC 14186.35(a)(2))

3. Determine whether the recipients' desires to have their IHSS providers involved in care planning or coordination, and if so, obtain express consent from the recipient or his or her authorized representative."

4. Provide information and referral of members who have complaints, grievances, or appeals related to IHSS, to the established grievance and appeal process established by CDSS and by the county agencies responsible for IHSS. (WIC 14186.35(c))

5. Support a member who is at risk for out-of-home placement in obtaining IHSS services.

6. Ensure compliance with WIC 12302.6, regarding agencies, approved by CDSS, that provide IHSS personal care, attendant care or chore services in the home for emergency back-up services, as necessary.

7. Report documentation that Health Plans have developed and will conduct a benefit orientation and training program specific to IHSS for staff or contractors. The Health Plan also provides documentation that it has trained personnel of IHSS organizations regarding the Health Plan's covered benefits and policies and procedures to access services and coordinate care.

For CBAS, Health Plans shall develop policies and procedures by no later than August 2014 to:

1. Arrange and show availability of providers of HCBS for members whose level of care needs correspond to CBAS benefit eligibility requirements, when CBAS centers are unavailable, inaccessible, limited in capacity, or cannot meet members' cognitive, cultural and linguistic needs.

2. Contract with all willing licensed and certified CBAS centers within the Health Plan's covered zip code areas and in adjacent zip codes accessible to members and for addressing loss of licensing or certification or closure of a contracted CBAS center.

3. Every effort should be made to ensure that Members receive CBAS services that are linguistically, culturally, and cognitively competent, when available.

4. Collaborate with CBAS centers to discuss at least annually on areas of collaboration and improvement.

5. Govern how the Health Plan will: 1) make referrals to CBAS (consistent with the waiver Special Terms and Conditions), 2) communicate generally with CBAS centers, 3) share the member's health information, and 4) coordinate care between the Health Plan and the CBAS center.

6. Work in collaboration with CBAS organizations and contracted providers to develop protocols for coordinating the Member's Interdisciplinary Care Team (ICT) with the CBAS Multi-Disciplinary Teams, and delineating roles and responsibilities among the entities.

7. Support any member who is at risk for out-of-home placement in obtaining CBAS services, when appropriate as determined by the Health Plan.

For MSSP, Health Plans[1] shall develop policies and procedures to:

1. Execute agreements with all MSSP organizations in the Health Plan's covered zip code areas for providing MSSP waiver services to eligible members, or have demonstrated that they have negotiated, in good faith, to attempt to secure executed contracts, in anticipation of plan readiness review, in order to have MSSP serve as a provider to the health plan.

2. Work with their contracted MSSP organizations to develop a care coordination and management model that supports appropriate referral of Health Plan members to the MSSP organization for assessment, eligibility determination, and services.

[1] Note, CalOptima is already an MSSP site. These rules will apply to CalOptima's interaction will all other MSSP sites.

3. Establish, convene, and consider the recommendations of MSSP organizations, Health Plan members and other stakeholders in the implementation of the MSSP contract.

4. Govern how the Health Plan will make referrals to MSSP and define the respective care management roles and duties of the Health Plan's ICT and MSSP care managers.

5. Govern MSSP assessment and eligibility determination as part of the Health Plan's care coordination process.

6. Contract with MSSP sites/organizations to provide Health Plan members who are MSSP waiver participants, MSSP case management services, and as needed, receive MSSP waiver services (such as supplemental personal care, respite, ramp, nutrition services, maintenance type, etc.).

7. Demonstrate the Health Plan has incorporated the use of MSSP services and other LTSS into its policies and procedures regarding:
   - Use of MSSP waiver resources for plan members.
   - Use MSSP sites to manage additional services outside of the scope of the MSSP waiver, at the discretion of Health Plans and MSSP sites.
   - Incorporation of features or elements of the MSSP care management approach.
8. Refer plan members, who have medical necessity, for coordinated care/case management to MSSP sites to receive needed services if there is sufficient and available capacity at the site. If there is no capacity, plans must provide some level of MSSP-like services through a network of providers selected by the health plan.

For NF/SCF, Health Plans shall develop policy and procedures to:

1. Govern authorization of NF/SCF services for members. Such policies and procedures shall cover criteria and authorization/reauthorization for placement in contracted facilities. These policies and procedures should be based on Medicare criteria for Medicare NF/SCF placement or Medicaid criteria for Medi-Cal nursing facility placement.

Nancy Hayward 2/4/13 1:22 PM
Comment [1]: SCF is a Medi-Cal level of care, not Medicare.

2. Offer and explain facility options to the member.

3. Ensure members have opportunities to transition from NF/SCF to community settings, as specified in the Care Coordination Standards.

4. Provide Health Plan members post-transition care coordination, as specified in the Care Coordination Standards.

5. Contract with licensed and certified nursing facilities. Health Plans must contract with a sufficient number of facilities located in the Health Plans' covered zip code areas. If NF/SCF facilities within the covered zip code areas cannot meet the member's medical needs, the Health Plan must contract with the nearest NF/SCF outside of the covered service area. Health Plans are responsible for all covered services even if their members are placed on short or long-term basis in NFs outside of their target service areas or contracted network. (WIC 14186.3(c))

   Reimburse NF/SCFs for Medi-Cal bed holds and leave of absences consistent with federal and state requirements (California Code of Regulations, Title 22 Section 72520)

6. A comprehensive policy on occurrence reporting, including, but not limited to unusual occurrences and quality issues impacting its members.

7. Provisions on how the Health Plan will accommodate the transfer of members residing in a contracted NF/SCF facility who experiences a loss of licensure, or any expected or unexpected closure.

8. Provisions on how the Health Plan will provide training to NF/SCF staff on working with the Health Plan.

For all LTSS, Health Plans shall develop policies and procedures to train:

1. All health plan staff involved in care coordination:
   - the person-centered planning processes;
   - linguistic, cultural, and cognitive competence;
   - core concepts of the Olmstead Decision, i.e. serving members in the least restrictive settings as appropriate;
   - accessibility and accommodations; independent living;
   - wellness principles;
   - criteria for safe transitions, transition planning, care plans after transitioning; and,
   - along with other required training as specified by DHCS—both initially and on an annual basis.

2. Specially designated care coordination staff in dementia care management including but not limited to:
   - understanding dementia;
   - its symptoms and progression;
   - understanding and managing behaviors and communication problems caused by dementia; caregiver stress and its management; and,
   - community resources for patients and caregivers.

Nancy Hayward 2/4/13 1:28 PM

Comment [2]: This should be clarified to also address sufficient contracts with subcontractors and delegees (independent physician associations and/or hospitals).

Nancy Hayward 2/4/13 2:56 PM

Comment [3]: This continues to be vague and undefined. SNFs report unusually occuances to CDPH, police and/or ombudsman (22 CCR 72541). If DHCS is requiring additional reporting to health plans, what is its statutory authority for this requirement? We suggest that DHCS revise to reflect the health plans need to be informed about changes in level of care and health status as it relates to case management for their beneficiaries.

3. Specially designated care coordination staff in MSSP including but not limited to:
   - an overview of the characteristics and needs of MSSP's target population;
   - MSSP's eligibility criteria;
   - assessment and reassessment processes, services, and service authorization process; and,
   - refer members to MSSP for assessment and eligibility determination.

4. All Health Plan staff generally on the addition of LTSS and social services to Health Plan operations. For all trainings, Health Plans shall meet specifications set by DHCS, document completion of training, and have specific policies to address non completion.

For all LTSS referrals, Health Plans will comply with current contractual standards for all covered services.

Financial Information/Claims Processing

For MSSP, Health Plans shall develop the following policy and procedures to:

1. Allocate, for nineteen months following the start date of the demonstration, funding for the capitation for MSSP slots as established in the three-way contracts with DHCS and CMS that will be the same level of funding (as estimated by DHCS) as those organizations otherwise would have been allocated under their MSSP contract with the California Department of Aging (CDA). (SB 1008)

For CBAS, MSSP, and NF/SCF, Health Plans shall develop the following policy and procedures to:

1. Ensure claims processing systems pay MSSP, contracted CBAS centers and NF/SCFs in a timely fashion; consistent with regulatory timeframes established for all other contracted Health Plan providers. Documentation of system readiness must be provided prior to enrollment beginning.

2. Resolve any disputed claims for CBAS, MSSP, or NF/SCF reimbursement consistent with any other contracted health plan providers and to avoid disruption in care to Health Plan members.

3. Report individual encounter, claims, and quality data to DHCS for their members' utilization of facilities and services, and admissions to hospitals from facilities.

4. Ensure readiness of electronic claims processing systems to pay claims submitted by contracted providers in accordance with current law and regulations under Medi-Cal and Medicare law and regulation, as evidenced by testing of claims submissions and successful payment; instructions and training for

Nancy Hayward 2/4/13 2:56 PM
Comment [4]: What does this mean? Please provide the specific regulatory timeframes—are you referring to federal or state regulations? Please cite for clarity.

contracted providers on the accurate submission process, including the use of required claim forms; required fields; availability of electronic fund transfer, and a Plan contact for resolving claims submission problems or errors. (Payments by the plan will be made using Medi-Cal standards for Medi-Cal benefits and Medicare standards for Medicare benefits.)This shall include any system design change to ensure the timely processing of authorizations. Specific documentation of this must be provided to DHCS prior to any enrollment.

Nancy Hayward 2/4/13 2:58 PM

Comment [5]: We are concerned that these statements are not specific enough to document the standards for readiness. The other concern is that the health plans and their subcontractors and delegees (independent physician associations and hospitals) must also demonstrate compliance with these requirements. Further, because of delegation of authorization, but not risk, for some SNF care, DHCS must require that the prior authorization system be automated and linked to the claims processing system, similar to the Medi-Cal Treatment Authorization Request (TAR) system. Otherwise, claims cannot be processed electronically.

Management Information System

For MSSP, Health Plans shall develop policy and procedures for the following:

1. Data sharing agreements, through MOU or contract, with CDA and DHCS for exchanging confidential and other information about Health Plan members who are enrolled in MSSP.

2. Data sharing agreements (to include sharing of clinical data, utilization of plan benefits and MSSP waiver services) with their contracted MSSP organization(s), consistent with state and federal privacy rules.

3. Policies, procedures, and systems to identify Health Plan members who should be evaluated for MSSP eligibility and a protocol and mechanism for transmitting data and sharing care plans and other information relevant to these Health Plan members' care between the Health Plan and the contracted MSSP organization(s).

Quality Improvement System

For LTSS, Health Plans shall develop policy and procedures to:

1. Detail how their contracted CBAS centers will adhere to Health Plan-established quality assurance provisions, to be developed in collaboration with CBAS leaders, and consistent with state quality and ICT metrics as specified in the demonstration. Health Plans will seek technical assistance from the State as is necessary.

2. Define how it will adhere to quality assurance provisions and other standards and requirements as specified by CDSS, as well as any other state or federal requirements. (WIC 14186.35(a)(7))

Provider Relations

Health Plans shall develop policies and procedures to:

1. Secure authorization from members or their legal representative to include IHSS provider of their choosing in the Interdisciplinary Care Team for that member, as deemed appropriate by the Health Plan.

2. Have assigned and trained staff specifically to address and expeditiously and process grievances, appeals, and complaints from contracted LTSS providers (CBAS centers, MSSP sites, and NF/SCFs) on all relevant areas of concern under the demonstration, including payment.

3. Develop and conduct initial and periodic orientation and training programs to familiarize contracted LTSS providers with Health Plans' operations, methods for provider communications, members' rights, plan-specific policies and procedures, claims submission and payment, coordination of benefits for the various types of beneficiaries reporting requirements, and conflict resolution process including how frequently such training will be conducted.

Member Grievance System

For IHSS, Health Plans shall develop policies and procedures to:

1. Inform beneficiaries that they will continue to be able to utilize the State Fair Hearing process with the County Social Service Agencies for issues of appeals to authorized IHSS hours.

2. Update contact lists for LTSS providers on a quarterly basis.

For CBAS, MSSP, and NF/SCF, Health Plans shall develop policies and procedures to:

1. Describe how Health Plan members' grievances regarding eligibility determinations, assessments, and care delivered by the Plan's contracted CBAS centers, MSSP sites, or NF/SCF should be submitted and will be adjudicated.

Member Services

For all LTSS, Health Plans shall develop policies and procedures to:

1. Train Health Plan staff to answer any service related questions or direct members to appropriate agency.

2. Ensure that all Health Plan members and/or authorized representatives are fully aware and informed of their rights, and that those rights are not violated.

3. Create and maintain a list of available LTSS providers; the list will be update no less than quarterly.

4. Demonstrate how authorizations and Individual Plans of Care will be transferred from one plan to another plan when a member disenrolls from one plan and enrolls in another to ensure no interruption in services to the member and no interruption in reimbursement to the provider responsible for the transferring member's care.

Health Insurance Portability and Accountability Act (HIPAA)

For IHSS, CBAS, MSSP and NF/SCF, Health Plans shall develop the following policy and procedures to:

1. Ensure compliance with the Health Insurance Portability and Accountability Act of 1996.

For IHSS, Health Plans shall develop the following policy and procedures to:

1. Ensure consistency with HIPAA to allow IHSS providers to speak on behalf of member, if the member has so authorized.

C A L I F

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February 6, 2013

Ms. Jane Ogle
Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Sacramento, CA

Dear Ms. Ogle:

I am one of thousands of people with disabilities in the Los Angeles area where about 1.8 million disabled people live. I used to be a recipient of a couple of government health care programs while I was just fresh from college and in between jobs not too long ago—I was on Medi-Cal and Medi-Care, on In-Home-Supportive Services, on subsidized housing which helped to tide me over until I founded our non-profit agency, Communities Actively Living Independent & Free (CALIF) serving the disabled of Central LA. As a polio survivor, I use a motorized wheelchair, I am on a ventilator at night, I have a live-in attendant and I belong to an HMO, all paid for by myself and my employer. My HMO Kaiser Permanente is not a perfect system but I'm reasonably happy with it. I want what I have attained also reachable by my brothers and sisters in the Disability Community which is why I follow very keenly what goes on with government health care.

This proposal for massive changes in Medi-Cal, Medi-Care, and many other related programs should not be scary. Even our way of communicating and shopping has radically changed. Computers and social networking have tremendously brought the world together and whereas we shopped in little stores before, now there are malls and mega-stores like Costco and Walmart that have become one-stop centers for consumers. So, I welcome the changes in health care directed at comprehensive services delivered with cost efficiency and intelligent coordination toward a greater quality of life. It is indeed, a very attractive, reasonable proposition until you read the fine print:

1. We do not see in the CCI, a well defined step by step process of providing advanced notice to Medi-Cal and Medi-Care recipients, of these drastic changes in their health care coverage. For people with severe disabilities on complicated therapies and treatment under the care of medical

specialists, there is no provision for the reasonable and timely transition so that those therapies are not abruptly discontinued and disapproved, putting the lives and health of the severely disabled in jeopardy. We demand, rather, to see the creation of an Emergency Triage of sorts, something like an emergency shelter for dislocated Medi-Medi recipients. This "ER Shelter" should consist of the following:

a.) Timely notification to Medi-Cal and Medi-Care recipients of at least 6 months in advance to provide reasonable accommodation under the Americans with Disabilities Act of 1990 and its subsequent amendments, so that those needing plenty of preparation time to understand what's going on have time to map out a medical plan of action and to get together the necessary finances to make the adjustments;

b.) Timely notification to HMOs chosen to implement the CCI so that they could better assess their capability to provide services and have time to design new programs or mimic other government programs like the different long-term care waivers currently open to Medi-Cal recipients; also to give HMOs the time to adequately inform the recipients about their plan to cover as comprehensive services as possible to assure a seamless transition for Medi-Medi and other recipient categories affected;

c.) Adequate accommodation for opt out options for Medi-Medi and Medi-Cal only recipients;

d.) A robust Ombudsman program that assures that recipients receive a seamless transition to the HMOs, through wise advise and competent advocacy, giving recipients continued access to their therapies and medically necessary treatment;

e.) The provision of a Special Circumstances Program in DPSS for the purchase and provision of goods and services needed by the severely disabled in the CCI transition process.

2. In the struggle for disability civil rights, we fought hard to move away from the medical model of disability which defined us more by our medical diagnosis and the limitations of disability. We have achieved some modest success in obtaining access to the environment through the building of ramps, accessible transit, accessible communication, etc. and access to the economic mainstream of jobs and opportunities, something really threatened by these abrupt changes in health care. To make sure that this progress is not stymied, we need HMOs to make sure that the following support services essential to independent living are not only guaranteed but protected:

   a.) The availability of Long-term Care waivers

b.) Durable Medical Equipment: purchase and repair of necessary life-saving and life-enhancing equipment
c.) Medications and alternative medication and therapies
d.) Other essential Assistive Technology
e.) In-Home Supportive Services: a supported and enhanced version of the current, state-run version that provides a good Back-up, 24/7 emergency on call system;
f.) Special paramedical services
g.) Home modification and environmental controls
h.) Assistance with adequate housing options before discharge to avoid homelessness.

In addition to the above, we also support all the arguments put forth and submitted to you by the National Senior Citizens Law Center and other major disability and senior groups. We are all one community here making sure that our once secure and generous health care system retains its effectiveness for the millions of Americans depending on it. Only a truly healthy nation can effectively be seen as a world leader!

Respectfully,

Lillibeth Navarro
Founder & Executive Director
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"Diverse communities, diverse abilities, one human family!"

Comment Template

Organization: California Association of Area Agencies on Aging
Contact Name: Derrell Kelch
E-Mail: aging@c4a.info

Page	Section Title	Existing Text	Comment or Suggested Edit
n/a	n/a		C4A applauds the department's efforts to expand the availability and use of additional home and community-based services (HCBS). The policy recognizes that non-medical services play an important role and in some cases a more essential role in the transition or delay of institutional care. We also applaud the department for finally identifying the potential role that area agencies o aging can play in the implementation of the CCI. It is within that context that C4A provides the following comments on the draft policies.
and 2	Purpose of this Paper		The assessment process should drive access to services and supports. The paper is delinquent in not discussing the assessment tool that should be used upo enrollment with the plan. At minimum, guidelines should be established until the adoption of the universal assessment tool. And finally, in regards to assessments, C4A believes that it is critical that health risk assessments must be done in person to ensure a

Comment Template

Organization: California Association of Area Agencies on Aging
Contact Name: Derrell Kelch
E-Mail: aging@c4a.info

Page	Section Title	Existing Text	Comment or Suggested Edit
			full evaluation. The paper ignores whether local organizations or area agencies o aging have the capacity to provide additional services. Area agencies are at or near capacity and having difficulty in meeting current need as well as serving those on waiting lists. Although the paper maintains that the plans will have incentives to offer additional HCBS, it does so without disclosure of the rate structure and knowing whether plans will have additional dollars to purchase these additional services. In regards to "Other Services" listed as one of the six additional HCBS, C4A suggests that "Other" be more definitive by referring those services described in the Older Americans Act and the Older Californians Act. Our understanding is that the state is not assuming budgetary savings in the first year.

Comment Template

Organization: California Association of Area Agencies on Aging
Contact Name: Derrell Kelch
E-Mail: aging@c4a.info

Page	Section Title	Existing Text	Comment or Suggested Edit
			This begs the question on how exactly will plans fund these services out of "savings"? Finally, C4A is concerned that the additional HCBS are optional. Because they are optional, we would encourage language that at least obligates the plan to offer the least restrictive level of care. Otherwise, Clients will unlikely enroll in a managed care plan without something additional being offered.
3	Vision for HCBS		The ability of health plans to keep people in the community and avoid institutionalization depends in large part upo an adequate rate structure and the rates ability to incentivize health plans to purchase services. C4A recommends that the provision of additional services be included in the rate methodology.
and 4	Preparing for the Demonstration		Engage with plans and providers: C4A is encouraged that the department recognizes the need and value to engage with plans and providers and to facilitate a meeting to develop shared understanding of each role. C4A would request that such a meeting include all plans and local organizations as whole rather than

Comment Template

Organization: California Association of Area Agencies on Aging
Contact Name: Derrell Kelch
E-Mail: aging@c4a.info

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			county by county and include department representatives. Offer Technical Assistance: Again, C4A is encouraged that the department understands the need of local organizations for technical services around contracting and costing out services. However, we request that the department work with providers in developing the agenda and curriculum before proceeding with any technical assistance.
4	Plan Approach		C4A has concerns with the second bullet and suggests that the current language be deleted and replaced with the following: "Develop a plan for the coordinated delivery of HCBS with area agencies on aging (AAAs), independent living centers (ILCs), and adult and aging resource centers (ADRCs), and, if needed additional local providers." This will allow the involved providers to decide amongst themselves how coordination occurs, who is referred and at what point in the process the member is referred and what assumptions are

Comment Template

Organization: California Association of Area Agencies on Aging
Contact Name: Derrell Kelch
E-Mail: aging@c4a.info

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			made about responsibility for the delivery of services to the member. The ADRC should be a particular point of access given the State's emphasis on the development of the ADRC system. Also, C4A recommends that the existing grievance and appeals process apply to all services, regardless of whether such services are included as a required benefit. Individuals should be permitted to appeal any determinations regarding their plan of care.
and 5	Readiness and Compliance		The requirements in the draft policy are vague and provide too much discretion to health plans to determine how to assess and authorize additional HCBS. As we stated previously, at minimum, guidelines should be established until the adoption of the universal assessment tool. Again, the draft policy ignores whether local organizations or area agencies o aging have the capacity to provide additional services. Area agencies are at or near capacity and having difficulty in meeting current need and in serving

Comment Template

Organization: California Association of Area Agencies on Aging
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E-Mail: aging@c4a.info

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			those on waiting lists. Referring members to an area agency without some payment will only cause confusion and frustration. One suggestion is that the services may be purchased through the California Community Transition program. Also language needs to clarify why the member is being referred. Is the referral for services or for information and assistance (I&A). Our final comment pertains to the clarity of terms. For example, the draft policy seems to convey that HCBS relates to "providers" whereas LTSS infers "services" provided. Being that these terms are being described as something different, we will not reach the goal of breaking down silos and integrating services.

Comment Template
Due February 6, 2013

Organization: CalOptima
Contact Name: Gisela Gómez
E-Mail: ggomez@caloptima.org

Page	Section Title	Existing Text	Comment or Suggested Edit
		HCBS draft Policy Paper	
1, 4	Footnotes 2 and 3 Plan Approach to Center Home-and Community-Based Efforts	Footnote 2, 3: The grievance process for these benefits shall be the same process as used for other benefits authorized by managed care plans, and shall comply with Section 14450, and Sections 1368 and 1368.1 of the Health and Safety Code." Pg 4: Since the six (6)additional services are not part of the core Medi-Cal program today, those services will not be subject to Medi-Cal grievance and appeals procedures if a plan chooses to offer them.	The Plan appreciates the flexibility provided by DHCS in offering the option to provide these benefits. Will DHCS consider reviewing and approving the processes of the Demonstration plans that will provide the additional services?
2	Purpose of Paper	List of services	The Plan appreciates guidance from DHCS for plan's requirements with respect to HCBS providers and handling duplicate payments. Specifically, some of these services are funded under other programs. For example, respite or home delivered meals and related nutritional assessments are funded under The Older Americans Act.
3	Plan Approach to Center Home-and Community-Based Efforts	As a requirement for participating in the demonstration, and with regard to the six additional HCBS only, plans will: • Coordinate such services for beneficiaries who need them. • Refer beneficiaries to community providers to deliver services and to work with those providers as the plan deems appropriate. • Develop a care plan where the member has input into the services to be provided (for members requiring such a plan.) • Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion. Plans will have the financial incentive to provide these additional HCBS; however, there is no obligation to offer the six additional services.	Please clarify the interplay between this policy guidance and the Care Coordination standards requirement to facilitate access to community-based resources. Is the plan obligated to coordinate, refer and develop a care plan for these services applicable only to the six (6) identified services? Or more broadly? Is the only the last bullet specific to the six (6) optional services?

Comment Template
Due February 6, 2013

Organization: CalOptima
Contact Name: Gisela Gómez
E-Mail: ggomez@caloptima.org

Page	Section Title	Existing Text	Comment or Suggested Edit
Overall			Please confirm if the additional optional services are limited to enrollees of the Duals Demonstration Project (DDP) only and not all Medi-cal members.
Overall		Policies and procedures to identify members that may need HCBS, and to refer members to community-based organizations and other entities that provide these services, such as California Community Transitions organizations, Area Agencies on Aging, Independent Living Centers, or ADRCs where available.	Please confirm if this intended to suggest that undertaking to refer a member to one of these agencies in and of itself, obligates the plan to pay for the services to be provided by those agencies under their standard charter (e.g., AAA provides I&R/A and ADRC provides Options Counseling).
HCBS Enrollment flow - Draft Guidance for Comment			
1		Each flow chart discusses how a beneficiary moves through the CCI in three situations:	The Plan recommends that DHCS also include a flow chart for those members that choose to opt-out of the Demonstration.
1		*Beneficiary is "Pending Enrollment Process into CCI"*	Please confirm this section does not apply in COHS counties, where all members are already mandatorily enrolled.
1	Attachments		The Plan suggests DHCS replace the "Appendix" A.1 on page 2 and A.2 on page 3 with "Attachment", as referenced on page 1.
2	Appendix A.1	Beneficiaries with Other Health Coverage	Please clarify how to differentiate the "Other Health Coverage" designation from other Medicare Advantage, SNP or other types of insurance (i.e. worker's compensation, life, etc.).
2	Appendix A.1	Continuously certified to meet share of cost	The Plan recommends that DHCS define continuously certified and detail any specific aid codes that are continuously certified or if certification is determined by other factors.
3	Appendix A.2	Partial-benefit dual eligibles	The Plan appreciates additional guidance DHCS may provide to clarify how the partial-benefit eligibles are defined. The Plan understands partial-benefit eligibles to be the QMB and SLMB. Is there another designation of partial-benefit dual that this references?
3	Appendix A.2	PACE and IDS Healthcare Foundation Enrollees	The Plan suggests the wording used in Appendix A.2 be consistent with that in Appendix A.1, namely, "Exempt from passive enrollment (May enroll if first disenrolls from PACE/AHF)".
3	Appendix A.2	Medicare Advantage and Special Needs Plan members	The Plan appreciates additional guidance from DHCS on the exclusion of D-SNP beneficiaries from MLTSS in 2013. The Plan also requests any additional information DHCS can share with respect to what is planned for the MLTSS for the D-SNPs in 2014.

Comment Template
Due February 6, 2013

Organization: CalOptima
Contact Name: Gisela Gómez
E-Mail: ggomez@caloptima.org

Page	Section Title	Existing Text	Comment or Suggested Edit
4	Attachment B	Completed CCI enrollment; Mandatorily enrolled in MLTSS…	Please confirm our understanding that MLTSS will come to CalOptima/Orange County all at the same time at the start of the Demonstration, rather than phased-in over 12-months. The Plan appreciates additional guidance regarding the applicability of this flow chart in COHS counties as well as how a Medi-Cal-only SPD is incorporated into the flow chart.
5	Appendix C	Currently Enrolled: Multipurpose Senior Services Program	The Plan recommends that DHCS consider including a footnote regarding whether or not this applies in COHS counties. The Plan appreciates guidance in the flow chart of how beneficiaries who are not eligible for the Demonstration but are in MLTSS through Medi-Cal managed care are included in the processes. The Plan envisions there may be a beneficiary who is enrolled for MLTSS, but not eligible for the Demonstration (e.g. due to other health plan coverage or receiving regional center service). The existing flow on the far right appears to imply that this person would "Stay in MSSP waiver slot, paid by Medi-Cal FFS", although the person is in MLTSS.
6 , 7	Appendix D and E	Boxes	The Plan appreciates additional guidance regarding the applicability of this flow chart in COHS counties, as consumers are already enrolled in Medi-Cal managed care. The Plan appreciates guidance in the flow chart of how beneficiaries that are not eligible for Demonstration but are in Medi-Cal managed care only are included in the processes. Please confirm that for Medi-Cal managed care beneficiaries, the waiver slots remain open and paid by Medi-Cal FFS.
8, 9	Appendix F, G	Plan may contract with CCT…"Plan provides care management and plan benefits, may contract with CCT; waiver slots are closed	Please clarify interplay with waiver program. From the Stakeholder conference call we understand that the Money Follows the Person Program (MFP)/CCT waiver will continue, however, there is no requirement for Demonstration plans to contract with CCT. If the Demonstration plan does not contract with the CCT provider, please confirm that MFP funding remains as it does today. Additionally, IHSS is included on this flow chart even though it is a required LTSS, please confirm its inclusion on the chart.

Comment Template
Due February 6, 2013

Organization: CalOptima
Contact Name: Gisela Gómez
E-Mail: ggomez@caloptima.org

Page	Section Title	Existing Text	Comment or Suggested Edit
			Additionally, for the CCT flow chart, please confirm that Medi-Cal only beneficiaries would continue to have access to waiver slots, which the Plan understands should be permitted. The Plan recommends that DHCS consider the following revision to the flow: Eligible for, not enrolled in, Demonstration → Plan provides care management and plan benefits → Waiver slot paid by Medi-Cal FFS if waiver slots are open Joins the Demonstration → Plan provides care management and plan benefits → Plan may contract with CCT if waiver slots are closed
9	Appendix G	Post-Transition	Please clarify whether this flow chart is applicable once the member has moved out of the SNF, or if it intended to be after the one year CCT waiver benefits expire? Or is it intended to clarify that if the person needs IHSS (or MSSP or CBAS) to transition, the Demonstration plan will pay those benefits, regardless of contracting with MFP grantee for the services?

CalOptima
A Public Agency
Better. Together.

February 6, 2013

SENT VIA ELECTRONIC MAIL: ***info@calduals.org***

Re: Comments on Draft Home and Community-Based Services Policy Document and Care Coordination and Long Term Services and Support Standards

To Whom It May Concern:

CalOptima (Plan) appreciates the opportunity to comment on the draft Home and Community-Based Services (HCBS) policy document and flow charts. We applaud the efforts of DHCS to incorporate stakeholder input and ensure comprehensive standards for the Demonstration. Attached is the comment document on the HCBS draft policy CalOptima submits for DHCS consideration.

In addition to the comments on the HCBS draft and pursuant to the stakeholder discussion last week, CalOptima understands that DHCS is receptive to receiving additional feedback on continued concerns or issues that relate to the Care Coordination and Long Term Services and Support (LTSS) standards, as published on January 28, 2013. As such, CalOptima appreciates DHCS consideration of the following comments on the Care Coordination standards:

- ***Timing of the initial Risk Stratification and Health Risk Assessment (HRA):***
  As currently described in the Care Coordination standards, the plans may conduct the Risk Stratification as late as the 44th day of enrollment. Therefore, the requirement to complete the HRA within 45 days presents significant challenges. CalOptima recommends that DHCS consider including language that allows for sequential timing of the Risk Stratification and HRA. For example, completing the HRA 60 days ***following*** the Risk Stratification for high-risk beneficiaries, and no later than 90 days following enrollment for other beneficiaries.

- ***The completion of the initial HRA assessment:***
  On page 13 of the Care Coordination standards, DHCS provides guidance on how plans can conduct the annual reassessment. CalOptima respectfully requests that that DHCS confirm whether these same processes are permissible for the initial HRA assessment. In addition, CalOptima believes that it is appropriate for customer service representatives, promotores (community health workers), or similar staff to conduct the HRA as long as the HRA responses are reviewed by a clinical staff person to determine the necessary level of care planning.

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We appreciate your consideration of our comments. As we move closer to the execution of the Memorandum of Understanding (MOU) and implementation of the Coordinated Care Initiative, CalOptima looks forward to our continued collaboration. If you have any questions, please feel free to contact me at jbomgren@caloptima.org or 1-714-246-8836.

Sincerely,

Julie Bomgren

Julie Bomgren
Director, Regulatory Affairs

cc: Jane Ogle, Deputy Director, Health Care Delivery Systems, DHCS
Margaret Tatar, Chief, Medi-Cal Managed Care Division, DHCS
Scott Coffin, Medi-Cal Managed Care Division, DHCS

Disability Rights California

California's protection and advocacy system

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www.disabilityrightsca.org

February 6, 2013

Jane Ogle, Deputy Director
Health Care Delivery Systems
Department of Health Care Services
Sacramento, CA

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

Dear Ms. Ogle,
Disability Rights California submits these comments on California's "Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)," shared with stakeholders via email on January 27, 2013.

We appreciate the administration's intent "to expand the availability and use of HCBS," and to "create a structure and culture where HCBS are broadly available." Draft HCBS Policy at 1. In our view, however, the current draft policy is not the way to achieve that goal, and could have the reverse effect of reducing access to needed home and community based services for seniors and persons with disabilities. Our comments and concerns are detailed in the attached Comment Template (as well as in previous letters). In addition, we wholly agree with the comments and cover letter submitted by the National Senior Citizens Law Center.

Adding to the concerns reflected in our comments in the template is the omission of the California Community Transitions/Money Follows the Person grant project as a plan benefit, or as a part of DHCS' intended plan for provision of HCBS. We understand that managed health care plans "may" contract with CCTs; however, given the existing program requirements and the value of the CCTs in assisting Californians with disabilities to leave institutions, we urge the Department to require plans to collaborate and contract with the lead agencies of the CCTs to

implement the terms of the CCT program.

Again, thank you for the opportunity to comment on this important policy. We welcome the opportunity to speak with you further on how to strengthen the Department's commitment to integration of people with disabilities and compliance with the *Olmstead* decision.

Sincerely,

/s/

Deborah Doctor
Legislative Advocate

Elissa Gershon
Senior Attorney

Comment Template

Organization: Disability Rights California
Contact Name: Deborah Doctor, Elissa Gershon
E-Mail: Deborah.doctor@disabilityrightsca.org, elissa.gershon@disabilityrightsca.org

Page	Section Title	Existing Text	Comment or Suggested Edit
COMMENTS TO DRAFT POLICY FOR DEMONSTRATION PLANS OFFERING ADDITIONAL HOME-AND COMMUNITY-BASED SERVICES (HCBS) JANUARY 24, 2013			
P. 1	Introduction	By definition, additional HCBS are available only by waiving federal law, which otherwise does not allow for such services. The notion that these additional HCBS are only available through a waiver creates a situation where such services are trapped in a silo. As a result, the Long Term Services and	The phrasing of this section misstates the benefits of HCBS waivers, omits the purpose of such waivers, and overstates, obscures or misrepresents managed care plans' ability and incentives to offer services currently available through HCBS Waivers. Moreover, under the current Waiver

Comment Template

Organization: Disability Rights California
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		Supports (LTSS) system is fragmented. These waivers were designed to provide care coordination and other long-term supportive services, but do not include medical and behavioral health services so beneficiaries do not have access to a fully integrated system of care. Under the Duals Demonstration, the California Department of Health Care Services (DHCS) intends to expand the availability and use of HCBS by allowing demonstration plans[1] to pay for these services out of the	programs, eligible individuals have an entitlement to Waiver services to the extent they meet eligibility criteria and slots are available, which includes the ability to understand which services are potentially available and the right to file for a hearing challenging denial of Waiver benefits. Both the phrasing of the draft policy and DHCS' statements on the January 30 call indicate that plans have complete discretion as to how and whether they will provide any of the current Waiver services. This diminishes the rights of Medi-Cal clients relative

[1] Demonstration plans are Medi-Cal managed care plans selected to participate in the Duals Demonstration that will offer medical, Long Term Services and Supports (LTSS), and behavioral health services.

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		monthly payments they receive to provide care to their enrollees. The goal is to create a structure and culture where HCBS are broadly available. Demonstration plans will have the incentive to offer additional HCBS in order to avoid costly institutional care.	to their current rights to access HCBS to avoid institutionalization. For instance, under the NF/AH waiver, there are set aside slots reserved to assist Medi-Cal recipients in nursing facilities to return to the community. In addition, there is currently no waiting list for Medi-Cal recipients who otherwise would require admission to a subacute nursing facility. These Medi-Cal recipients would lose their entitlement via the waiver to the services they need from the waiver menu. The State has repeatedly represented that Waivers are a

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			means for the State to comply with the ADA and the *Olmstead* decision. This transition-- from an entitlement to discretionary services-- implicates and potentially violates the ADA. Our comments throughout this document reflect this overarching concern. Specific edits (which do not address the broader concerns described above, but at least describe the Waivers with more accuracy and clarity) could include: HCBS currently offered through the Nursing Facility/Acute Hospital (NF/AH) and Assisted Living (AL) Waivers are specifically intended to offer an alternative to institutional care to individuals who would otherwise qualify for services in nursing

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			facilities. While limited in their current configuration by State fiscal and policy restrictions, these HCBS Waivers provide an invaluable benefit to those individuals who are able to access them. By definition, additional HCBS Waiver services are available only by waiving federal law, which otherwise does not allow for such services. The Long Term Services and Supports (LTSS) system is fragmented, little care coordination is available, and Medi-Cal and federal policy still favor institutional care over home and community based services. Also, the waivers do not include medical and behavioral health services.. Under the Duals Demonstration,

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			the California Department of Health Care Services (DHCS) intends to permit the expansion and use of HCBS by allowing demonstration plans to pay for these services out of the monthly payments they receive to provide care to their enrollees. The goal is to create a structure and culture where HCBS are broadly available.
p. 1	Introduction	Demonstration plans will have the incentive to offer additional HCBS in order to avoid costly institutional care.	As we query below, we have concerns about this assertion that plans will offer services which are not mandatory. Did DHCS consider any incentives to reward practices which reflect *Olmstead* compliance?
p. 2	Purpose of this Paper	This particular guidance is focused on the provision of a limited number of additional HBCS that are	The list of services in the authorizing legislation (WIC § 14186.1(c)) does not track the services currently provided by

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		listed in the authorizing legislation for the duals demonstration, which "may include": 1. Respite care: in home or out-of-home; 2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; 3. Habilitation ; 4. Nutrition: Nutritional assessment, supplements and home delivered meals; 5. Home maintenance and minor home or environmental adaptation; and, 6. Other services (the list provided by	the NF/AH and AL Waivers. While it is helpful that the policy points out that the list in the legislation is "permissive", it is important for plans and members (current and prospective) understand what "HCBS" can encompass and what services will be considered legitimate expenses in rate formulation. Since NF/AH and AL Waiver services are the currently available alternative to nursing facility placement for eligible individuals, it is only logical that the universe of HCBS that plans make available includes those services. The limited list in the legislation does not make it clear that the waiver services are to be considered or that plans may offer those services. Thus, the Policy

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		legislation is permissive.)[4]	should include the list of services currently offered under the NF/AH and AL Waivers and make it clear that plans are authorized and encouraged to offer such services as an alternative to institutional care. These services include, in addition to those listed in the authorizing legislation: Case Management/Coordination; Habilitation Services; Home Respite; Community Transition Services; Continuous Nursing and Supportive Services; Environmental Accessibility Adaptations; Facility Respite; Family/Caregiver Training; Medical Equipment Operating Expense; Personal Emergency Response (PERS) Systems, Installation and Testing; Private

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			Duty Nursing - Including Home Health Aide and Shared Services; Transitional Case Management; and Assisted Living Services. California has a Money Follows the Person grant which will be in place for the duration of the CCI. The list should also include the CCT/MFP services, with plans required to work with the existing infrastructure of local designated CCT agencies. In addition, covered HCBS should include money management and taxi vouchers. Both are services covered under the MSSP waiver and should be available to more than just the

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			limited (and over age 65) population who receive MSSP. Money management is critical to enable persons to remain in the community – i.e., help in getting the rent and utilities paid. Taxi vouchers also help persons get to the doctor and shopping.
p. 2	Purpose of this Paper	4 The legislation allows for "other services," which could include Personal Emergency Response Systems (PERS), assistive technology, In-home skilled nursing care, and other items. DHCS invites comment on additional services to be listed.	See comment directly above.
pp. 2-3	Background	Medicaid HCBS are delivered through federal	See comments above re accurate description of HCBS

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		waivers, frequently called "1915(c) waivers" in reference to the authorizing section of the Social Security Act. Under these waivers, states furnish an array of HCBS that enable Medi-Cal beneficiaries to live in the community and avoid or transition out of institutionalization. Most Medicaid services are offered on a statewide basis and in a uniform manner, but the services provided through waivers are typically available only to a set number of enrollees who have a need for level of care that qualifies them for admission into a nursing facility.	Waivers and need to be transparent about services currently offered through the NF/AH and AL Waivers. In addition, for comparison to the number of individuals currently covered under the identified waivers, the policy memo should also include the number of individuals in subacute and Level B and A nursing facilities whose care is paid for by Medi-Cal.

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		Out of the 8 million Medi-Cal beneficiaries, approximately 13,000 receive HCBS through California's 1915(c) waivers today that are directly related to the CCI. These waivers each have enrollment caps on a statewide basis and in some cases regionally. (Please see Table A and Appendix A.)	
P. 3	Duals Demonstration Vision for HCBS	At the same time, demonstration plans will have the incentive to offer the six additional HCBS discussed in this paper in order to keep persons in the home and community, resulting in a higher quality of life for their members and avoiding unnecessary	1. Unless the demonstration plans and members understand that the menu of services available under the NF/AH and AL waivers are within plans' ability and discretion to provide, and the plans actually provide them to individuals who would otherwise receive Waiver services, the CCI will not

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		and costly institution-based care.	"eliminate the need for the waivers." The text should be modified to say “demonstration plans will have the incentive to offer the full range of HCBS in order to keep persons in the home and community…” 2. There must be a requirement that a detailed description of the available HCB services be made available to members. 3. It would be helpful to better understand the "incentive" for plans to offer these services, such as how the initial and future rates are constructed in the Demo and the CCI, whether the rates are sufficient to support the services which members need, exactly how the

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			incentive will operate, and how the state will determine whether the incentive is producing the desired results, including decreased used of hospitals and long term care institutions.
p. 3	Preparing for the Demonstration	• *Engage with plans and providers about the vision, goals, operations and potential partners of the new system.* There is an array of HCBS providers available to individuals who are dual eligible in addition to the programs being integrated into demonstration plan services, including, but not limited to,	DHCS' and managed care health plans efforts should also include collaborating with mental health plans and the Department of Developmental Services and regional centers to ensure that managed care enrollees have full and timely access to mental health and regional center services that they may require in addition to health plan benefits. We have a concern that plans will conclude that they have no obligation re

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		Area Agencies on Aging, Independent Living Centers, Aging and Disability Resource Connections, and California Community Transition Lead Organizations. Starting in Spring 2013, DHCS will help facilitate a focused effort to help make sure that such providers are meeting with the demonstration plans and building relationships in order to develop a shared understanding of each entity's role.	HCBS for members who are also regional center or mental health clients. This is based on our experience with COHS. In addition, the list of organizations should be expanded to include direct HCBS service providers such as NF/AH Waiver providers (supported living providers and home health agencies), Assisted Living Waiver providers, AIDS Waiver and MSSP providers, CBAS providers and other HCBS providers. While these providers may be "available" to plan members, there is no guarantee that their services are available. If

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			providers have waiting lists for their services, or have no funding available to serve more individuals, there will be little for the plans to integrate. And while the CCT agencies will still be in place, if the plans do not pay for the services which the plans identify as needed for transition, the members will not be able to leave or avoid institutional placement.
p. 4	Plan Approach to Certain Home- and Community-Based Efforts	As a requirement for participating in the demonstration, and with regard to the six additional HCBS only, plans will: • Coordinate such services for beneficiaries who	1. Again, reference to "the six additional HCBS only" ignores that "other" services could and should be considered to actually provide an alternative to institutional placement. 2. The four bullet points

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		need them. • Refer beneficiaries to community providers to deliver services and to work with those providers as the plan deems appropriate. • Develop a care plan where the member has input into the services to be provided (for members requiring such a plan.) • Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion. Plans will have the financial incentive to provide	outlining plans' requirements are extremely vague about their obligations with respect to providing and coordinating and providing HCBS and otherwise preventing unnecessary institutionalization. The plans should be obligated to assess for and consider the full range of HCBS in a timely manner to avoid or mitigate risk to health (including health deterioration or loss of functional abilities), to ensure that members are not inappropriately or needlessly placed in or remain in hospitals and institutions contrary to their wishes. A primary concern is that without HCBS, members' health and functional abilities will deteriorate leading to hospitalization and institutional placement. Please refer to

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		these additional HCBS; however, there is no obligation to offer the six additional services. Since the six additional services are not part of the core Medi-Cal program today, those services will not be subject to Medi-Cal grievance and appeals procedures if a plan chooses to offer them. Plans will develop internal procedures as part of developing a care plan that is patient-centered. In contrast to the provision of the six additional HCBS services, health plans have very specific requirements to meet regarding the	previous comments submitted jointly by DRC and NSCLC regarding care coordination and LTSS for further detail on these concerns. 3. There is no legal basis to omit HCBS from Medi-Cal rights to grievances and appeals. Because part of the service package offered by managed care plans uses Medi-Cal funds, and particularly because individuals have no choice about whether to receive their Medi-Cal HCBS services through managed care or fee-for-service, members must retain their due process rights that exist in the current Waiver programs. It is a misstatement to say that HCBS services are "not part of the core Medi-Cal

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		provision of key LTSS through IHSS, MSSP, CBAS, and nursing facilities, as set forth in separate guidance. For the LTSS benefits that are required to be offered under Medi-Cal, the grievance and appeals procedures that exist today will continue.	program today." To the extent that services that are available through Medi-Cal HCBS Waivers, and are replacing such Waiver services, or are offered in institutional settings, members must retain their Medi-Cal rights to grievances and hearings for reduction, termination, denial, or suspension of such services. Moreover, since HCBS services are provided in lieu of institutional care, diminishment of individuals' rights to receive HCBS, while maintaining plans' obligation to offer and provide institutional services, implicates the ADA and *Olmstead*.
p. 4-5	Readiness and Compliance	The provision of these certain HCBS will be a new function for many	We would like to see much more specificity here regarding the required components of plans'

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		demonstration plans. As such, the state will require that plans take a number of steps to prepare for implementation. More specifically, for the services discussed in this document, demonstration plans must create: 1. Policies and procedures that guide the demonstration plans' care coordinators, Interdisciplinary Care Teams, and primary care physicians in assessing the appropriate authorization of these services and/or benefits, in addition to the required community-based LTSS (i.e. CBAS and IHSS), including but	policies and procedures, timing, DHCS' monitoring, and compliance with state and federal laws protecting due process and disability rights. We repeat our previous requests for information about what functional assessments will be used, who will administer them and the connection between the assessment and the offer of services.

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		not limited to assessment tools and reassessment cycles. 2. Policies and procedures to identify members that may need HCBS, and to refer members to community-based organizations and other entities that provide these services, such as California Community Transitions organizations, Area Agencies on Aging, Independent Living Centers, or ADRCs where available. 3. A training curriculum and program for demonstration plan staff that provides for an orientation for all staff on	

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		the Americans with Disabilities Act, the Olmstead Decision and HCBS issues, and detailed training on community and county HCBS that maybe available.	

Disability Rights
Education & Defense Fund **DREDF**

Ms. Jane Ogle
Deputy Director
Health Care Delivery Systems
California Department of Health Care Services

Via email to info@calduals.org

February 6, 2013

Re: January 24, 2013 HCBS Documents relating to the Coordinated Care Initiative

Dear Ms. Ogle:

Thank you for the opportunity to comment on the above referenced documents that were recently released by the California Department of Health Care Services (DHCS). The Disability Rights Education and Defense Fund (DREDF) is a leading national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. We have been involved in the stakeholder process for the state's Coordinated Care Initiative, and have been especially interested in the transition of Long-term Services and Supports (LTSS) to managed care since the home and community-based services (HCBS) component of LTSS is so critical to our constituents' desire to live as independently as possible in their communities.

We appreciate DHCS's willingness to clarify the relationship between HCBS offered through California's 1915(c) waivers and HCBS that will be offered through managed LTSS under the Coordinated Care Initiative (CCI). As a disability advocacy organization, DREDF has long shared DHCS's desire, expressed in its "Additional HBCS draft policy," to "expand the availability and use of HCBS." We had equally hoped that the CCI demonstration plans would be directed toward using their resources and capitated payments to make HCBS broadly available to members who need such services to maintain productive and engaged lives outside of institutions.

After closely reviewing the "Additional HCBS draft policy" and "Interaction of Select HCBS with the CCI" documents, we are deeply concerned that the proposed policy and interactions will *restrict* the availability of HCBS to managed plan members, in terms of scope, amount and duration. We have enumerated our concerns and ongoing questions below with particular reference to each document where appropriate.

Mismatch between Waiver Services and CCI Services

The Additional HCBS document provides six categories of HCBS that are characterized as services that the demonstration plans "may include" as benefits. DREDF strongly

recommends that this list fully enumerate the gamut of HCBS approved for individuals age 65 and older and younger individuals with disabilities who are on California's 1915(c) waivers. The catch-all "Other services" category is insufficient to capture the range of services that are available through the Assisted Living (AL), In-Home Operations (IHO), and Nursing Facility/Acute Hospital (NF/AH) Waivers such as community transition services, family/caregiver training, personal emergency response system (PERS) and PERS installation and testing, medical equipment operating expenses, and private duty nursing – including shared services, home health aides, and transitional case management. If this policy is to serve as guidance to the demonstration plans, it is also important to give additional guidance around the habilitation category, since these services are likely to be as conceptually unfamiliar to managed care plans as they are critical to the success of individuals who want to return to or remain in the community. Habilitation should be broadly defined as the acquisition, improvement, and retention of skills necessary to reside successfully in a non-institutional setting or a person's "natural environment," and should be carefully distinguished from rehabilitation which seeks to return an individual to a physical, cognitive, or emotional status quo previously in place.

There are at least two reasons to clearly include the full range of waiver services as "additional services" in the Additional HCBS document. First, the waivers are the state's community-based alternative to a nursing facility level of care, and have been put forth as a key component of California's response to its obligations under the Supreme Court's *Olmstead* decision. Since these are the waiver services that individuals need to avoid institutional care, these are logically *all* the same services that the demonstration plans must provide in conjunction with medical and behavioral health services to members who seek to avoid institutional care.

Secondly, the flow charts provided in the Interaction document appear to cut some individuals off from eligibility for a waiver slot. Specifically, waiver slots will be closed to Medi-Cal only seniors and people with disabilities who are not excluded or exempt from receiving LTSS through managed care and any dual-eligible individual who enrolls or is passively enrolled in the duals demonstration, regardless of whether they are already on a waiver waiting list.[1] Those who are on a waiver waiting list have already demonstrated their need for a nursing facility level of care, and therefore their eligibility for the full range of waiver services that are offered in lieu of institutionalization. People

[1] Attachments D and F do not appear to contemplate the full universe of those potentially affected by the CCI. According to the charts, a beneficiary who would like to be on a NF/AH or ALW waiver or use California Community Transitions to leave a nursing home could be a Medi-Cal only senior/person with a disability, or a Medi-Cal and Medicare eligible person who is eligible for the demonstration. If the Medi-Cal only SPD is exempt from enrolling in MLTSS (e.g., has been granted a current Medical Exemption Request or is an American Indian who chooses to opt out of MLTSS), then he continues to be eligible for a Medi-Cal FFS waiver slot. If a dual eligible chooses to remain out of the demonstration and continue to receive FFS Medicare, then he also continues to be eligible for a Medi-Cal FFS waiver slot. It is unclear what happens to an SPD beneficiary who must complete CCI enrollment to continue receiving LTSS, but who is also not eligible for enrollment in the demonstration since they are not a dual eligible. There is nothing to indicate that such individuals will simply be able to occupy a waiver slot paid for by Medi-Cal FFS when their name comes up on the waiting list.

with disabilities[2] are apparently required to give up their entitlement to establish eligibility for a broad set of services, and in return will receive eligibility for a set of services whose scope is *at the discretion* of a demonstration plan. This is not an equal trade.

Even more confusing is the fact that according to the flow charts and Appendix A2 in the Interaction document, those who are already in a NF/AH, HIV/AIDS, AL, or IHO waiver will get to keep their waiver slot paid for by Medi-Cal FFS, but presumably are still required to receive some elements of LTSS through mandatory Medi-Cal managed care. The additional waiver HCBS are vested in the beneficiaries who hold the waivers, and cannot be "discretionary" at the option of the demonstration plan that is delivering IHSS, CBAS, and MSSP. Putting aside for a moment the question of how a mix of managed HCBS and waiver HCBS will practically be administered, if the demonstration plans are actually responsible for coordinating the demonstration HCBS *and* the mandatory additional waiver services, they will already have to undertake provider contracts and gain some level of familiarity with additional HCBS services. The department could reasonably require the demonstration plans to therefore lay the kind of groundwork and connections that would enable them to provide a full gamut of additional HCBS more broadly to non-waiver members.

Optional Nature of "Additional HCBS" Under CCI and Lack of Due Process

The characterization of additional HCBS as essentially optional means that the policies, procedures, and due process governing the administration of these services by demonstration plans will fall out of the LTSS Standards and Care Coordination Standards documents recently finalized by DHCS. While advocates may continue to find those documents imperfect, senior and disability advocacy organizations, our constituents, and demonstration plans have all at least had some opportunity to provide input into the crafting of those standards. It makes little sense for important HCBS services to be characterized as "discretionary" and simply excluded from the operation of relevant standards; a "universal assessment tool" is hardly universal unless the beneficiary is assessed for *all* his or her service needs, in light of the full array of HCBS needed to avoid institutionalization. The Additional HCBS draft asserts that "[t]he demonstration plans' new authority to offer these services will eliminate the need for the waivers for those eligible for the Duals Demonstration," but this clearly will not be the case as long as (1) the additional HCBS do not clearly and fully match the services available under the waivers, and (2) CCI participants are not given the same or better assessment procedures, availability standards and due process protections for the additional HCBS as for waiver services.

[2] Since the MSSP is included within the HCBS that plans must provide under the CCI, people with disabilities over 65 should be eligible for and receive from demonstration plans the full range of HCBS services that they would receive under the MSSP waiver. There is also some indication that demonstration plans should be providing a MSSP level of care coordination for all plan members who require it, but there is nothing to indicate that MSSP waiver services would be freely available to younger people with disabilities who would not qualify for the MSSP waiver, despite needing a nursing facility level of care.

DREDF also has grave practical concerns about leaving service assessments, discretion to contract with community-based organizations and provider entities, and appeal procedures for the additional HCBS entirely in the hands of demonstration plans. We appreciate that there may be some plans that are planning as fully and efficiently as they can to provide the broad range of HCBS that they know will be needed by the CCI populations, but we are also deeply cognizant that some plans are not necessarily even aware of what they do *not* know about transitional planning and wrap-around services. Managed care plans are much more familiar with the provision of medical services, and yet in that realm plans are generally provided with a bright line between services that are required and those that are not. Plans that are already working to overcome the LTSS learning curve are simply not in the best position to be left to themselves to figure out which additional HCBS should be authorized. The Additional HCBS document refers to managed care plans as "the most appropriate vehicle capable of achieving integration of acute and long-term care services at scale," but failing to *require* and standardize at least consideration of the full scope of HCBS that may be required by some CCI participants means that plans are much less likely to achieve scale for services that they are not obligated to offer.

Financial Incentives

The Additional HCBS document alludes at pages 1 and 4 to the "financial incentive" that demonstration plans will have to offer additional HCBS "in order to avoid costly institutional care." While that is true from a systemic "50,000 foot" level, it is not always immediately apparent or influential on the level of the individual service, assessment, and budgeting decisions that are made on the ground. Demonstration plan employees will not be facing simple one-time decisions about the annual amount that a beneficiary will cost if she resides in a nursing home or is provided with an unchanging HCBS benefit package. Instead, employees face a series of decisions over time about authorizing or cutting the myriad kinds of one-time and monthly service expenses that a beneficiary with complex care needs may require. A demonstration plan's reduction of a beneficiary's service by a couple of hours a week, or plan to adopt a more restrictive meal benefits policy, is not going to automatically trigger a wider cost-benefit analysis in the context of institutionalization, for any individual member or group of members. In this scenario, "optional" additional HCBS will be the first services to be cut or not considered in the first place if a beneficiary's total monthly service expenses accumulate close to or beyond the beneficiary's capitation rate. As rational as the financial incentive argument may initially appear, it is insufficient to overcome the unwillingness to incur optional short-term costs for the benefit of long-term savings that individuals, corporate entities, and governments tend to share.

The demonstration plans likely will not even have the guidance provided by the waivers' maximum annual cost caps, which in themselves have not kept up with actual current nursing facility costs. The "financial incentive" to reduce hospitalizations and avoid institutionalization that the additional HCBS document relies upon as the motivation for demonstration plans to offer additional HCBS is, in fact, *the same* financial incentive that the state itself has to make the waiver services more widely and readily available to Medi-Cal beneficiaries. By the same logic, DHCS can and should be motivated to

require plans to offer the additional HCBS, and financially incentivize plans' doing so by offering sufficient capitated rates. The state will reap the financial benefits of establishing DHCS' close monitoring and incentivization of plans that achieve diversion of beneficiaries from nursing facilities, and the appropriate and supported return of nursing facility residents to the community over time.

Sufficient Notice of Policy

The impact of Additional HCBS policy on those seeking the NF/AH and AL waivers, and particularly those on the waiver waiting lists who will be passively enrolled in the demonstration unless they actively communicate their desire to not join the demonstration, argues in favor of individualized notices being sent on this issue to those waiting for implicated waivers or the California Community Transitions (CCT) program. These are individuals who will already be receiving numerous, complicated CCI notices and instructions on the duals demonstrations and/or the transition to MLTSS. Nonetheless, the distinction between the optional nature of the additional HCBS and the scope and due process inherent in waiver services demands that this specific issue needs to be raised as something that will be determined by the individual's choice to join or not join the demonstration. Moreover, there are individuals who are currently exempt from MLTSS because they have been granted a Medical Exemption Request (MER) and remain eligible to stay in a waiver, or presumably remain on the waiting list for a waiver, but who will lose this capacity if their MER expires and they are no longer exempt from MLTSS. These individuals should also receive special individualized notice, since this is a significant change affecting the scope of their HCBS in future that depends on the maintenance of their MER status.

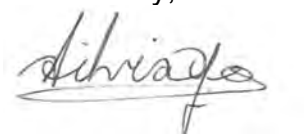
Recommendations

- The Additional HCBS policy must clarify that additional HCBS services encompass the full gamut of AL and NF/AH waiver services.
- Plan Assessments, LTSS assessment tools, and HCBS recommendations must operate on the basis that the full gamut of HCBS services is available to all member beneficiaries as needed.
- Where waiver services are assessed as needed, they must be made available to all members.
- If the state of California continues to take federal funding for the waiver slots and the CCT program, it must fully maintain those slots and appropriate funding for those slots, and continue to support the de-institutionalization work of recognized community-based providers. If the state acts to pass responsibility for waiver services and the CCT program to the demonstration plans, then any plan member that qualifies for nursing home level of care must be entitled to be assessed for and receive the full scope of waiver services, irrespective of the finalized Additional HCBS policy, and regardless of whether the member is enrolled in the demonstration, is on a waiver waiting list, is a dual-eligible, or is a Medi-Cal only senior or person with a disability who receives MLTSS.

- Waiver and CCT operational funds must be sequestered to the provision of waiver services and the continued de-institutionalization of nursing facility residents in compliance with the *Olmstead* decision, and not appropriated to general CCI use.
- The capitated rate negotiated with the demonstration plans must include sufficient funding to incentivize demonstration plans' provision of additional HCBS waiver services on a mandatory basis, of sufficient scope, amount and duration to support members' remaining in, or returning to, the community.
- The final LTSS and CCI standards must be made applicable to additional HCBS, and there members who are denied additional HCBS services must have access to due process and state fair hearing procedures.
- All policy documents and individual notices must clearly reflect how a beneficiary's choice to enroll in the demonstration, or to accept MLTSS, including IHSS, will affect or not affect the beneficiary's eligibility for a waiver slot funded by Medi-Cal FFS.

Thank you again for the opportunity to provide comments on these critical CCI HCBS documents. We would be more than happy to engage in discussions or answer any questions on any aspect of our letter or the above recommendations. For the most part, our comments were not directed at particular sections of the policy documents so we have foregone the use of the comment template provided by DHCS for the purpose. Nonetheless, we strongly support the specific suggestions put forth by our colleagues at Disability Rights California and National Senior Citizens Law Center, as well as their letters.

Yours Truly,



Silvia Yee
Senior Staff Attorney

February 7, 2013

Jane Ogle
Deputy Director
Department of Health Care Services

Dear Jane:

On behalf of six (6) health plans that are designated to participate in the Duals Demonstration Project (Alameda Alliance for Health, CalOptima, Community Health Group, Inland Empire Health Plan, Santa Clara Family Health Plan, and the Health Plan of San Mateo), we are writing about two draft documents dated January 24, 2013 and released last week. One is called "Draft Policy for Demonstration Plans Offering Additional HCBS Services" and the other is entitled, "Interaction of Select HCBS Programs with the CCI, Draft Guidance for Comment."

Our six plans welcome the flexibility outlined in the first document, namely that Demonstration plans will have the option to provide "additional" HCBS, often referred to as "in lieu of" services. These services (e.g., respite, home delivered meals, home adaptation, etc.) are provided at plan discretion to help members avoid more costly services in institutions. They are similar to what PACE programs can provide their members. We also welcome DHCS clarification that these are services offered at plan discretion, not benefits subject to grievance and appeals rights and procedures. Plan discretion is critical so that plans can ensure services are provided in a cost effective manner, i.e., in situations where they are alternatives to more costly services.

However, we are concerned that this flexibility appears to be limited to enrollees of the Duals Demonstration Project (DDP). While the documents are not clear on this issue, DHCS staff stated on a stakeholder call last week that the current intention is to limit such flexibility to DDP enrollees.

The provision of additional HCBS services as described in the document should be available to all Medicaid members in the demonstration counties:

- All Medicaid members are included in the CCI in that they will be required to access long term institutional care, IHSS, and MSSP through the health plans (they already receive CBAS through the plans).
- Given the above, plans should have the flexibility to offer less costly additional services to non DDP members in order to help them avoid institutionalization.
- In response to the comment on the call that plans will not have access to Medicare funds to offer these services to non Demonstration enrollees, plans should still have the option to fund these additional services from Medicaid savings. Plans will still have incentives to avoid Medicaid funded hospital and nursing home stays and should be given all the tools to effectively do so.

- Creating Medicaid LTSS services packages for dual and non dual enrollees will result in additional and unnecessary administrative burdens and complexities for plan staff.
- All plan members who desire to live in the least restrictive setting should be provided support from plans to do so. In some circumstances, the additional HCBS services are critical for fulfilling this vision.

Thank you for your consideration of these comments.

Sincerely,

Maya Altman, CEO
Health Plan of San Mateo

cc: Toby Douglas
Margaret Tatar
John Shen

Comments:
Draft Policy for Demonstration Plans Offering Additional HCBS

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

Page	Section Title	Existing Text	Comment or Suggested Edit
1	Footer	[1] "Home- and community-based services (HCBS) plan benefits" may include in-home and out-of-home respite, nutritional assessment, counseling, and supplements, minor home or environmental adaptations, habilitation, and other services that may be deemed necessary by the managed care plans, including its care coordination team. The department, in consultation with stakeholders, may determine whether plans shall be required to include these benefits in their scope of service, and may establish guidelines for the scope, duration, and intensity of these benefits. The grievance process for these benefits shall be the same process as used for other benefits authorized by managed care plans, and shall comply with Section 14450, and Sections 1368 and 1368.1 of the Health and Safety Code."	**Comment:** Please clarify the grievance process for these services. The footer indicates that the grievance policy for other benefits would also apply to these additional services. However, page 4 of the document indicates that these services are not subject to the Medi-Cal grievance and appeals process.
2	Purpose of this paper	This particular guidance is focused on the provision of a limited number of additional HBCS that are listed in the authorizing legislation for the duals demonstration, which "may include": 1. Respite care: in home or out-of-home; 2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; 3. Habilitation ; 4. Nutrition: Nutritional assessment, supplements and home delivered meals; 5. Home maintenance and minor home or environmental adaptation; and, 6. Other services (the list provided by legislation is permissive.)	**Comment:** Please define Habilitation services.
Appendix	Interaction of Select HCBS Programs with the CCI		**Comment:** If a member who receives waiver services elects to enroll in the demonstration, is the expectation for the plan to provide those waiver services?

Comment Template

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

Page	Section Title	Existing Text	Comment or Suggested Edit
Comments on Document: Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)			
1	Introduction	Paragraph #3: "… intends to expand the availability and use of HCBS by allowing demonstration plans[1] to pay for these services out of the monthly payments they receive to provide care to their enrollees. The goal is to create structure and culture where HCBS are broadly available."	We are not aware of any criteria for assessing how/when to authorize payment for additional HCBS. In addition, we do not have adequate utilization data to assess rates paid to the health plans will be sufficient to achieve the stated goal. Does DHCS anticipate providing this criteria and utilization data in order for the health plans to know how to pay for this out of the PMPM?
1	Introduction	End of Paragraph #3: "Demonstration plans will have the incentive to offer additional HCBS in order to avoid costly institutional care."	Please note that health plans d not have sufficient data to know to identify opportunities or if additional HCBS will avoid costly institutional care. Has DHCS, or any other entity, done the analysis showing the maximum amount of HCBS that could be provided to one person (by health plan payment) does not ever exceed the cost of institutional care? Said another way, if we were able wrap u all of the HCBS that could possibly be provided to anyone person (e.g., maximum user), would this not exceed the cost of SNF/LTC placement? Is there any information or even insight into the algorithm the state is using to show this is the case?
1	Footnote #2	"The department, in consultation with the	Since the development of policies and

Comment Template

Organization: Health Net
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Page	Section Title	Existing Text	Comment or Suggested Edit
		State Department of Social Services, shall develop policies and procedures for these additional benefits, which managed care plans may authorize."	procedures for the health plan (which is also a readiness requirement) is dependent upon first receiving the stated policies and procedures from DHCS and DPSS, is there a timeline that can be shared as to when the plans can expect to see these policies and procedures? Or even a draft of these policies and procedures?
1	Footnote #3	"Home- and community-based services (HCBS) plan benefits" may include in-home and out-of-home respite, nutritional assessment, counseling, and supplements, minor home or environmental adaptations…."	What constitutes environmental adaptation?
2	Purpose of this Paper	"In particular, the Care Coordination Standards focus on how to improve chronic disease management by bringing MSSP practices of care coordination to demonstration plans. The Coordinate Care Initiative (CCI) legislation also provides specifications for how the Program of All-Inclusive Care for the Elderly (PACE) will interact with the CCI."	It is unclear what the purpose of this paragraph is. Is this meant to convey a requirement or intention for the health plans? If so, please clarify.
2	Purpose of this Paper	"This particular guidance is focused on the provision of a limited number of additional HBCS that are listed in the authorizing legislation for the duals demonstration, which “may include”: "	Does this also mean the "plans may not"?

Comment Template

Organization: Health Net
Contact Name: Diane Sargent
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Page	Section Title	Existing Text	Comment or Suggested Edit
3	Preparing for the Demonstration	"The demonstration plans' new authority to offer these services will eliminate the need for the waivers for those eligible for the Duals Demonstration."	As we have indicated in previous comments, we are unclear how the state intents for the plans to interact with the existing HCBS entities. Most of these services right now are being paid for through means other than the health plans. We are assuming that before the health plans would pay for additional HCBS, beneficiaries would still be able to first exhaust what is already available to them as they are today. Is it the intention that after the current slots are filled, that is when the health plans may pay for additional services? Is this statement suggesting that managed care members will not be able to have the HCBS services unless the health plan is paying for them?
3	Preparing for the Demonstration	*Offer Technical Assistance to HCBS Community Groups.* Today, many community providers function under a funding model of grants and donations. For these organizations new to the managed care contracting world, it is incumbent on DHCS to help create opportunities to educate and support such community providers in learning about contracting with demonstration plans and new business model opportunities (as needed).	What are the criteria that constitute this? What are the credentials of the people and entities interacting in this scenario?

Comment Template

Organization: Health Net
Contact Name: Diane Sargent
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Page	Section Title	Existing Text	Comment or Suggested Edit
Comments on Document: "Interaction of Select HCBS Programs with the Coordinated Care Initiative"			
N/A	Overall Comment	Overall Comment	1. For MSSP, will the health plan members still have access to MSSP services that are already being funded (e.g. not funded by the health plan?), or will health plan members only be able to receive MSSP services if the health plan is paying for them? 2. Is DHCS planning on regulating how many available slots the MSSP and other HCBS programs can have that are already funded as well as how many additional slots that can be purchased from the health plans? It is unclear how to maximize utilization of these HCBS without exhausting resources. The health plans need to know what that additional number of available slots will be. 3. As it stands today, MSSPs currently have an algorithm/process that shows if services are available through another program in the community which they use before they purchase those services for their members. If there are services available in the community, to what extent are they available to the managed care plans to use before they are need to purchase services from the MSSPs?

Comment Template

Organization: Health Net
Contact Name: Diane Sargent
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Page	Section Title	Existing Text	Comment or Suggested Edit
Attachment F			It is not clear what DHCS intents what the specific scope of services the health plans would contract with CCT for. Please clarify.
Attachments: D, E, F, G			Recommendation - The CCT and nursing waiver need to be phased in after the first two years of the Demonstration. This way, the health plans have enough data from the medical side to be able to appropriately assess the added value of these programs. The health plans will need this information to create objective criteria for utilization.
Comments on Document: "Care Coordination Standards"			
2	General Principles for Care Coordination (Paragraph 2)	These standards cover the care coordination process for both dual eligible beneficiaries and Medi-Cal-only beneficiaries who will receive long-term services and supports (LTSS) benefits through a health plan under the Coordinated Care Initiative (CCI). (Separate standards are under development to dual eligible beneficiaries enrolled in the plans for Medi-Cal benefits only.)	Since separate standards are being developed for beneficiaries enrolled for Medi-Cal only benefits (LTSS) we suggest that any other reference to Medi-Cal only beneficiaries be deleted from this document in order to avoid confusion and clearly delineate which requirements apply to each population. However, for Medi-Cal only members, some members may already be receiving services deeming an HRA unnecessary. We suggest the HRA for Medi-Cal only members be limited in scope.
2	General Principles for Care Coordination (Paragraph 4)	These standards will be incorporated into a Plan readiness tool that will be used to assess the participating plans' readiness to implement the Demonstration and provide managed long-term services and supports	We suggest deleting the language "and provide managed long-term services and supports (MLTSS) to Medi-Cal only beneficiaries." Since separate standards are being developed for this population, removing the language will avoid

Comment Template

Organization: Health Net
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Page	Section Title	Existing Text	Comment or Suggested Edit
		(MLTSS) to Medi-Cal only beneficiaries.	confusion.
4	Health Assessment Process (Paragraph 3)	For Member identified as higher risk, Plans will administer a DHCS approved health risk assessment (HRA) survey within 45 days.	We suggest adding at the end of the sentence "from the date of the completed risk stratification." Because the plans are given 44 days to complete the risk stratification, it is not reasonable to require the HRA to be completed within one day of stratification. The plans will not know which members are Higher Risk until the risk stratification is completed.
4	Health Assessment Process (Paragraph 4)	For Members who are lower risk, community well, or residents of nursing homes, Plans will administer a health risk assessment within 9 days.	We suggest adding at the end of the sentence "from the date of the completed risk stratification." This will allow the plans adequate time to complete the HRA after identifying which stratification level applies to the member.
4	Health Assessment Process (Paragraph 5)	The health assessment process must be completed for Members who are enrolled in the duals demonstration and Medi-Cal only members who receive LTSS	We suggest removing the language "and Med-Cal only members who receive LTSS." Since it is stated earlier in the document that separate standards are being developed for this population, we suggest that all references to the Medi-Cal only population be removed from this document.
5	Health Assessment Process (Paragraph 1)	Plans will develop and submit policies and procedures that demonstrate compliance with the following requirements to DHCS and CMS three months prior to	Page states that these requirements will be incorporated into the readiness tool. However, this language states that the policies and procedures demonstrating these requirements

Comment Template

Organization: Health Net
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Page	Section Title	Existing Text	Comment or Suggested Edit
		implementation.	should be submitted to DHCS and CMS three months prior to implementation, which with the proposed implementation date of September 1, 201 would mean submission on June 1, 2013. Our understanding is that the Readiness Review will take place prior to June 2013. Please clarify when the policies and procedures will need to be submitted to DHCS and CMS for review.
5	Health Assessment Process (#2)	Showing how the plan will complete stratification within 44 calendar days of enrollment, pending timely receipt of the data from DHCS and CMS.	The standards state that the plans will receive the DHCS and CMS data upon enrollment. Please confirm that "timely receipt" means that the data is received at or before the members' enrollment date.
5	Health Assessment Process (#3)	Testing the stratification mechanism or algorithm by using Plan utilization data to stratify currently enrolled dual eligible members …	Please confirm that this requirement is anticipated to happen after enrollment begins in September 2013. If this requirement is to test the stratification algorithm prior to members being enrolled, then it is dependent o having the rates and executed three way contracts so can proceed with timely implementation with the HRA vendor. Also, we suggest replacing "(third group)" with Community Well.
5	Health Risk Assessment	Overall comment	This document assumes that every member will be solicited for an HRA. Will members have an opportunity to opt-out of receiving this HRA solicitation?

Comment Template

Organization: Health Net
Contact Name: Diane Sargent
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Page	Section Title	Existing Text	Comment or Suggested Edit
5	Health Risk Assessment (Paragraph 3)	Health Plans will conduct the SF-12 Health Survey questions, or another similar health survey, in addition to their HRA tool.	There are several concerns with this requirement: 1. This is new assessment that is being required of the health plans and places additional costs and administrative burdens o the plans. This includes programming the case management systems to automatically load the answers from the assessments and create suggested goals for the Care Plan. 2. This is another touch point for the member which places another burden o the member. 3. Please clarify if the SF-12 questions must be utilized, do they need to be modified to a 6th grade reading level to meet other DHCS requirements? 4. Implementing a new assessment for a single year of the Demonstration (prior to the Universal Assessment Tool being implemented) will not allow consistent results to be compared across years since different questions will be asked based o the different assessments being required. Health Net has developed an HRA that includes the SF-1 questions. Would it be possible for DHCS and CMS to review this document and possibly approve it as the base

Comment Template

Organization: Health Net
Contact Name: Diane Sargent
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Page	Section Title	Existing Text	Comment or Suggested Edit
			Universal Assessment Tool that could be utilized beginning Year 1 and then added on to, as needed, for the subsequent years of the Demonstration?
5	Health Risk Assessment (#1a)	Within 45 calendar days of enrollment for those identified as higher risk by the risk stratification mechanism or algorithm	As mentioned above, we suggest that the words "of enrollment" be removed and the requirement be modified to require that the HRA be completed within 45 days of completion of the risk stratification.
6	Health Risk Assessment (#1b)	Within 90 calendar days of enrollment for nursing facility residents or those identified as lower-risk	As mentioned above, we suggest that the words "of enrollment" be removed and the requirement be modified to require that the HRA be completed within 90 days of completion of the risk stratification. We also suggest that the stratification group "Community Well" be added to this sentence to clarify when the HRA must be completed for this group.
7	Health Risk Assessment (#11)	Sharing assessment results with Members, the ICT, the PCP, the MSSP care manager, etc.	Information should not be shared unless the appropriate consent to do so has been received from the member.
8	Individual Care Plan (#13a)	Identification of providers should promote co-location of service delivery, especially for Members receiving specialty mental	The requirement to promote co-location of service delivery is difficult to achieve, especially for specialty mental health and substance abuse

Comment Template

Organization: Health Net
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Page	Section Title	Existing Text	Comment or Suggested Edit
		health or chronic substance abuse disorder services.	services which will be provided by the County and would not allow for co-location. We suggest that this requirement be deleted.
10	Basic Case Management Services	Overall Comment	The definition of and expectations for Basic Case Management Services are not consistent with the CMS requirements listed in Chapter 16B and are not consistent with the process described in the Dual Eligible Model of Care that was submitted and approved by CMS and DHCS. We suggest that any case management definitions be consistent with the CMS requirements.
13	Reassessment and Review (#1)	Reassessment may be conducted by phone, email, or in-person for beneficiaries in lower-risk group, and will be conducted in person or in the setting of the Member's choice for higher risk group and nursing facility residents.	The Health Assessment Process listed earlier in the document does not have a specific requirement listed for assessments to be conducted in-person for Member's in higher risk or nursing facility residents. Please clarify if the requirement is for either the initial HRA or annual reassessment to be conducted in person for any of the populations. All enrollees are assessed for the need for in-person assessments, and this requirement should not be mandated, but left to the ICT/CM based upo individual need.
15	Interdisciplinary Care Team (ICT)(#4)	The membership of the ICT will include the Member and/or authorized representative if willing or able to participate, PCP, Plan care coordinator …	Please confirm that the requirement for ICT membership is the same regardless of the member's primary diagnosis (medical, behavioral, LTSS)

Comment Template

Organization: Health Net
Contact Name: Diane Sargent
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Page	Section Title	Existing Text	Comment or Suggested Edit
18	Definitions of Basic Case Management and Complex Case Management		The differentiation of Basic vs. Complex Case Management is not clear. The language "include Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system" is the definition for both Basic and Complex Case Management. We suggest that the definitions be utilized from the standard industry recognized definitions from CMSA that are consistent with CMS requirements, i.e. CMS requires ICT for all members while per Basic CM definition an ICT is not required.

Comment Template

Organization:
Contact Name:
E-Mail:

Page	Section Title	Existing Text	Comment or Suggested Edit
DRAFT HCBS Policy Paper		While it is unclear in the documents, DHCS stated on the call last week that the draft HCBS policy dated January 24, 2013 only applies to enrollees in the DDP.	It is critical the provision of additional HCBS services described in the document also be available to all Medicaid members, since all Medicaid members are to be part of the CCI in the eight Demonstration counties. These members will be required to access LTC, IHSS, CBAS, and MSSP through health plans. Therefore, plans should have the flexibility to offer less costly additional services to no DDP members, in order to help them avoid institutionalizations as well. The State will still save money since many of these members are Medicaid only and both nursing home and hospitals stays are Medicaid funded. For those duals not enrolled in the DDP, Medicaid is still the funder for long nursing home stays, which are more likely to occur once person enters a nursing home without immediate planning for a transition to another setting once Medicare funded rehab services have ended. In addition, offering different service packages to DDP and no DDP members for LTSS will create additional and unnecessary administrative complexities for both the plans and their county and community partners. Finally, it is unfair and unnecessary (not to mention in conflict with Olmstead) to deny additional services to non DDP members if the plans can offer these services within their funding by limiting institutional spending.

Comment Template

Organization:
Contact Name:
E-Mail:

Page	Section Title	Existing Text	Comment or Suggested Edit
DRAFT HCBS Policy Paper – Page 2	Additional HCBS Services	6. Other services (the list provided by legislation is permissive.)	While we believe that the draft HCBS policy provides the flexibility to pay for assisted living (under #6, Other Services), such as is provided under the Assisted Living Waiver, please confirm that this is the case.
DRAFT HCBS Policy Paper – Page 2	Additional HCBS Services	6. Other services (the list provided by legislation is permissive.)	We strongly support the DHCS decision to clarify that the six additional services are indeed services, not benefits, and therefore not subject to Medi-Cal grievance and appeals procedures. Plans must have flexibility whether or not to offer these services; if they are deemed covered benefits, there must be additional funding to cover the additional services. We assume such funding is unavailable; otherwise the current waivered services would not have enrollment caps.
DRAFT HCBS Enrollment Flow Charts	Appendix A.2 Coordinated Care Initiative, Participating Populations Chart for MLTSS		This section is confusing. It states that MA and SNP members are exempt from the CCI and MLTSS in 2013. Does this mean that all our current SNP members cannot access any HCBS (IHSS, MSSP, or the additional HCBS services) through the Plan in 2013? We have assumed that all HCBS for all our Medicaid members would become HPSM's responsibility on Sept. 1. Doing this "all at once" will be much less confusing for our members and our community and county partners, and will again avoid unnecessary administrative complexity for the

Comment Template

Organization:
Contact Name:
E-Mail:

Page	Section Title	Existing Text	Comment or Suggested Edit
			plan. We urge you to reconsider this approach, at least for HPSM, which has different enrollment process for the DDP in any case.
DRAFT HCBS Enrollment Flow Charts	Appendix A.2 Coordinated Care Initiative, Participating Populations Chart for MLTSS		Related to the above, we urge the State to seek Medicaid waiver that includes institutional deeming (we assume the State must obtain a separate Medicaid waiver for the LTSS services for all Medicaid beneficiaries). Again, non DDP enrollees in the Demonstration counties should not have to suffer from the Medicaid program's institutional bias either and to the greatest extent possible there should be consistent service and benefit offerings for all plan enrollees.

Comment Template

Organization:
Contact Name:
E-Mail:

Page	Section Title	Existing Text	Comment or Suggested Edit

Comment Template for CCI Care Coordination Standards
Due October , 2012

Organization: HPSM
Contact Name: Chris Baughman
E-Mail: chris.baughman@hpsm.org

Page	Section Title	Existing Text	Comment or Suggested Edit
Page 4	Health Assessment Process	Based o the stratification results, Members should be assigned to the following four groups: • Higher risk: means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health or functional status if they d not receive their initial contact by the Plan within 45 calendar days of enrollment. • Lower risk • Community Well: These are all other members who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services • Residents of nursing homes	• Why are plans being asked to assign members to these four groups? We understand that these groupings are similar to but not exactly reflective of the risk adjustment population categories included in DDP rate methodology materials. • Our understanding is that the State is using readily accessible State data sources to determine membership in the risk adjustment categories, so why are the plans being asked to collect these data? Is the State planning to use these plan data for risk adjustment to develop capitation rates in the future? • This document appears to assume anyone categorized in the Community Well group are people who are not resident in LTC facilities and do not utilize CBAS, MSSP, or IHSS services. However, we do have members in this group who we might still consider high risk. Please clarify.

Comment Template-Care Coordination Standards

Organization: Inland Empire Health Plan
Contact Name: Rohit Gupta
E-Mail: gupta-r@iehp.org

Page	Section Title	Existing Text	Comment or Suggested Edit
13	Reassessment and Review	Reassessment may be conducted by phone, email, or in-person for beneficiaries in lower-risk group, and will be conducted in person or in the setting of the Member's choice for higher-risk group and nursing facility residents (D-SNP).	This is vague. Please further clarify and define 'reassessment.' Is this reassessment of the ICP or the annual HRA reassessment . In any way, this will have a huge financial cost to the plans, while the benefit of the face-to-face assessment has not been clearly documented, especially given that this face-to-face encounter is not a clinical encounter. Perhaps health plans can conduct the Reassessment according to a high risks member's needs. An initial screening by phone or mail could include questions that would determine the best possible mode of assessment for each member.
2	GENERAL PRINCIPLES FOR CARE COORDINATION	These standards cover the care coordination process for both dual eligible beneficiaries and Medi-Cal-only beneficiaries who will receive long-term services and supports (LTSS) benefits through a health plan under the Coordinated Care Initiative (CCI). (Separate standards are under development to dual eligible beneficiaries enrolled in the plans for Medi-Cal benefits only.)	Please provide update on when the separate guidance will be released for the Duals population that 'opts out' for Medicare.
4	Health Assessment Process	The initial risk stratification will be completed for each Member within 44	Please clarify this timeframe. This implies that health plans only have 1 day to conduct the HRA

Comment Template-Care Coordination Standards

Organization: Inland Empire Health Plan
Contact Name: Rohit Gupta
E-Mail: gupta-r@iehp.org

Page	Section Title	Existing Text	Comment or Suggested Edit
		days of enrollment… For Members identified as higher risk, Plans will administer a DHCS approved health risk assessment (HRA) survey within 4 days.	for high risk members after the initial stratification.
6	Health Risk Assessment	4b. For higher-risk beneficiaries, professionally knowledgeable and credentialed personnel to review, analyze, identify and stratify health care needs, such as physicians, nurses, social workers, or behavioral health specialists.	This language is unclear. Please clarify. This implies that HRAs for higher risk members will be conducted by physicians, nurses, etc. If so, this will be very cumbersome and administratively expensive for plans. Instead, we recommend that plans we allowed to utilize existing process to conduct the HRAs for higher risk members but that the HRAs be reviewed, analyzed and stratified by professionally knowledgeable and credentialed personnel.

Comment Template: HCBS Enrollment Flow Paper dated 1/24/13

Organization: Inland Empire Health Plan
Contact Name: Rohit Gupta
E-Mail: gupta-r@iehp.org

Page	Section Title	Existing Text	Comment or Suggested Edit
1	Intro: "Beneficiary is "Pending Enrollment Process into CCI"	In addition, eligible beneficiaries enrolled in MSSP will be passively enrolled all at the same time in September 2013; this step is being taken as a requirement for rate setting.	As part of the rate setting process, we highly recommend that the State also include the total number of members on the MSSP waiting list, along with members that become newly-eligible each year for MSSP, since these members will be provided "MSSP-like" (or MSSP-Contract) services by the health plans outside of the county. Without the inclusion of these members, and their associated costs, in the rate setting process, the health plans may not have the financial capacity to offer such services outside of the county and MSSP providers.
2	*Beneficiary has "Completed CCI enrollment; Mandatorily enrolled in MLTSS"*	Such beneficiaries can choose to join the Demonstration, however they would be required to disenroll from their waiver to do so.	We feel that it is detrimental to require members to disenroll from their respective waiver program as a requirement for enrolling into the Demo. If, in the future, the member chooses to disenroll from the Demo and return to FFS, they will have no guarantee of being able to re-enroll into the waiver program, and may be required to wait a long time on the waiting list. As such, few people on these waiver programs may actually choose to enroll in the Demo. Instead, we think waiver members should be allowed to remain in the waiver and enroll in the Demo or be allowed the ability to re-enroll in the waiver program if they disenroll from the Demo in the future.

Comment Template: HCBS Enrollment Flow Paper dated 1/24/13

Organization: Inland Empire Health Plan
Contact Name: Rohit Gupta
E-Mail: gupta-r@iehp.org

Page	Section Title	Existing Text	Comment or Suggested Edit
			The current requirement creates disincentive for waiver members to enroll in the Demo.
Attachment B	Not Enrolled: Beneficiary Seeks Multipurpose Senior Services Program	MSSP members eligible for, not enrolled in, Demonstration will be enrolled when slot opens	The State is proposing separate MSSP processes based on whether or not the member is participating in the Demonstration. We understand that the State wants to create an incentive for members to enroll in the Demo but we believe that MSSP and other HCBS services are critical to achieve the CCI goals (e.g., reduce institutionalization) and believe that all eligible members should be allowed to have access to MSSP and MSSP-like services regardless of whether or not they are in the Demo (e.g., regardless of whether or not they 'opt out' for Medicare.) Since the Demo plans will still have financial risk for these 'opt out members for their LTSS, it is critical that Demo plans be able to provide these MSSP-like services to members that 'opt out'. Additionally, these costs should be included as part of the rate setting process.
Attachment B	Not Enrolled: Beneficiary Seeks Multipurpose Senior Services Program	Joins the Demonstration – MSSP slot unavailable – plan contracts for services	For scenarios where Duals member (part of the demonstration) does not have a MSSP slot available, these services will be provided by the health plan. We believe that there should be some language that clearly states that, while the plan provides these services if a slot is unavailable, these

Organization: Inland Empire Health Plan
Contact Name: Rohit Gupta
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			members will get services through MSSP once a slot does become available. Otherwise, it is evident that eventually, in Year 3 of the Demo, many of the members using MSSP will not be part of the Demo, and that more people are likely to be getting MSSP-like services through the health plan than those that are getting MSSP services through the county. Additionally, this realization should also be included in the rate setting process.

Comment Template-LTSS Standards

Organization: Inland Empire Health Plan
Contact Name: Rohit Gupta
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Page	Section Title	Existing Text	Comment or Suggested Edit
4	For MSSP, Health Plans[1] shall develop policies and procedures to: #8	Refer plan members, who have medical necessity, for coordinated care/case management to MSSP sites to receive needed services if there is sufficient and available capacity at the site. If there is no capacity, plans must provide some level of MSSP-like services through a network of providers selected by the health plan.	Per our comments on the HCBS policy paper, we believe it is critical that DHCS accurately estimate the total number of members that will require and utilize LTSS-like (e.g., IHSS-like and MSSP-like) services and HCBS and appropriately include this in the rate setting process. Plans must have the financial flexibility to be able to offer these 'like' services. The current Medi-Cal payment methodology does not take this into consideration and does not create the financial incentive for plans to offer these services until Year 3 of the Demo

[1] Note, CalOptima is already an MSSP site. These rules will apply to CalOptima's interaction will all other MSSP sites.

Comment Template: HCBS Paper dated 1/24/13

Organization: Inland Empire Health Plan
Contact Name: Rohit Gupta
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Page	Section Title	Existing Text	Comment or Suggested Edit
1	Intro	Demonstration plans will have the incentive to offer additional HCBS in order to avoid costly institutional care.	It is clear that one of the goals of the CCI is to reduce institutional rates via managed care efficiencies (through care coordination and management) and, secondarily through use of LTSS (HCBS) services such as IHSS, MSSP and CBAS. It is also clear that health plans should be inherently motivated to reduce utilization, reduce costs and work towards transitioning members to the community and/or the least restrictive, most integrated setting. But it is not inherently accurate to say that Demo plans have the incentive to offer additional HCBS in order to avoid costly institutional care. Without the release of the rates or the finalization of the Medi-Cal payment methodology, it is inaccurate to say that Demo plans have a financial incentive to reduce institutional rates. To the contrary, based on the draft Medi-Cal payment methodology, given that the relative mix factor (RMF) is adjusted monthly in Year 1 and quarterly in Year 2, Demo plans will actually get paid more if a member is institutionalized. True incentives may not be apparent until Year 3. Additionally, without the projection of the true costs of providing these HCBS services (in lieu of institutionalization) and without the inclusion of these costs in the Demo rates, it is inaccurate to say that Demo plans have an incentive to offer these services.
1	Footnote 3	The department, in consultation with stakeholders, may determine whether plans shall be required to include these benefits in their scope of service, and may establish guidelines for the scope, duration, and intensity of these benefits.	We agree that Demo plans should be required to disclose whether or not they will provide these services and under which criteria but we do not agree that Demo plans <u>should</u> be required to provide any or all of these six HCBS. The provision of these services should solely be at the discretion of the Demo plans.
4	Preparing for the Demonstration	MSSP sites will remain open to enrollment in demonstration counties for any populations excluded from the demonstration.	We feel that if MSSP sites will remain open to enrollment in demonstration counties (which is contrary to what was previously communicated), they should not only remain open to populations excluded from the demonstration but also stay open to populations included in the demonstration. The process shall remain the same as it is now, with Demo plans having financial responsibility for their members getting MSSP services through the county.

Comment Template

Organization: Kaiser Permanente Southern California
Contact Name: Gwen Leake Isaacs
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<table>
<tr><th>Page</th><th>Section Title</th><th>Existing Text</th><th>Comment or Suggested Edit</th></tr>
<tr>
<td>Additional Home-and Community-Based Services (HCBS) January 24, 2013, page 3</td>
<td>Table A: California HCBS waivers most Relevant to CCI (Statewide)</td>
<td>
<table>
<tr><th>Waiver</th><th>Enrollment Count</th></tr>
<tr><td>Assisted Living Waiver (ALW)</td><td>1,840</td></tr>
<tr><td>In-Home Operations (IHO)</td><td>134</td></tr>
<tr><td>Nursing Facility/Acute Hospital (NF/AH)</td><td>2,220</td></tr>
<tr><td>Multipurpose Senior Services Program (MSSP)</td><td>8,987</td></tr>
<tr><td>TOTAL</td><td>13,181</td></tr>
</table>
</td>
<td>The California Community Transitions (CCT) Project assists in transitioning beneficiaries to the various levels of care noted here. Will the CCT Project be available for theses dual eligibles until the Project ends in 2016?</td>
</tr>
<tr>
<td>Additional Home-and Community-Based Services (HCBS) January 24, 2013, page 3</td>
<td>Preparing for the Demonstration</td>
<td></td>
<td>1) We recommend that DHCS inform members eligible for HCBS that additional HCBS above and beyond the IHSS, CBAS, MSSP, NF and SCF services may be provided at the discretion of the health plan.
2) We suggest deleting the “and not subject to grievance and appeals”</td>
</tr>
<tr>
<td>Coordinated Care Initiative, Draft assessment and care Coordination Standards, January 22,2013</td>
<td>2. Health Assessment Process, page 4</td>
<td>Based on the stratification results, Members should be assigned to the following four groups:

• Higher risk: means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health or functional</td>
<td>Please provide more specific criteria for the higher risk, lower risk and Community Well categories. . For example: may historical utilization, number of admissions, educational visits, etc. play into which group a member will be assigned to?</td>
</tr>
</table>

Comment Template

Organization: Kaiser Permanente Southern California
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Page	Section Title	Existing Text	Comment or Suggested Edit
		status if they do not receive their initial contact by the Plan within 45 calendar days of enrollment. • Lower risk • Community Well: These are all other members who are not resident in long-term care facilities and do not utilize CBAS, MSSP, or IHSS services • Residents of nursing homes	
Coordinated Care Initiative, Draft assessment and care Coordination Standards, January 22,2013	2. Health Assessment Process, page 4 and 5	For Members identified as higher risk, Plans will administer a DHCS approved health risk assessment (HRA) survey within 45 days. For Members who are lower risk, community well, or residents of nursing homes, Plans will administer a health risk assessment within 90 days. This stratification will occur within 44 calendar days of enrollment.	Please clarify if the timing for the HRA (45/90 days) starts from the day after the member is classified into their relevant stratification group.
Coordinated Care Initiative, Draft assessment and care Coordination Standards, January 22,2013	2. Health Risk Assessment, page 5	Plans will use a health risk assessment (HRA) tool to assess a Member's current health and functional risks, including medical, LTSS, and behavioral health elements. Health Plans will conduct the SF-12 Health Survey questions, or another similar health survey, in addition to their HRA tool. A standardized component of the HRA across all Health Plans will provide	1) The use of the SF-12 should be reconsidered. Most of the SF-12 questions are typically part of a plan's health risk assessment, and plans do NOT want to duplicate any questions or surveys. Such duplication will be a burden on enrollees in terms of time and add confusion for both providers and enrollees. Duplication of effort will also add unnecessary cost. How will DHCS approve the use of the current tool?

Comment Template

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Page	Section Title	Existing Text	Comment or Suggested Edit
		great value to the department addressing clinical, quality, and policy decisions. A common data set on assessments will be helpful for stakeholder reporting purposes.	2) We recommend that plans with SNPs be allowed to use the HRA tool used for SNP members.
Coordinated Care Initiative, Draft assessment and care Coordination Standards, January 22, 2013	2. Health Risk Assessment, page 6, item 4	1. How the HRA will be conducted by: a. Personnel trained in the use of the assessment instruments, and b. For higher-risk beneficiaries, professionally knowledgeable and credentialed personnel to review, analyze, identify and stratify health care needs, such as physicians, nurses, social workers, or behavioral health specialists.	1) We think that the term "credentialed personnel" is not clear. 2) We recommend that document say "For higher risk beneficiaries, professionally knowledgably and licensed personnel to review. . . . "
Coordinated Care Initiative, Draft assessment and care Coordination Standards, January 22, 2013	Reassessment and Review: DHCS proposes the following provisions regarding reassessment page 14	1. Plans will conduct an annual comprehensive reassessment for the individual care plan (including medical, LTSS, behavioral health utilization data analysis and risk stratification) within 12 months of last assessment, or as often as the health of the enrollee requires. Reassessment may be conducted by phone, email, or in-person for beneficiaries in lower-risk group, and will be conducted in	The cost is high to have an in person assessment on an annual basis. We recommend that the re-assessment for the higher risk members be done by phone, if appropriate. Please clarify what is the requirement for initial face to face assessments . i.e., in-person or by phone or email.

Comment Template

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Page	Section Title	Existing Text	Comment or Suggested Edit
		person or in the setting of the Member's choice for higher-risk group and nursing facility residents (D-SNP).	
LTSS Network Adequacy and Readiness Standards,	Member Services Page 9, item 3	Update lists of available LTSS providers on a quarterly basis.	1. Will plans be required to provide the updated list to members upon request? May plans determine what notice process to use? 2. We recommend that the plans be allowed to update list on their web site quarterly and provide the written list to members upon request. More frequent mailings would be administratively burdensome and add extra expense and complexity for plans and members.
LTSS Network Adequacy and Readiness Standards	Member Grievance System page 8-9	For CBAS, MSSP, and NF/SCF, Health Plans shall develop policies and procedures to: 1. Describe how Health Plan members' grievances regarding eligibility determinations, assessments, and care delivered by the Plan's contracted CBAS centers, MSSP sites, or NF/SCF should be submitted and will be adjudicated.	We recommend that these services be subject to the same grievance process as any other service under the benefit plan. As such, we suggest that CBAS, MSSP, and NF/SCF related grievances be processed in the same manner as other Plan services.

Comments for Draft – Interaction of Select HCBS Programs with the CCI
Due February 6, 2013

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

Page	Section Title	Existing Text	Comment or Suggested Edit
ALL		"… managed Medi-Cal long-term service and supports…"	**General Comment:** For consistency and clarity, **replace** all uses of **"MLTSS"** with **"LTSS"** which is the term that has been used up until now and is most familiar to stakeholders. Also, the word "service" should be plural **"services"**
ALL			**General Comment:** For consistency and clarity, replace all uses of "the Demonstration" with the correct "Dual Eligible Demonstration Project Pilot" (DEDPP) or whatever is the correct name of the pilot
Appendix A.1.:	Beneficiary has "Completed CCI enrollment: Mandatorily enrolled in MLTSS	"The **Demonstration**, but will not be… choose to join the **Demonstration**, however, they would be required to …"	**General Comment:** For consistency and clarity, replace all uses of "Duals Demonstration" and "the Demonstration" with the correct "Dual Eligible Demonstration Project Pilot" (DEDPP) or whatever is the correct name of the pilot
4 -9	ALL Flowcharts		**Simplify** flowcharts; The flowcharts were very confusing and did not help us in trying to visualize how beneficiaries will navigate the various options they will have. We are concerned that the vulnerable IHSS population we serve will be even more confused that we are.

Comments for Demonstration Plans Offering Additional HCBS
Due February 6, 2013

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

Page	Section Title	Existing Text	Comment or Suggested Edit
ALL			**General Comment:** For consistency and clarity, **replace** all uses of "the plan" or "plans" with "demonstration plan," throughout the document.
ALL			**General Comment:** For consistency and clarity, replace all uses of "Duals Demonstration" and "the Demonstration" with the correct **"Dual Eligible Demonstration Project Pilot" (DEDPP)** or whatever is the correct name of the pilot
1	None (1st paragraph)	Today, Medicaid pays for nursing home care and ~~**In-Home Supportive Services (**~~IHSS~~)~~ for anyone who meets the eligibility requirements.	**Delete** In-Home Supportive Services and the parentheses, so that text reads as follows: Today, Medicaid pays for nursing home care and IHSS for anyone who meets the eligibility requirements.
1	None (1st paragraph)	However, other ~~**home and community-based services (**~~HCBS~~)~~ are provided to several specific groups of beneficiaries through federal "waivers" of Medicaid law.	**Delete** home and community based services and parentheses, so that text reads as follows: However, other HCBS are provided to several specific groups of beneficiaries through federal "waivers" of Medicaid law.
1	None (2nd paragraph)	The notion that these additional HCBS are only available through a waiver creates a situation where such services are **trapped in a silo**.	**Clarify** what is meant by "trapped in a silo." Phrasing may not be understood by diverse reading audience.
1	Purpose of this Paper	DHCS has already issued guidance on central HCBS activities through the **Long-Term Services and Supports Network Adequacy and Readiness Provisions** and the **Care Coordination Readiness Standards**.	**Recommend** italicizing and/or underlining *Long-Term Services and Supports Network Adequacy and Readiness Provisions* and the *Care Coordination Readiness Standards* to identify them as document titles
2	Purpose of this Paper	In particular, the **Care Coordination Standards** focus on how to improve chronic disease management by…	**Clarify** whether this statement is referring to the *Care Coordination Readiness Standards* document. If so, **insert** the word "Readiness."

Comments for Demonstration Plans Offering Additional HCBS
Due February 6, 2013

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

Page	Section Title	Existing Text	Comment or Suggested Edit
2	Purpose of this Paper	"The **Coordinate** Care Initiative (CCI)	**Add** a "d" to read **"Coordinated…)**
2	Background	Under these waivers, states furnish an array of HCBS that enable Medi-Cal beneficiaries to live in the community and avoid or transition out of **institutionalization**. Most Medicaid services are offered on a statewide basis and in a uniform manner, but the services provided through waivers are typically available only to a **set** number of enrollees who have a need for level of care that qualifies them for admission into a nursing facility	**Replace** "institutionalization" with institutions" and "set" with "limited", so that text reads, Under these waivers, states furnish an array of HCBS that enable Medi-Cal beneficiaries to live in the community and avoid or transition out of institutions. Most Medicaid services are offered on a statewide basis and in a uniform manner, but the services provided through waivers are typically available only to a limited number of enrollees who have a need for level of care that qualifies them for admission into a nursing facility
3	Duals Demonstration Vision for HCBS	At the same time, demonstration plans will have the **incentive** to offer the six additional HCBS discussed in this paper in order to keep persons in the home and community…	Clarify what the "incentive" is for the demonstration plans.
3	Duals Demonstration Vision for HCBS	"demonstration plans will have the **incentive** to offer…"	**Clarify** in plain language what the actual incentive is. Does this mean that demonstration plans are not required/mandated to offer the additional HCBS?
3	Duals Demonstration Vision for HCBS	"and avoiding unnecessary and costly institution-based care."	**Clarify** who would pay for this "institution-based care," should the demonstration plans decide not to offer additional six HCBS
3	Preparing for the Demonstration	"Engage with plans and **providers**…"	**Clarify/define** the term **"providers."** In IHSS, a "provider" is the person who provides services to IHSS recipient." Consider using another term that is less confusing.
3	Preparing for the Demonstration	"DHCS will help **facilitate a focused effort** to make sure that such **providers**…"	**Clarify** what **"facilitate a focused effort" means,** and in reference to the word **"provider,"** refer to comment above

Comments for Demonstration Plans Offering Additional HCBS
Due February 6, 2013

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

Page	Section Title	Existing Text	Comment or Suggested Edit
3	Preparing for the Demonstration	"Community **Groups**…community **providers**…" "For these **organizations**…"	**Clarify/define** and for consistency, select one term and use throughout document. The uses of different terms (groups, providers, organizations, etc...) creates confusion as to what entity is being referenced.
4	Plan Approach to Certain Home-and-Community-Based Efforts	"Refer beneficiaries to **community providers**…"	**Clarify/define** and for consistency, select one term and use throughout document. The uses of different terms (groups, providers, organizations, etc...) creates confusion as to what entity is being referenced.
4	Plan Approach to Certain Home-and-Community-Based Efforts	"Plans will have the **financial incentive** to…"	**Clarify** in plain language what the actual incentive is. Does this mean that demonstration plans are not required/mandated to offer the additional HCBS?
6 & 7	Appendix A: California HCBS Waivers Relevant to CCI *Population served and number of enrollees*		**General Comment:** Under the "Population served and number of enrollees" column, indicate, positive or negative, whether there is an enrollment capacity for each waiver listed.

Organization: LeadingAge California (formally Aging Services of California)
Contact Name: Jack Christy
E-Mail: Jchristy@aging.org
CalDuals Demonstration: DRAFT POLICY ON HCBS

Page	Section Title	Existing Text	Comment or Suggested Edit
------	General Observation on the two docs for comment and the docs where comments are closed.		Requiring comments by 2/6/13 is too short. Moreover, the cover materials stating that the period for comment on the LTSS Network Standards and the Care Coordination Standards is closed, yet those docs still contain unresolved issues. The structure of the demonstration requires a much fuller consideration of the inter-play among these four documents in light of the rate plans will be paid. It is expected that the inter-play among these policy documents, with all facts on the table, including rates, will be part of the continuing stakeholders' role.
1.	Introduction	"The Long Term Services and Supports (LTSS) system is fragmented."	True statement. But the fragmentation is not helped by further fragmenting services available under current law. The Demonstration is premised on providing appropriate, timely care in the least costly setting possible. Since available services will not be consistent plan to plan or county to county, LTSS will continue to be fragmented.
1.	Introduction	"Demonstration plans will have the incentive to offer additional HCBS to avoid costly institutional care."	This appears to be the only incentive identified to encourage plans' to provide "additional services." Maybe true, maybe

Page	Section Title	Existing Text	Comment or Suggested Edit
			not. Has such an incentive been demonstrated to work? The plan's payment rate will have an important influence on this incentive and should be part of the discussion over the efficacy of this incentive.
2.	Purpose of this Paper	This particular guidance is focused on the provision of a limited number of additional HBCS that are listed in the authorizing legislation for the duals demonstration, which "may include": 1. Respite care: in home or out-of-home; 2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; 3. Habilitation ; 4. Nutrition: Nutritional assessment, supplements and home delivered meals; 5. Home maintenance and minor home or environmental adaptation; and, 6. Other services (the list provided by legislation is permissive.)	What is the role of money follows the person program in HCBS? Such resources are vital to the goal of independent living and deserve more explanation.
3.	Duals Demonstration Vision for HCBS	At the same time, demonstration plans will have the incentive to offer the six additional HCBS discussed in this paper in order to keep persons in the home and community,	Given the "iffy" nature of this incentive the state must require some sort of mechanism to capture the number of beneficiaries wanting the service, whether the service was

Page	Section Title	Existing Text	Comment or Suggested Edit
		resulting in a higher quality of life for their members and avoiding unnecessary and costly institution-based care.	provided in a timely way, whether the lack of service is due to the lack of providers or the plan's decision that the service isn't needed.
3.	Preparing for the Demonstration	*Engage with plans and providers about the vision, goals, operations and potential partners of the new system.*	It is not clear what relationship is expected between the plans and Area Agencies on Aging, Independent Living Centers, Aging and Disability Resource Connections, and California Community Transition Lead Organizations. If the meals on wheels program is already at capacity, is the plan expected to arrange for a meal? At whose cost? Again, tracking the need and use of "services" is vital information for system integrity.
4.	Plan Approach to Certain Home and Community-Based Efforts	As a requirement for participating in the demonstration, and with regard to the six additional HCBS only, plans will: • Coordinate such services for beneficiaries who need them. • Refer beneficiaries to community providers to deliver services and to work with those providers as the plan deems appropriate. • Develop a care plan where the member has input into the services to be provided (for members	Will the tool to assess whether beneficiaries need HCBS be universal so that policy makers have the information to make comparable analyses of need to actual attainment of services or not? If community providers' programs are at capacity, whose responsibility is it for the needed service? Will that information be tracked by the data system?

Page	Section Title	Existing Text	Comment or Suggested Edit
		requiring such a plan.) • Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion. Plans will have the financial incentive to provide these additional HCBS; however, there is no obligation to offer the six additional services.	
4.	Readiness and Compliance	The provision of these certain HCBS will be a new function for many demonstration plans. As such, the state will require that plans take a number of steps to prepare for implementation. More specifically, for the services discussed in this document, demonstration plans must create: 1. Policies and procedures that guide the demonstration plans' care coordinators, Interdisciplinary Care Teams, and primary care physicians in assessing the appropriate authorization of these services and/or benefits, in addition to the required community-based LTSS (i.e. CBAS and IHSS), including but not limited to assessment tools and reassessment cycles. 2. Policies and procedures to identify members that may need HCBS, and to refer members to community-based	How are policy makers to evaluate the efficacy of HCBS if there is no state guidance on these important policies and procedures? If each plan develops its own policies and procedures on these fundamental issues, it challenges the evaluation component of the Demonstration because it makes meaningful comparisons of plans' experiences more difficult. Consideration of how to structure the evaluation to account for such differences is vital to understanding what has been demonstrated.

Organization: LeadingAge California (formally Aging Services of California)
Contact Name: Jack Christy
E-Mail: Jchristy@aging.org
CalDuals Demonstration: DRAFT POLICY ON HCBS

Page	Section Title	Existing Text	Comment or Suggested Edit
		organizations and other entities that provide these services, such as California Community Transitions organizations, Area Agencies on Aging, Independent Living Centers, or ADRCs where available. 3. A training curriculum and program for demonstration plan staff that provides for an orientation for all staff on the Americans with Disabilities Act, the Olmstead Decision and HCBS issues, and detailed training on community and county HCBS that maybe available.	Training is a crucial dimension of the Demonstration that needs greater emphasis and back-up. The goal of an independent life requires knowledge, and a variety of services to maintain that independence. More specificity about training and materials will help address these issues.

Dual Eligible Comments: After Stakeholder's phone call, 1-30-13- (Seven (7) pages)

What is the state going to do about the U.S. Dept. of Labor changing their regulations barring providers in home care from working more than 40 hours per week?

Analysts comments: Peter stated that people will have to check with their plans whether the long term care will offer the "cost savings" as a matter of using "incentives". Why is this being left up to the plans? Why aren't members ensured that long term care services are an expected service…and "Optional Services" afforded or required to each member in each health plan. Do we want to begin with new silos which do nothing but clog the medical service which will eventually be statewide.

Since rural counties are not included in CCI at this time and will be brought in separately, what assurance with the rural counties have to the same services that the urban counties have? Some people taking public transportation in rural counties cannot get to their doctors or medical facility AND RETURN in one day! This seems to be a very dangerous omission to those who live in rural CA.

Will Indian reservations medical programs be exempt from any form of managed care and funded by the State of CA? The tribes who have gambling will no doubt have their own health care program but those tribes who do not due to poverty of the tribe, will they be incorporated into the Dual Eligible demonstration? Will their needs be incorporated into the health plans? They do have distinctly different needs in some cases due to their belief systems. Will their languages be acceptable to the health plans and will the health plans be required to speak and address their language(s)?

Q. Shouldn't all plans offer the same benefits so there is continuity between plans on LTSS

RTI will be measuring…how will the individual communicate what is not working on a one-on-one basis.
The states "Managed Care" help line is not answered now despite ensurance that help is available. Calling a toll-free number with an individual issue…will those calls be recorded and passed onto RTI.

Otherwise so much will be missed to ascertain systemic problems growing? While each need may have a slightly different twist/need, RTI should be made aware of each because the "Help" toll-free number may not document the called-in complaints or needs?

Depending on a "Managed Care Help Line" to sort through the issues unless a detailed check mark list may not bear fruit of growing problems. People taking the calls should be marking every reason a person may be calling and offered extra lines if an issue is not part of the reason for calling the Help Line.

Hospitals discharge patients based on doctor's orders…patients do not have a choice of going home with all the planning in place. How will the plans ensure that all benefits are well known by ALL hospitals in demo. AND that the patient be required to participate in the dischare planning!?

ALL Discharge Planners have never heard of IHO/HCBS/WPCS and do not incorporate the waivers in their discharge planning. In addition, they have never heard of Olmstead, its meaning and directives.

Services vs benefits: Established Guidelines should encompass all plans and how soon can a member have a resolve to their concerns? —hopefully before they are discharged to either a nursing facility or home.

ALL PLANS **MUST** know that Medicare has a protection built-in which give the patient at least the 72 hours for an answer NOT after the patient leaves acute care hospital! **A patient should be told how they can use their Medicare to prevent discharge and how to use the review board to get their discharge status turned back to continued care. This is not done in hospitals unless the patient knows the specific statement that stops the discharge, "I am not medically ready to leave the hospital." THIS STOPS THE DISCHARGE "**

What happens when there is a denial for services when other plans allow? Medicare requires a complete review IF a patient states that they are being discharge too soon. This action takes the decision out of the hands of the hospital. HOWEVER…Medicare will not act on anything related to Medi-Cal issues which have different criteria.

How can we be ensured and assured that ALL plans must do specific things for all plan members regardless of age? In addition, if there is a fracture and surgery is denied or not provided what steps can a patient take for a second opinion outside of the plan? All plans should allow for an outside of plan opinion. This is not clear at all.

What are the "incentives" for health plans to provide all the services required of them?

I'm confused HCBS…AND long term supports are not a required benefit rather they are "incentified". WHY are these not a requirement for each plan? Cost? Bad outcomes will result.

"Optional Services" excluded for SPDs? Why?

"Other" services seem to be available to some but not all. Why? Is this agreed to via Olmstead? This limited "flexibility" seems to violate a number of laws.

"Hope to see"…John' comments…cost savings enough to allow home and community-based programs. This does not guarantee that a person will have the LTSS services rather than go into a facility…those with major disabilities do not seem to be guarantee all the services that they will need to remain in the member's choice rather in the plan's determination as a cost saving. Some people with multi-complex disabilities who need R.N. care in the home environment will be put into nursing facilities as most medical personal AND HOME HEALTH providers do not support home and community-based services if a person has multiple disabilities.

Currently, there are severe limitations on what constitutes 24/7 care at home. These need to be relaxed offering greater use in situation meriting additional higher level care. Example: newly discharged from acute care major surgery; a person discharged who is on life support but do not have IV drip; Hospice-like waiver services. People face too many hours alone when on a temporary premise they could have care after, for example, been weaned from a respirator in an acute care hospital.

Why are the plans not **required** to provide any/all services. Will this lack of requirement violate Olmstead?

Will this create unintended bad outcomes?

Suggestion: FAQs for enrolled members be constructed by a team, including plan member so that language is in understandable language for members…at least in six grade language. The state's explanations are far too technical and complicated language that is not at some member's comprehension.

Plans should develop and adopt the member's FAQs ONLY by consensus.

Are each plans required to have member serve on a board that reviews the problems that arise? If not, why not? This board should also have connection to RTI! Members will not always be the same configuration. This group should be members ONLY working together with legal representation groups like Western Center, Disability Rights-CA and independent attorney access to ensure Olmstead application is in place within each plan. This group should review any changes a plan representative who is reporting to this board the changes.

Changes must be presented verbatim and complete wording of any/all changes NOT AN OVERVIEW or summary. Too much can be hidden within a "Summary"

When potential members who want to opt-out be allowed to do so without persuasion or pressure to the member? Ei: have to explain why they are opting-out. They should be allowed not to be questioned! Opt-out means "opt-out". They should be told that if they want to be consider being opted-in; what would they give up such as a slot as a Waiver participant. What is the process mailed to the beneficiary at the time and sent this mail to the person once a year. Medicare allows for a monthly change BUT…why is a person only allowed to opt-out on a monthly basis. This is radical, a hardship to ask people to opt-out monthly. This should be done by all plans.

Waiver who wants to be in the demonstration who has to disenroll from the waiver…how does the person get back on the waiver!?? They don't the slot is given to someone else. It is CRITICAL that the waiver sign a paper acknowledging that they are leaving the HCBS Waiver with full knowledge of the lost benefit…it would be too easy for a plan to make this happen. There would be no recourse if the slot is surrendered without the person's full understanding.
IMPORTANT! Please change all of the "May" to "Shall" in the "Drafts". Plans must have an absolute otherwise the incentives will not be understood and provided to the new member. Plans should not be allowed to determine denial.
This should be done outside the plan with valid reasons and a copy of the denial should be sent to RFI for data collection purposes.
"MSSP-like services" each plan will do something different. Why isn't there continuity between plans? Doesn't this create multiple silos which is something we are trying to eliminate.

Will people who are not enrolled in the demonstration have access to "Optional Services" because they have to enroll in the Medi-Cal portion of the Managed Care to get IHSS? Should all plans have the same requirement? Again, the lack of continuity will have those following what works and what are problematic? This will have 8 different responses. How will this help the member…one plan does, another doesn't…how will this benefit the member? Building in silos because the plans are all different. One last comment/concern…
Thank you for accepting my comments and concerns. Hopefully the demonstration is a "living document" which will require dramatic changes to make a potentially good program one that really serves the SPD and Dual populations.

There are so many concerns over new policies and developing regulations. There are so many

people who doubt that health plans will produce a viable program that will benefit the community because health plans have a long history of money making profit corporations that the trust is simply not there for those served by any health plan…especially for those who are poor and find health care to be lacking. Health plans have cut so many corners to make huge profits by denying surgeries and other medical services which has produced serious outcomes.

One last question…how will the state penalize those plans who simply will not meet member needs systematically?

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Comment Template

Organization: InHomeCare.com
Contact Name: Mark Wells
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Page	Section Title	Existing Text	Comment or Suggested Edit
			Questions for clarification- 1) Can Health Plans contract with private In-Home Care agencies to provide these additional HCBS in-home care services or must the Health Plan use IHSS providers to provide the additional in-home care services? 2) If so, what contracting standards are required? 3) If IHSS only authorizes 2 hours per day of in-home care for a recipient because he/she has n help at home and hours is all IHSS believes he/she needs, but the Health Plan believes he/she needs 4 hours/day and provides an additional hours day, could IHSS now say the recipient no longer qualifies for 2 hours/day because he/she has 2 hours of in-home help (albeit) provided by the Health Plan's additional HBCS services? 4) How will disputes over the perceived need for services, such as the one example above, be resolved between IHSS and Health Plans?

Comments:
Draft Assessment and Care Coordination Standards

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

Page	Section Title	Existing Text	Comment or Suggested Edit
6	Health Risk Assessment	2. Contacting Members within the required assessment timeframes that will include repeated documented efforts (letter followed by at least two phone calls) to contact each Member.	**Suggested Edit:** 2. Contacting Members within the required assessment timeframes that will include repeated documented efforts (for example: letter followed by at least two phone calls) to contact each Member.
6	Health Risk Assessment	9. Identifying and assessing the need for referrals to home- and community-based services (HCBS), including Community-Based Adult Services (CBAS), MSSP, IHSS, and other community services, such as those provided through Area Agencies on Aging, Centers for Independent Living or Community Care Transitions leads. Referral processes will be developed jointly with the appropriate agencies.	**Comment:** Please clarify the requirements around the Community Care Transitions programs. What are the requirements for care coordination with the CCT agencies and what are the financial relationships?
8	Individual Care Plan	13. Considering behavioral health needs of Members and coordinating those services with appropriate behavioral health providers, including the county mental health plan and/or county department responsible for drug and alcohol services as part of the Member's care management plan when appropriate. (SB 1008) a. Identification of providers should promote co-location of service delivery, especially for Members receiving specialty mental health or chronic substance use disorder services.	**Comment:** Please clarify if plans are expected to promote co-located services over non-co-located services. Also please clarify if plans are expected to create co-located services.
9	Ongoing Care Management 1A. Person-Centered Planning	4. How the Plan will ensure that Members receive all necessary information regarding treatment and services so that they may make informed choices.	**Suggested Edit:** 4. How the Plan will ~~ensure that~~ advocate on behalf of the Member and assist the Member~~s~~ ~~receive~~ in obtaining all necessary information regarding treatment and services ~~so that they may~~

Comments:
Draft Assessment and Care Coordination Standards

Organization: Molina Healthcare of California
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			to make informed choices.
12	Ongoing Care Management 1D. Coordinating care management with external organizations	5. Process for conducting an annual review, analysis and evaluation of the effectiveness of the care management program processes and identify actions to be implemented to improve the quality of care and delivery of services. Plan will have a process for developing a corrective action plan, with specified timelines, for any out of compliance findings as a result of the annual review, analysis, and evaluation. a. In cases where Members are using county-provided social services or behavioral health services, plans will coordinate this review process with the respective county agency.	**Comment:** Please confirm that this is global evaluation of the care management program and not member specific.
13	Ongoing Care Management 2. Planning for Care Transitions	F. Policies and procedures governing expedited MSSP assessment and eligibility determination as part of the Plan's care coordination process for Plan Members who are being discharged from the hospital or at risk of immediate placement in a SNF.	**Comment:** We understand that not all MSSP sites currently conduct expedited assessments. We further understand that not all sites conduct assessments and eligibility determination if they are at capacity. By way of this standard, are MSSP sites now required to conduct expedited assessments and eligibility determinations even when at capacity?

Comment Template for Care Coordination Standards

Organization: Motion Picture and Television Fund
Contact Name: Sharon Siefert, Vice President, Legal Affairs
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Page	Section Title	Existing Text	Comment or Suggested Edit
4-5	**Long-Term Services and Supports Network Adequacy Standards** **November 21, 2012** **Provider Network and Contracting**	Health Plans must contract "with a sufficient number of facilities" located in the Plan's service area that provide "all levels of care."	**Dual Demonstration Network Adequacy Standards Are Insufficient To Assure Adequate Access To All Levels and Intensity of Long-Term Care Services.** DHCS Network Adequacy Standards state the Health Plans must contract "with a sufficient number of facilities" located in the Plan's service area that provide "all levels of care." The "levels of care" and what would constitute a "sufficient" number of facilities are not defined. Legislative authorization for the Duals Demonstration project for long-term services and supports added Welfare & Institutions Code section 14132.276(b). That section requires each demonstration site "to pay nursing facilities providing post-acute skilled and rehabilitation care or long-term and chronic care rates that reflect the different level of services and intensity required to provide these services." (Senate Bill 1008 (2012), Sec. 2.) **WE ARE RENEWING OUR REQUEST THAT Dual Demonstration Network Adequacy Standards should be clarified to require health plans to contract with long-term care facilities**

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			providing all levels of long-term care inpatient services, including facilities that serve more medically complex patients. This includes hospital-based skilled nursing facilities which generally treat skilled nursing patients presenting more complex medical needs and which generally have higher nursing-staffing levels compared to freestanding SNFs.
4-5	**Long-Term Services and Supports Network Adequacy Standards** **November 21, 2012** **Provider Network and Contracting**		**Dual Demonstration Network Adequacy Standards Fail to Adequately Protect Access to Culturally Diverse Skilled Nursing Facilities that Serve Unique Populations** Reflecting the broad diversity of California's cultural and religious heritage, a number of long term care facilities and distinct part nursing facilities have developed over time across the State to care for the social needs of unique populations. These facilities create and maintain communities embodying shared values, customs and practices. Many of these facilities enable individuals to reconnect to members of their community, enhancing the quality of their life when they are most frail and isolated. The Network Standards fail to ensure that individuals who desire to live "in

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			community" as they define it, will continue to have access to such care. **WE ARE RENEWING OUR REQUEST THAT Th Network Standards should be clarified to require health plans to contract with long-term care facilities that serve unique populations.** Notably, preservation of cultural diversity has been recognized by the Department. For example, the Darling v. Douglas final judgment requires DHCS to utilize "due diligence" in assuring sufficient CBAS capacity in geographic areas where ADHC services have previously been provided, including an adequate number of providers so that Medi-Cal beneficiaries can transition seamlessly from ADHC to CBAS without interruption. The Department is also required to exercise due diligence to assure "language and cultural competence [and] … program specialization to meet the specific health needs of the CBAS-eligible population." Darling v. Douglas, Settlement Agreement, Sec. XII.B.4 (emphasis added).

Comment Template for Care Coordination Standards

Organization: Motion Picture and Television Fund
Contact Name: Sharon Siefert, Vice President, Legal Affairs
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Coordinated Care Standards

Organization: MSSP Site Association
Contact Name: Denise Likar
E-Mail: dlikar@scanhealthplan.com

Page	Section Title	Existing Text	Comment or Suggested Edit
	General Observation		Releasing a redline version of the last document would have helped to see what has changed and updated to allow a stronger focus on the actual content versus trying to identify the updated language.
	Health Assessment Process and entire document		Diagram each group's timeline for risk stratification, assessment and implementation of care to easily show progression.
5	Health Assessment Process	Plans will submit to DHCS policies and procedures for the following: 1. Incorporating stakeholder and consumer input into development of the mechanism or algorithm (SB 1008). 2. Showing how the plan will complete stratification within 44 calendar days of enrollment, pending timely receipt of the data from DHCS and CMS. 3. Testing the stratification mechanism or algorithm by using Plan utilization data to stratify currently enrolled dual-eligible Members into at least four groups: higher-risk, lower-risk, (third group) and nursing facility residents. 4. Describing how the stratification of Members corresponds to the care coordination approaches.	In the absence of data or if there is an issue regarding quality or age of data, how will plans stratify members and ensure that the higher risk members will be assessed quickly to prevent service delays and harm? What is the mechanism to ensure that plans have met with appropriate stakeholders and consumers specifically to discuss this topic and have used this information to inform their policies and procedures? What is the timeline to complete all four of these steps and thus demonstrate readiness prior to the start date of the demonstration?

Coordinated Care Standards

Organization: MSSP Site Association
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5	Health Risk Assessment	Health Plans will conduct the SF-12 Health Survey questions, or another similar health survey, in addition to their HRA tool. A standardized component of the HRA across all Health Plans will provide great value to the department addressing clinical, quality, and policy decisions. A common data set on assessments will be helpful for stakeholder reporting purposes.	It would be helpful to have the SF-12 Health Survey posted on the CalDuals website so that those not familiar with it can review. The SF-12 is limited in what it assesses and does not account for LTSS utilization. How will LTSS screening questions or other areas of the continuum of care be integrated in "their HRA tool"? Who will ensure that the tool used will cover all required elements?
5	Health Risk Assessment	Plans will submit to DHCS policies and procedures for the following: 1. For meeting the required assessment timeframes: a. Within 45 calendar days of enrollment for those identified as higher risk by the risk-stratification mechanism or algorithm, and b. Within 90 calendar days of enrollment for nursing facility residents or those identified as lower-risk.	How will urgent cases such as persons at risk for homelessness or institutionalization be identified, received and handled in a timely manner to avoid a crisis?
7	Individualized Care Plans	2. Incorporating Medicare and Medi-Cal continuity of care provisions.	Please include source information about these provisions on the CalDuals website or in this document as an appendix.
7	Individualized Care Plans	5. How the ICP will be shared with the Member, a Member's designee, ICT members, the PCP, MSSP care manager, county IHSS and behavioral health partners, or any other LTSS or health care provider, as appropriate, within 90 days of	It is our understanding that the MOU's are not standardized and are being designed and negotiated at the local level. This can change the dynamic of the demonstration in each county and may impact the delivery of care. We recommend that the types of data/information

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		enrollment. a. For IHSS Members, the sharing of assessment results will be conducted and acted upon according to terms specified in each respective MOU between the plan and county social services agency, and plan and county behavioral health agency.	being exchanged be standardized to ensure maximum cooperation and measurement of outcomes to benefit the member. Sharing of IHSS assessment results is essential for effective care coordination, and thus MSSP providers currently and in the new demonstration design, must also have access to the member's IHSS assessment and award of hours.
9	Ongoing Care Management	Plan will maintain procedures for monitoring care management provided to Members including but not limited to all medically necessary services delivered both within and outside the Plan's provider network. Health Plans will follow the requirements below, **unless they have an alternative process approved by DHCS.**	Suggest removing reference to "medically necessary services."In the new world envisioned by the state, health plans are called to be stewards of much more than just medical services, and therefore any and all language referring to this old model should be transformed to reinforce the comprehensive health and LTSS continuum of care. Please elaborate what "unless they have an alternative process approved by DHCS" means, who would have the ability to make such an arrangement with DHCS and why.
13	Reassessment and Review	1. Plans will conduct an annual comprehensive reassessment for the individual care plan (including medical, LTSS, behavioral health utilization data analysis and risk stratification) within 12 months of last assessment, or as often as the health of the enrollee requires.	Suggest revising to allow the plan's annual comprehensive reassessment elements to be delegated to qualified and trained plan partners who also assess and serve the member in the home setting, including (as applicable) county behavioral health, MSSP, CBAS, and IHSS.

Coordinated Care Standards

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		Reassessment may be conducted by phone, email, or in-person for beneficiaries in lower-risk group, and will be conducted in person or in the setting of the Member's choice for higher-risk group and nursing facility residents (D-SNP). a. For IHSS recipients, upon the recipient's request and when feasible, plan reassessments may be conducted in conjunction with in person, in home, county IHSS reassessments. b. For Members with serious mental illness or chronic substance use disorder, upon request and when feasible, plan reassessments may be conducted in conjunction with behavioral health specialist.	
16	Subcontracts	General Comment	The document is silent on, and should clarify the role of plan contractors such as MSSP relative to these assessment and care coordination standards. The document is also silent on differentiating the roles of primary contract health plans and subcontract health plans. This should be clarified as health plans in many counties are envisioning using subcontractors.

CA Duals Draft Policy for Demonstration Plans
Offering Additional HCBS

Organization: MSSP Site Association
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1		Third paragraph, second sentence: "The goal is to create a structure and culture where HCBS are broadly available."	Creating a structure and culture both take careful planning, meaningful and thoughtful collaboration, facilitation and time to develop and take hold. The major systemic changes taking place in California create a huge shift and bring together two very different systems and cultures extremely quickly. To make these changes successfully, there need to be controls in place that do not erode the programs and services which keep people safe until the new changes are tested and found to offer the same protections to patient health and safety.
1		Third paragraph, last sentence: "Demonstration plans will have the incentive to offer additional HCBS in order to avoid costly institutional care."	This theme is repeated throughout the policy paper. Besides a rate differential, what additional incentives will be provided to the plans? Is there a meaningful quality performance incentive? What will the state do to ensure that plans do not only provide the minimum requirements as stated in their contracts until they have enough time to see what the realized savings will be and then decide to invest in more than MSSP, CBAS and IHSS? Are there measures in place to ensure increased capitation rates will be used to expand availability of LTSS/HCBS and not increased profit margins?
2	Purpose of this Paper	This particular guidance is focused on the provision of a limited number of additional HBCS that are listed in the authorizing legislation for the duals demonstration,	This list is insufficient and does not represent the long-term supports needed to maintain living in the community at a lesser level of care. Since health plans do not have experience

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		which "may include": 1. Respite care: in home or out-of-home; 2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; 3. Habilitation ; 4. Nutrition: Nutritional assessment, supplements and home delivered meals; 5. Home maintenance and minor home or environmental adaptation; and, 6. Other services	providing LTSS, it is incumbent upon the State to take leadership and provide a more comprehensive list of HCBS services.
3	Background	Table A: Enrollment Count MSSP 8,987.	The enrollment count as stated does not reflect the artificially low enrollments brought about by years of budget cuts and thus the potential capacity that exists if funding were restored to 100%. If this section is truly setting the background, it needs to be acknowledged that MSSP is authorized to provide services through a 16,000 slot count that has been eroded away by funding cuts. The unfilled slots are still authorized by the waiver approved by CMS, but are currently unfunded.
3	Duals Demonstration Vision for HCBS	California's existing LTSS system for providing and funding HCBS is experiencing a number of challenges, including fragmented delivery, isolated data systems and limited access. The Duals Demonstration seeks to transform today's system, to one where **services are more**	The stated vision seems to run counter to the plans of continuing to allow waiting lists for waiver services, leaving it up to each participating health plan to decide what HCBS services to fund and how, and failing to provide uniform standards for quality and geographic access to care for LTSS and HCBS.

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		broadly and consistently offered. Under California's Medi-Cal system, managed care plans are the most appropriate vehicle capable of achieving integration of acute and long-term care services at scale.	
3	Duals Demonstration Vision for HCBS	The demonstration plans will be given flexibility to provide supports to enhance a member's care, allowing members to stay in their own homes safely, thereby preventing unnecessary hospitalization and prolonged care in institutional settings. The demonstration plans' new **authority to offer these services will eliminate the need for the waivers for those eligible for the Duals Demonstration**. At the same time, demonstration plans will have the incentive to offer the six additional HCBS discussed in this paper in order to keep persons in the home and community, resulting in a higher quality of life for their members and avoiding unnecessary and costly institution-based care.	California's vision is to eliminate HCBS waivers while other States are retaining and incorporating them into their demonstrations. Since it will take years to study outcomes and determine the demonstration's savings and outcomes, in the meantime communities throughout California are at risk of losing vital safety net services while health plans try to learn to assume this role. To guard against this, there should be some phase in and strong evidence that health plans are fully prepared to administer this level of care.
4	Preparing for the Demonstration	It is worth noting that, MSSP sites have specific statute and policy addressing their role: • State law requires that MSSP sites be allocated the same level of funding during the first 19 months of the demonstration as was allocated in 2012. • MSSP sites will remain open to	Second bullet: The statement, "MSSP sites remaining open for excluded populations" is not clear. Are excluded populations subject to the waitlist? Do health plans receive priority for their members? What guarantees will be put in place to ensure the excluded populations get the services they need if there is a waiting list? How will this work?

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		enrollment in demonstration counties for any populations excluded from the demonstration.	
4	Plan Approach to Certain Home and Community-Based Efforts	As a requirement for participating in the demonstration, and with regard to the six additional HCBS only, plans will: • Coordinate such services for beneficiaries who need them. • Refer beneficiaries to community providers to deliver services and to work with those providers as the plan deems appropriate. • Develop a care plan where the member has input into the services to be provided (for members requiring such a plan.) • Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion. Plans will have the financial incentive to provide these additional HCBS; however, there is no obligation to offer the six additional services.	The six additional HCBS listed are limiting and by no means a comprehensive list of services that would enable an at risk person to remain community-dwelling. If the intent of the state's plan is to allow for flexibility, why is the vision limited to the six HCBS? How do the "MSSP-like" services referred to elsewhere fit in with the additional HCBS described in this document?
4	Plan Approach to Certain Home and Community-Based Efforts	Since the six additional services **are not part of the core Medi-Cal program today**, those services will not be subject to Medi-Cal grievance and appeals procedures if a plan chooses to offer them. Plans will develop internal procedures as part of developing a care plan that is patient-	Waivers allow States the flexibility to provide non-traditional Medi-Cal services with built in oversight to ensure the services are delivered per policies and procedures. Since the HCBS services being provided by the Health Plan are how the State will eliminate or

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		centered. In contrast to the provision of the six additional HCBS services, health plans have very specific requirements to meet regarding the provision of key LTSS through IHSS, MSSP, CBAS, and nursing facilities, as set forth in separate guidance. For the LTSS benefits that are required to be offered under Medi-Cal, the grievance and appeals procedures that exist today will continue.	replace waiver programs, beneficiaries should have grievance and appeal rights beyond Plan-level grievance and appeal. Patients will not know what to appeal if they have not previously had MSSP, NF-AH or other waiver services. Will Health Plan members be able to go to CMS instead if they are not satisfied through the Health Plan's grievance and appeal process?
4	Readiness and Compliance	The provision of these certain HCBS will be a new function for many demonstration plans. As such, the state will require that plans take a number of steps to prepare for implementation. More specifically, for the services discussed in this document, demonstration plans must create: 1. Policies and procedures that guide the demonstration plans' care coordinators, Interdisciplinary Care Teams, and primary care physicians in assessing the appropriate authorization of these services and/or benefits, in addition to the required community-based LTSS (i.e. CBAS and IHSS), including but not limited to assessment tools and reassessment cycles.	Appears MSSP was inadvertently left out and should be included with CBAS and IHSS. Suggested edit: "(i.e. CBAS, IHSS and MSSP). Without minimum standards for health plans to assess for and develop a plan of care for beneficiary needs, there is lack of uniformity and risk that individuals will not be appropriately assessed for risk, therefore, we recommend that the State establish a minimum set of standards and requirements to which all health plans must adhere.
5	Readiness and Compliance	3. A training curriculum and program for demonstration plan staff that provides for an orientation for all staff on the Americans with Disabilities Act, the	Who creates this, provides the training, and how is it monitored? Existing approved, licensed and/or certified providers should be involved in curriculum development and

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		Olmstead Decision and HCBS issues, and detailed training on community and county HCBS that maybe available.	training.
7	Appendix A	MSSP Enrollment capacity: 16,335 MSSP Enrollment is: 8,987	This incorrectly leaves the impression that only 8,987 Californians qualify for or need MSSP. The difference in these numbers is a funding issue only. Data suggests that many more than 16,000 Californians qualify for and would benefit from MSSP.

Interaction of Select HCBS Programs with the Coordinated Care Initiative

Organization: MSSP Site Association
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Page	Section Title	Existing Text	Comment or Suggested Edit
1	Introductory Comments	• Beneficiary is "Pending Enrollment Process into CCI": Because the CCI enrollment process will generally be phased in, eligible individuals will be enrolled on a rolling basis. The flow charts are based on the assumption that phase-in process will begin in September 2013 and occur over 12 months for most counties (though immediately in San Mateo county and over 18 months in Los Angeles.) In addition, eligible beneficiaries enrolled in **MSSP will be passively enrolled all at the same time in September 2013; this step is being taken as a requirement for rate setting.**	The original proposal envisioned having MSSP clients enroll in the demonstration beginning 4 months after the start of the CCI. The rationale for this delay was to allow health plans and the state to "work out the kinks" in data flows, enrollments, and other key processes prior to moving in the more frail, vulnerable, community-dwelling population served by MSSP. We are unclear on the reason why this changed to MSSP clients beginning the demonstration on day 1. Please explain. Please clarify what is meant by the statement "requirement for rate setting" exists as a reason for the September 2013 start. Additionally, substantial questions remain for MSSP sites and a very short timeframe to resolve these questions. A sampling of the many questions that remain are: Will MSSP sites retain their current vendors or will the health plans require new contracts with their contracted vendors? While the waiver is still in place, we have to continue with our existing service authorization process. Will the health plans require different processes and additional work for necessary approvals? Will we need new software or training in order to bill the plans? In order to use waiver funds a site must prove they have exhausted informal options.

Interaction of Select HCBS Programs with the Coordinated Care Initiative

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			Will the plan be engaging in that process at all? How do we ensure plan staff are not duplicating MSSP staff work that would satisfy this waiver requirement?
2	Appendix A.1: CCI Participating Populations Chart for Duals Demonstration	Beneficiaries with a Share of Cost – in skilled nursing facility, MSSP, or IHSS and continuously certified to meet share of cost	MSSP is a no-share of cost program as part of eligibility requirements. Only one grandfathered population (aide code 17/27/67) is able to be enrolled currently.
2	Appendix A.1: CCI Participating Populations Chart Duals Demonstration	Individuals enrolled in a prepaid health plan that is a non-profit health care service plan with at least 3.5 million enrollees statewide, that owns or operates its own pharmacies and that provides medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it operates to provide services to enrollees.	Please provide a list of health plans to make this easier to understand. The CCI goes beyond health care delivery, and yet this very specific description makes no reference to the health plan including long term services and supports as a part of its model of care. How would members of such a health plan, who are exempted from the CCI, access needed LTSS? Please clarify
4	Attachment B: Not Enrolled: Beneficiary Seeks MSSP	Eligible beneficiary who would like to be in MSSP	Change to "Beneficiary eligible for and referred to MSSP"
4	Attachment B: Not Enrolled: Beneficiary Seeks MSSP	Footnote #2: Waiting list applies.	How does the waitlist work with Medi-Cal portability if someone on an MSSP site's waitlist moves (from a non-demonstration or a demonstration county) and is seeking services provided by another MSSP site? What is the requirement for portability and how do we prevent that person from being harmed?
4	Attachment B: Not Enrolled: Beneficiary Seeks MSSP	Footnote #4: Plans will provide services consistent with "Policy for Demonstration	It is unclear if MSSP-like is required or optional based on this chart and footnote. Is MSSP-like

Interaction of Select HCBS Programs with the Coordinated Care Initiative

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		Plans Offering Additional Home- and Community-Based Services (HCBS)". The plan ***may choose*** to do this through MSSP by purchasing services or by working with other providers. NOTE: 19 months after commencement of enrollment, MSSP will become an integrated managed care benefit. (WIC 14186(b)(7)) A report is required by January 1, 2014 to explain the transition of MSSP to a plan benefit. (WIC 14186.3(b)(4)(B)(C)).	considered one of the additional 6 HCBS optional benefits or will it be required for those in the demonstration when MSSP waiver slots are full? MSSP-like should have standards and a list of core services such as in-home assessments, a care plan, monthly contact, and quarterly face to face in-home visits and so on. MSSP should work with DHCS and CDA to develop this definition.
4	Attachment B: Not Enrolled: Beneficiary Seeks MSSP	Overall Chart	As stated by The SCAN Foundation, we echo the following: The flow chart is configured such that individuals who are not eligible for or opt-out of the demonstration and seek enrollment into MSSP (as part of the Medi-Cal managed LTSS benefit) would not be able to access this benefit unless and until a MSSP slot becomes available. If a slot is unavailable, we recommend that the health plan provide access to a comparable suite of MSSP-like services based on an individual's plan of care.
5	Attachment C: Currently Enrolled: MSSP	Overall Chart	What happens if a beneficiary falls out of Medi-Cal eligibility or MSSP eligibility (such as protracted out-of-home placement) and wants to return to MSSP? How will those be handled with MSSP and the rest of the demonstration?

California Duals Demonstration LTSS Network
Adequacy and Readiness Standards

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	Document in General		Throughout this document it states that the plans will be constructing policies and procedures with multiple avenues of input. It is not stated if the DHCS departments and partner agencies such as CDA, DPSS, current providers, and others will be a part of the review team to ensure that the policies and procedures are appropriately standardized, meet appropriate criteria and reflect the models of care as instructed. We ask that by some methodology those assurances are communicated. Additionally, please state the role of DHCS/CDA/DPSS and any other State departments in the ongoing monitoring and oversight of regular operations. Based on this document, the oversight roles are unclear.
3	Provider Network and Contracting--MSSP	1. Execute agreements with all MSSP organizations in the Health Plan's covered zip code areas for providing MSSP waiver services to eligible members, or have demonstrated that they have negotiated, in good faith, to attempt to secure executed contracts, in anticipation of plan readiness review, in order to have MSSP serve as a provider to the health plan.	Contracts must be executed as the MSSP waiver services are mandated by law. DHCS/CDA will provide a contract template for the health plan and respective MSSP to sign. Due to these strict requirements, remove "or have demonstrated that they have negotiated, in good faith, to attempt to secure executed contracts". Since MSSP contracting is required, this sentence is not appropriate.
3	Provider Network and Contracting--MSSP	2. Work with their contracted MSSP organization to develop a care coordination and management model that	A standardized timeline for making referrals to MSSP is recommended to ensure that those individuals at highest risk are prevented from

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		supports appropriate referral of Health Plan members to the MSSP organization for assessment, eligibility determination, and services.	readmission, hospitalization or institutionalization. MSA recommends a timeline of 10 working days of identifying the need for MSSP services if the need is non-urgent, and within 3 working days if the need is urgent.
4	Provider Network and Contracting--MSSP	3. Establish, convene, and consider the recommendations of MSSP organizations, Health Plan members and other stakeholders in the implementation of the MSSP contract.	1. A stated timeline for this step is recommended to ensure that this is completed prior to policy setting and implementation of the demonstration.
4	Provider Network and Contracting--MSSP	4. Govern how the Health Plan will make referrals to MSSP and define respective care management roles and duties of the Health Plan's ICT and MSSP.	"Govern" is unclear and can be misinterpreted. What if any of the health plan's policies and procedures interfere with or override the waiver requirements or the MSSP Site Manual? What role will DHCS and CDA have in oversight? Please clarify. Additionally, in counties with multiple MSSPs and health plans, when including contractors and subcontractors must have a uniform referral and process to ensure easy access and not jeopardize waiver compliance. If this is going to be included in the contract template, please state that here so it is clear.
4	Provider Network and Contracting--MSSP	5. Govern MSSP assessment and eligibility determination as part of the Health Plan's care coordination process.	MSSP assessment and eligibility determination is a set process outlined in the MSSP Site Manual, consistent with the federal requirements of the 1915(c) waiver. MSSP sites are required to complete this process. This

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			statement implies that the Health Plan is responsible to complete this process. Please clarify as we believe this statement is intended to refer to the health plan's role to identify health plan members at risk and refer to MSSP for eligibility determination and assessment.
4	Provider Network and Contracting--MSSP	7. Demonstrate the Health Plan has incorporated the use of MSSP services and other LTSS into its policies and procedures regarding: • Use of MSSP waiver resources for plan members. • Use MSSP sites to manage additional services outside of the scope of the MSSP waiver, at the discretion of Health Plans and MSSP sites. • Incorporation of features or elements of the MSSP care management approach.	Intent of this statement is unclear as it relates to the MSSP waiver services. This needs clarification, for example: First bullet--Use of Waiver resources as a separate bullet point is confusing as the MSSP waiver includes both care management and purchased services which are integral components of the model, and neither waiver service nor resource exists as a "stand alone" service. Unclear why this is separated and singled out for policy and procedures. Second bullet—Please clarify the intent. Third bullet—unclear what this means or references in terms of MSSP waiver services, MSSP-like services or some other product. Please clarify.
	Provider Network and Contracting--MSSP	8. Refer plan members, who have medical necessity, for coordinated care/case management to MSSP sites to receive needed services if there is sufficient and available capacity at the site.	A. The strength of the MSSP model is its ability to go beyond the traditional medical model's definition of "medical necessity" in targeting persons most at risk who can benefit from the program. We suggest revising to state: "Refer

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		If there is no capacity, plans must provide some level of MSSP-like services through a network of providers selected by the health plan.	plan members who meet MSSP eligibility criteria, to MSSP sites to receive needed services…" B. "MSSP-like" remains undefined at this point and we are concerned that the State does not have enough time or bandwidth to complete the tasks in SB1008 related to the design and structure of an MSSP-like model. Health plans should not be left to define and use "MSSP-like" in any way they choose, but rather should be provided minimum standards, consistent with the intent of this document, for what "MSSP-like" includes. In collaboration with the MSSP Site Association, the state must provide standards prior to the readiness review period and well in advance of September 1, 2013 regarding contracting for services that are "MSSP-Like".
6	Provider Contracting—For all LTSS Health Plans shall develop policies and procedures to train:	3. **Specially designated care coordination staff** in MSSP including but not limited to: • an overview of the characteristics and needs of MSSP's target population; • MSSP's eligibility criteria; • assessment and reassessment processes, services, and service authorization process; and, • refer members to MSSP for assessment and eligibility determination.	CDA and DHCS, in partnership with the MSSP Site Association, will develop and provide a workshop (then add below) Change to …."Specially designated **Health Plan** care coordination staff…." to clarify.

California Duals Demonstration LTSS Network
Adequacy and Readiness Standards

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6	Financial Information/Claims Processing—For MSSP	Whole Section	The methodology and whether plans will be allowed to delegate payment for MSSP to subcontracted plans is still unclear and needs to be outlined either in this document or the contract template. Cross-references should be appropriately applied.
7	Management Information System	Entire section	This section is weak and needs to ensure that there is standardized data exchange for all plans.

NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

February 6, 2013

Jane Ogle, Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Sacramento, CA

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

Dear Ms. Ogle,

The National Senior Citizens Law Center submits these comments on California's "Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)," shared with stakeholders via email on January 27, 2013.

We appreciate the administration's intent "to expand the availability and use of HCBS," and to "create a structure and culture where HCBS are broadly available." Draft HCBS Policy at 1. In our view, however, the current draft policy is not the way to achieve that goal, and could in fact have the reverse effect of reducing access to needed home and community based services for seniors and persons with disabilities.

Our core objection to the proposed HCBS policy is the Department's decision not to include the additional HCBS benefits currently available through waivers (including respite, nutritional assessment, counseling, supplements, home or environmental adaptations, habilitation, transition assistance, supplemental home health and personal care, and other services) as required elements of the covered benefit package, which form the basis for capitated rates paid to plans. Similarly, for the reasons described below, we disagree with the exclusion from the covered benefit package of Community Care Transitions (CCT) services, as well as the draft policy's lack of commitment to the Multipurpose Senior Services Program (MSSP) waiver beyond the legislatively required 19 month funding period.

Failure to include these types of additional HCBS services as part of the covered benefit package sends a signal to plans that additional or supplemental HCBS are optional rather than mandatory, even for those who need them to avoid nursing home or other less-inclusive living arrangements. As a former health plan executive recently explained, the difference between covered and non-covered benefits in managed care is

traditionally "a fairly bright line, and if it is not our service, if the service or product in question is not a benefit, then it is highly unlikely that managed care will provide it."[1]

At best, giving complete discretion to plans to decide whether to offer waiver-level HCBS turns these important services into a 'hidden' benefit. Members of a dual demonstration plan may not know that these benefits exist. These beneficiaries will be denied access to the appeals and other due process protections currently available to waiver participants. And without strong reporting requirements, neither DHCS, nor the legislature, nor stakeholders will know whether plans are in fact providing these HCBS benefits.

We understand that the draft policy is based on the assumption that because managed care plans will have the financial incentive to avoid more costly institutional care, they will provide all waiver-level HCBS to those who need it. If this financial incentive is truly sufficient, however, there is no reason *not* to formally include these services in the agreed-upon benefits package. Inclusion in the benefit package will ensure that plan rates are sufficient to provide the services; that plans establish a network of providers to deliver the services; and that plans actually offer these services to beneficiaries that need them to live in the community.

California's policy to exclude these benefits runs counter to a national trend among states to include HCBS waiver services in the required benefit package. Our review of other states' contracts with managed care organizations shows that a significant number of states with existing managed LTSS programs (including Arizona, Minnesota, Tennessee, Texas and Wisconsin) explicitly identify HCBS waiver services as part of the benefit package in their contracts with managed care organizations.

Waivers are currently an important part of California's plan for meetings its obligations under the Americans with Disabilities Act, pursuant to *Olmstead v. LC*, 527 U.S. 581 (1999). *See* California's Olmstead Plan at 27- (describing Medi-Cal Waivers). The current waivers offer participants a necessary venue for enforcing their rights under *Olmstead*, namely the state fair hearing process. DHCS' current proposal would essentially eliminate that right for future recipients of waiver-like services enrolled in the duals demonstration.

Furthermore, California's Olmstead plan rightly describes the waiver's purposes as not merely avoidance of institutionalization, but "to ensure the provision of all services that are necessary to ensure *successful community living*." Id. at 28 (emphasis added). Yet

[1] Bruce Chernof, The SCAN Foundation, "TSF Webinar: Managed Care 101- Presenting the Fundamentals of Integrating Long-Term Services and Supports into a Managed Care Model," Dec. 14, 2012, available at http://www.thescanfoundation.org/tsf-webinar-managed-care-101-presenting-fundamentals-integrating-long-term-services-and-supports.

nothing in the current draft document explains how managed care plans will be incentivized to meet this objective, or how their success at this objective will be measured.

Finally, we are very concerned that the draft policy would deny Medi-Cal only seniors and persons with disabilities, and dually eligible individuals, from the benefits of supplemental HCBS. While we understand and appreciate that DHCS intends to preserve the waivers themselves, these waivers are and would continue to be oversubscribed. The non-Medicare options for those enrolled in a duals demonstration plan versus those enrolled only in Medi-Cal managed care should be fairly aligned. Moreover, the administration of two separate benefits for groups with the same level of need would generate significant confusion and logistical difficulty.

In addition to these general comments, we also include some specific suggestions in the attached comment template. Please do not hesitate to contact us with any additional questions. We look forward to continued participation in the stakeholder process.

Sincerely,

Kevin Prindiville
Deputy Director

Anna Rich
Senior Staff Attorney

Comment Template

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COMMENTS TO DRAFT POLICY FOR DEMONSTRATION PLANS OFFERING ADDITIONAL HOME-AND COMMUNITY-BASED SERVICES (HCBS) JANUARY 24, 2013	Title	"Additional Home and Community-Based Services (HCBS)"	The use of HCBS as an acronym to refer to services provided in lieu of those otherwise available to waiver participants is confusing, because "HCBS" typically is a broad term, often used to refer to all non-institutional Long Term Supports and Services (LTSS). We suggest a special acronym, such as "E-HCBS" (Extra or Enhanced HCBS), or a suitable alternative.
P. 1	Introduction	N/A	See accompanying letter for suggestions for how to better ensure provision of E-HCBS. If DHCS' intention is that CCI participants who opt out of the duals demonstration plans will continue to receive E-HCBS through waivers, this should be made clear in the introduction.

Comment Template

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p. 2	Purpose of this Paper	This particular guidance is focused on the provision of a limited number of additional HBCS that are listed in the authorizing legislation for the duals demonstration, which "may include": 1. Respite care: in home or out-of-home; 2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; 3. Habilitation ; 4. Nutrition: Nutritional assessment, supplements and home delivered meals; 5. Home maintenance and minor home or environmental	We recommend that this policy list all services currently offered under HCBS waivers and special programs, and make it clear that plans are authorized and encouraged to offer such services as an alternative to institutional care. These services include, in addition to those listed in the authorizing legislation: MSSP; CCT; Case Management/Coordination; Habilitation Services; Home Respite; Community Transition Services; Continuous Nursing and Supportive Services; Environmental Accessibility Adaptations; Facility Respite; Family/Caregiver Training; Medical Equipment Operating Expense; Personal Emergency Response (PERS) Systems, Installation and Testing; Private Duty Nursing - Including Home

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		adaptation; and, 6. Other services (the list provided by legislation is permissive.) [4]	Health Aide and Shared Services; Transitional Case Management; and Assisted Living Services
p. 2	Purpose of this Paper	4 The legislation allows for "other services," which could include Personal Emergency Response Systems (PERS), assistive technology, In-home skilled nursing care, and other items. DHCS invites comment on additional services to be listed.	See comment directly above.
P. 3	Duals Demonstration Vision for HCBS	At the same time, demonstration plans will have the incentive to offer the six additional HCBS discussed in this paper in order to keep persons in the home and community,	1. Unless the demonstration plans and members understand that the menu of services available under waivers are within their ability and discretion to provide, and they actually

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		resulting in a higher quality of life for their members and avoiding unnecessary and costly institution-based care.	provide them to individuals who would otherwise receive Waiver services, the CCI will not "eliminate the need for the waivers." The text should be modified to say "demonstration plans will have the incentive to offer the full range of HCBS in order to keep persons in the home and community…" 2. This section (or a new separate section) should make clear the measures that will be taken to evaluate whether demonstration plans do respond to these incentives appropriately, including transparent reporting of E-HCBS services provided to

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			former waiver participants and those eligible for waivers.
p. 3	Preparing for the Demonstration	• *Engage with plans and providers about the vision, goals, operations and potential partners of the new system.* There is an array of HCBS providers available to individuals who are dual eligible in addition to the programs being integrated into demonstration plan services, including, but not limited to, Area Agencies on Aging, Independent	1. In order for the CCI and duals demonstration to be successfully implemented, this process of engagement and education needs to have already begun. Based on our conversations with county level providers, however, while some plans are taking this obligation seriously, others are not. DHCS should check with plans and local HCBS providers to determine which counties are sufficiently far along in this process for a September enrollment to

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		Living Centers, Aging and Disability Resource Connections, and California Community Transition Lead Organizations. Starting in Spring 2013, DHCS will help facilitate a focused effort to help make sure that such providers are meeting with the demonstration plans and building relationships in order to develop a shared understanding of each entity's role.	be realistic, and should delay implementation of the duals demo where this process is not yet sufficiently underway. 2. While these providers may be "available" to plan members, there is no guarantee that their services are available. If providers have waiting lists for their services, or have no funding available to serve more individuals, there will be little for the plans to integrate. And while the CCT agencies will still be in place, if the plans do not pay for the services which the plans identify as needed for transition, the members will not be able to leave or avoid institutional

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			placement. 3. DHCS' and managed care health plans efforts should also include collaborating with mental health plans and the Department of Developmental Services and regional centers to ensure that managed care enrollees have full and timely access to mental health and regional center services that they may require in addition to health plan benefits. 4. In addition, the list of organizations should be expanded to include direct HCBS service providers such as NF/AH Waiver providers (supported living providers and home health

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			agencies), Assisted Living Waiver providers, AIDS Waiver and MSSP providers, CBAS providers and others
p. 4	Plan Approach to Certain Home- and Community-Based Efforts	As a requirement for participating in the demonstration, and with regard to the six additional HCBS only, plans will: • Coordinate such services for beneficiaries who need them. • Refer beneficiaries to community providers to deliver services and to work with those providers as the plan deems appropriate. • Develop a care plan where the member has input into the	1. Again, reference to "the six additional HCBS only" ignores that "other" services could and should be considered to actually provide an alternative to institutional placement. 2. The four bullet points outlining plans' requirements are extremely vague about their obligations with respect to providing and coordinating and providing HCBS and otherwise preventing unnecessary institutionalization. The plans should be obligated to assess for and consider the full range of HCBS to minimize institutionalization, in a timely

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		services to be provided (for members requiring such a plan.) • Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion. Plans will have the financial incentive to provide these additional HCBS; however, there is no obligation to offer the six additional services. Since the six additional services are not part of the core Medi-Cal program today, those services will not be subject to Medi-Cal grievance and appeals procedures if a plan	manner, to ensure that members are not needlessly placed in and do not needlessly remain in institutional placements. Please refer to previous comments submitted jointly by DRC and NSCLC regarding care coordination and LTSS for further detail on these concerns. 3. We strongly believe that there is no legal basis to omit HCBS from Medi-Cal rights to grievances and appeals. As part of the service package offered by managed care plans using Medi-Cal funds, particularly when individuals are not provided with a choice about whether to receive their Medi-Cal HCBS services through managed care or fee-for-service, members must retain

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		chooses to offer them. Plans will develop internal procedures as part of developing a care plan that is patient-centered. In contrast to the provision of the six additional HCBS services, health plans have very specific requirements to meet regarding the provision of key LTSS through IHSS, MSSP, CBAS, and nursing facilities, as set forth in separate guidance. For the LTSS benefits that are required to be offered under Medi-Cal, the grievance and appeals procedures that exist today will continue.	their due process rights that exist in the current Waiver programs. It is a misstatement to say that HCBS services are "not part of the core Medi-Cal program today." To the extent that services that are available through Medi-Cal HCBS Waivers, and are replacing such Waiver services, or are offered in institutional settings, members must retain their Medi-Cal rights to grievances and hearings for reduction, termination, denial, or suspension of such services.
p. 4-5	Readiness and Compliance	The provision of these certain HCBS will be a new	We would like to see much more specificity here regarding the

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		function for many demonstration plans. As such, the state will require that plans take a number of steps to prepare for implementation. More specifically, for the services discussed in this document, demonstration plans must create: 1. Policies and procedures that guide the demonstration plans' care coordinators, Interdisciplinary Care Teams, and primary care physicians in assessing the appropriate authorization of these services and/or benefits, in addition to the required community-based LTSS (i.e. CBAS and IHSS), including but	required components of plans' policies and procedures, timing, DHCS' monitoring, and compliance with state and federal laws protecting due process and disability rights. We repeat our previous requests for information about what functional assessments will be used, who will administer them and the connection between the assessment and the offer of services.

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		not limited to assessment tools and reassessment cycles. 2. Policies and procedures to identify members that may need HCBS, and to refer members to community-based organizations and other entities that provide these services, such as California Community Transitions organizations, Area Agencies on Aging, Independent Living Centers, or ADRCs where available. 3. A training curriculum and program for demonstration plan staff that provides for an orientation for all staff on the Americans with	

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		Disabilities Act, the Olmstead Decision and HCBS issues, and detailed training on community and county HCBS that maybe available.	
6-7	Appendix A	Population served and number of enrollees- column	DHCS should clarify that institutional deeming rules will continue to apply to recipients of E-HCBS who would be otherwise eligible for nursing facility care.

Comment Template

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1	**Long-Term Services and Supports Network Adequacy and Readiness Standards-** Provider Network and Contracting	Subsequent MOUs for future years will be jointly developed with the Health Plan and stakeholders.	In what way would the MOU for the first year of IHSS be different from the MOUs in subsequent years on the demonstration? Will there be any difference between the MOUs for IHSS recipients in the demo vs. those that are not?
2	Long-Term Services and Supports Network Adequacy and Readiness Standards- Provider Network and Contracting	Determine whether the recipients' desires to have their IHSS providers involved in care planning or coordination, and if so, obtain express consent from the recipient or his or her authorized representative."	Will there be a standardized consent form?
2	Long-Term Services and Supports Network Adequacy and Readiness Standards- Provider Network and Contracting	Support a member who is at risk for out-of-home placement in obtaining IHSS services.	Need to specify a timeframe in which this support must be provided. Without adequate reimbursement, there cannot be an immediate response for support.
4	Long-Term Services and Supports Network Adequacy and Readiness Standards- Provider Network and Contracting	3. Establish, convene, and consider the recommendations of MSSP organizations, Health Plan members and other stakeholders…"	Who are the other stakeholders in this process? Need to include that Area Agencies on Aging & ADRCs are included in the list of stakeholders.
4	Long-Term Services and Supports Network Adequacy and Readiness Standards- Provider Network and	5. Govern MSSP assessment and eligibility determination as part of the Health Plan's care coordination process.	What does this mean? Will the Health Plans make the final determination on who is eligible for MSSP and will they screen all clients up front prior to referring to MSSP?

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	Contracting		
4	Long-Term Services and Supports Network Adequacy and Readiness Standards- Provider Network and Contracting	8. Refer plan members… plans must provide some level of MSSP-like services through a network of providers selected by the health plan.	Who will evaluate the delivery of MSSP delivered through 'a network of providers' to ensure that they are adequate and comparable to those received by clients of MSSP?
9	Long-Term Services and Supports Network Adequacy and Readiness Standards- Member Services	Create and maintain a list of available LTSS providers; the list will be update no less than quarterly.	Member services need to be trained on the role of the ADRC in counties where there is an ADRC. The ADRC is the no wrong door for information and access for LTSS.
3	**Coordinated Care Initiative Draft Assessment and Care Coordination Standards-** GENERAL PRINCIPLES FOR CARE COORDINATION	3. This includes facilitating access appropriate community-based resources and monitoring skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between facilities and the community.	This includes facilitating access **to** appropriate community-based resources and monitoring skilled nursing utilization, with a focus on providing services in the least restrictive setting and transitions between facilities and the community.
4	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- HEALTH ASSESSMENT PROCESS	Higher risk: means Medi-Cal beneficiaries who are at increased risk of having an adverse health outcome or worsening of their health or functional status if they do not receive their initial contact by the Plan within 45 calendar days of enrollment.	So the health plans will have 1 day after completing the initial risk stratification (44 days after enrollment) to contact the member (within 45 calendar days of enrollment)?
6	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- Health Risk Assessment	2. Contacting members within the required assessment timeframes…	Are these assessments to be done in person? It doesn't seem to state this, but it is unclear how a full assessment can be done if it isn't done in person.

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6	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- Health Risk Assessment	9. Identifying and assessing the need for referrals to home- and community-based services (HCBS), including Community-Based Adult Services (CBAS), MSSP, IHSS, and other community services, such as those provided through Area Agencies on Aging, Centers for Independent Living or Community Care Transitions leads. Referral processes will be developed jointly with the appropriate agencies.	Need to add the ADRC as a resource in counties that have an established ADRC.
7	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- Individual Care Plan	5a. For IHSS Members, the sharing of assessment results will be conducted and acted upon according to terms specified in each respective MOU…	We were under the impression that CDSS was coming up with common data elements to be shared with the plans by the State. This would be our preference.
8	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- INDIVIDUAL CARE PLAN	Coordinating transitions of care between service locations and multiple entities, including those outside the provider network, to ensure that discharge planning is provided to Members admitted to a hospital or institution.	The role of the health plan staff vs. the hospital discharge planner needs to be spelled out. It should also be required that the care transitions coordination by the health plan be consistent with local initiatives, for example CCTP. There are several CCTP sites in the demonstration counties and dual eligibles who are in the health plan for LTSS are eligible for CCCTP services which are being paid for by the member's Medicare.
10	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- Person-Centered Planning	4. For Members with significant decline in health or functional status (e.g., Alzheimer's disease and related dementias), Plans will work with the Members, and/or their authorized representatives, as appropriate, to determine their current needs and interest in continuing to self-direct their	What happens with members who don't have an authorized representative and appear to lack capacity to self-direct their care?

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Page	Section Title	Existing Text	Comment or Suggested Edit
		care.	
10	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- B. Basic Case Management Services	Basic case management services may include:	Replace with "Basic case management services must include and must be done in the client's preferred location (home)"
10	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- Footnote #1	Plans should consult with the California Department of Social Services (CDSS) and DHCS to confirm policies are consistent with IHSS statute and regulations.	Add- Plans should consult with the California Department of Aging (CDA) and DHCS to confirm policies are consistent with MSSP statute and regulations.
11	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- C. Complex Case Management Services	3. Intense coordination of resources	What is intense coordination? Daily calls, home visits, etc?
11	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- D. Coordinating care management with external organizations	3. Contracts with MSSP organizations that include processes for referrals, assessment, eligibility determination, services delivery and delineation of roles and responsibilities for care management.	Add "delineation of roles and responsibilities for care management that involves the care manager and nurse."
12-13	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- Planning for Care Transitions	Discharge planning will include ensuring that necessary care, services, and supports are in place in the community for the dual-eligible Member once they are discharged from a hospital or institution, including scheduling an outpatient appointment	The role of the health plan staff vs. the hospital discharge planner needs to be spelled out. It should also be required that the care transitions coordination by the health plan be consistent with local initiatives, for example CCTP. There are several CCTP sites in the demonstration counties and dual eligibles who are in the health

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		and/or conducting follow-up with the patient and/or caregiver.	plan for LTSS are eligible for CCCTP services which are being paid for by the member's Medicare.
13	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- Planning for Care Transitions	F. Policies and procedures governing expedited MSSP assessment and eligibility determination as part of the Plan's care coordination process for Plan Members who are being discharged from the hospital or at risk of immediate placement in a SNF.	Expedited MSSP assessment and eligibility. Does mean within 72 hours?
13	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- DHCS proposes the following provisions regarding reassessment:	1. Plans will conduct an annual comprehensive reassessment …Reassessment may be conducted by phone, email, or in-person for beneficiaries in lower-risk group, and will be conducted in person or in the setting of the Member's choice for higher-risk group and nursing facility residents (D-SNP).	Reassessments must be conducted in person (not by phone or email). A member's health can quickly worsen in a matter of a year.
14	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- DHCS proposes the following provisions regarding reassessment:	2. Plans will regularly use electronic health records and claims data (including IHSS, other LTSS and behavioral health data) to identify Members at high-risk, using newly diagnosed acute and chronic conditions, or high frequency emergency department or hospital use, or IHSS or behavioral health referral.	Other ways to identify high-risk for members who are not high users of health system/services but may need more assistance than a high user. Consider cultural differences of members who may not reach out to get help.
14	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- RESPONSIBILITIES AND QUALIFICATIONS OF CARE	1. The requirement for the education and experience level of the care coordinator will be determined by the health plan according to the needs of the Member. For Members identified as high risk, care coordinators will have substantial training regarding medical,	For high risk members the requirement is substantial training in medical services? Why not indicate by nurses?

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	COORDINATOR	LTSS, and behavioral health services.	
14	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- RESPONSIBILITIES AND QUALIFICATIONS OF CARE COORDINATOR	For Members identified as high risk, care coordinators will have substantial training regarding medical, LTSS, and behavioral health services.	Who should provide the training?
15	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- RESPONSIBILITIES AND QUALIFICATIONS OF CARE COORDINATOR	J. Frequent Member contact	Replace with Monthly member contact.
15	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- Footnote #2	Initial Enrollment Recommendation: To facilitate communication between Plans and social service agencies, particularly during the initial enrollment period, DHCS and the CDSS recommends that Plans consider identifying a limited group of care coordinators that work with county social service agencies, as well as a limited group of care coordinators that work with county behavioral health agencies	Replace the word “recommends” with the word “must”. This transition, especially during initial enrollment will be crucial to ensure the success of the client.
16	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- SUBCONTRACTS	3.ii. Consulted with county social services agencies regarding the scope of the subcontractor duties related to IHSS referrals and communication with county agencies, and revised as necessary any existing MOU or written agreements to reflect subcontractor responsibilities as they relate to Members with IHSS.	Add a viii. Consulted with county social services agencies regarding the scope of the subcontractor duties related to MSSP referrals and communication with county agencies, and revised as necessary any existing contract or written agreements to reflect subcontractor responsibilities as they relate to Members with MSSP.

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18	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- DEFINITIONS	Basic Case Management: A collaborative process of assessment … AND Complex Case Management: The systematic coordination and assessment…	This is the only difference between basic and complex case management.
18	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- DEFINITIONS	Basic Case Management:…This may also include Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.	Critical event or diagnosis that requires extensive use of resources does not seem basic case management.
18	Coordinated Care Initiative Draft Assessment and Care Coordination Standards- DEFINITIONS	Basic Case Management:… Coordination of services outside the health plan, such as community social services or specialty mental health or Drug Medi-Cal services, are considered basic case management services.	MSSP is offered by social services does this mean MSSP is considered basic case management?
			Initial Health and Psychosocial assessments not included.
			Confused about services provided by MSSP. Also, when it comes to detail about reassessments, MSSP is not mentioned.
2	**Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)-** Purpose of this Paper	This particular guidance is focused on the provision of a limited number of additional HBCS that are listed in the authorizing legislation for the duals demonstration, which "may include":	The list provided by legislation is permissive. the list needs to include the following services:
2	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services	…"additional HCBS that are listed in the authorizing legislation for the duals demonstration, which "may include": 1. Respite care: in home or out of	In addition to the services listed, need to include the following: • Translation services • Emergency response devices

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Page	Section Title	Existing Text	Comment or Suggested Edit
	(HCBS)- Purpose of this Paper	home, etc.	• Counseling • Money management • Emergency moves/temporary shelter funding and services • Assistive devices not already covered • Legal assistance • Transportation • Dental & vision
2	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)- Purpose of this Paper	1. Respite care: in home or out-of-home; 2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; 3. Habilitation ; 4. Nutrition: Nutritional assessment, supplements and home delivered meals; 5. Home maintenance and minor home or environmental adaptation; and, 6. Other services (the list provided by legislation is permissive.) [4]	Habilitation services need to be explained further.
3	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)- Duals Demonstration Vision for HCBS	The demonstration plans will be given flexibility to provide supports to enhance a member's care, allowing members to stay in their own homes safely, thereby preventing unnecessary hospitalization and prolonged care in institutional settings.	Replace "Plans will be given flexibility to provide supports" with "Plans must provide supports…"
3	Draft Policy for Demonstration Plans Offering	The demonstration plans' new authority to offer these services will eliminate the need	The demonstration plans' new authority to offer these services will eliminate the need for the

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	Additional Home- and Community-Based Services (HCBS)- Duals Demonstration Vision for HCBS	for the waivers for those eligible for the Duals Demonstration.	waivers for those eligible for the Duals Demonstration. This suggests that the waiver exists because the plans provide these services and that by not offering the services, the waiver can be eliminated.
3	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)- Duals Demonstration Vision for HCBS	At the same time, demonstration plans will have the incentive to offer the six additional HCBS discussed in this paper in order to keep persons in the home and community, resulting in a higher quality of life for their members and avoiding unnecessary and costly institution-based care.	1) Other potential services need to be spelled out. Stakeholder feedback is needed to identify the full array of such services. The health plans aren't familiar with these services and can't provide services they don't know about. 2) Remove the word incentive and state that the plans will offer the six additional services.
3	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)- Offer Technical Assistance to HCBS Community Groups.	…it is incumbent on DHCS to help create opportunities to educate and support such community providers in learning about contracting with demonstration plans and new business model opportunities…	The health plans also need to be educated about the requirements/needs of the HCBS providers r/t to staffing to meet specific capacity needs for the health plans and what the HCBS provider needs to include in the provider's rate for services.
4	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)- Preparing for the Demonstration	It is worth noting that, MSSP sites have specific statute and policy addressing their role: …MSSP sites will remain open to enrollment in demonstration counties for any populations excluded from the demonstration.	Further clarification is needed regarding populations excluded from the demonstration (i.e. ESRD) we will need to remain open for enrollment and services?
4	Draft Policy for Demonstration Plans Offering Additional Home- and	Plans will have the financial incentive to provide these additional HCBS; however, there is no obligation to offer the six	Without requiring the health plans to provide additional services, there is little incentive for a dual to remain in the demo for both acute and

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	Community-Based Services (HCBS)- Plan Approach to Certain Home- and Community-Based Efforts	additional services.	long term services. There has to be some sort of carrot.
4	Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS)- Plan Approach to Certain Home- and Community-Based Efforts	Since the six additional services are not part of the core Medi-Cal program today, those services will not be subject to Medi-Cal grievance and appeals procedures if a plan chooses to offer them.	These six additional services are part of the core Medi-Cal program today, those services and will be subject to Medi-Cal grievance and appeals procedures if a plan chooses to offer them.
Att. B	**Interaction of Select HCBS Programs with the CCI**	Attachment B, footnote 4. NOTE: 19 months after commencement of enrollment…, MSSP will become an integrated managed care benefit. A report is required… to explain the transition…	It would be extremely helpful to better understand what is meant by "MSSP will become an integrated managed care benefit" and to have a chance to discuss this further. Does this mean all gatekeeping for the service will be done by health plans? Does it mean they are no longer required to contract with MSSP providers but can do so if they choose? Further discussion is needed.

Comment Template for LTSS Network Adequacy Standards
Due February 6, 2013

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2	"Provider Network and Contracting"	"e. Until the function transfers to the ***Statewide Public Authority***, acting as employer of record, and providing access to trained IHSS providers and backup providers."	Once a county has transitioned into the demonstration and is thus no longer responsible for the collective bargaining of wages and benefits for IHSS providers, pursuant to Government Code Section 6531.5, the responsibility is then that of the California In-Home Supportive Services Authority (aka the Statewide Authority). It is crucial that the name of the joint powers authority given in statue (i.e. "Statewide Authority") be used properly in all documentation relating to the Duals Demonstration or the Coordinated Care Initiative in order to prevent confusion pertaining to the statutory obligations of the county, the local Public Authorities and the Statewide Authority. **Suggested Edit:** "e. Until the function transfers to the ***Statewide Authority, pursuant to Government Code Section 6531.5***, acting as employer of record, and providing access to trained IHSS providers and backup providers."
4-5	"For NF/SCF, Health Plans shall develop policy and procedures to:"		Considering the dual-eligible population, currently or soon to be residing in nursing facilities, is among our state's most vulnerable

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			populations, we must ensure that these facilities are of the highest quality. Furthermore, for those who currently reside in nursing facilities and may be required to transfer to an "in-network" facility, we must ensure that they are transferring into a facility of equal or higher quality. **To address this concern, we recommend the following suggestions:** Health plans must contract with a sufficient number of "high quality" facilities. We recommend that "high quality" be defined using one or a combination of the following metrics: ▪ CMS Nursing Home Compare Data, Star Ratings ▪ CNA Turnover rates (as reported to OSHPD) ▪ Nursing Hours Per Patient Day (as reported to OSHPD) Alternatively, or in conjunction with the above suggestion, we recommend the creation of boards of community members in each county consisting of a representative from the nursing home industry, labor, nursing facility resident and/or family member and a senior advocate, who will meet annually to determine the list of high quality nursing facilities in each county.

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4-5	"For NF/SCF, Health Plans shall develop policy and procedures to:"		**Suggested textual additions:** When contracting with NF/SCFs, the executed contract must include evidence of the following: • A comprehensive policy on occurrence reporting, including, but not limited to sentinel events and quality issues. • ***At minimum, include the following quality measures for reporting:*** • ***Any days that staffing went below 3.2 direct nursing hours per patient per day (State minimum) within the past year*** • ***Any enforcement actions or citations received from the State*** • ***Direct caregiver turnover rates (annual, every six months, monthly)*** • ***Status as a CMS Special Focus Facility*** • ***Ownership information: a list of any and all companies and people who have 5% or more ownership in the NF/SCF licensee and or operating company***
4-5	"For NF/SCF, Health Plans shall develop policy and procedures to:"		**Suggested textual additions:** Evidence of quality standards for NF/SCF services provided to members, and policies and

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			procedures for health plans to monitor quality and the process to address any deficiencies identified by Health Plans. ***At minimum, the following needs to be provided to members:*** ▪ ***CMS Nursing Home Compare (including star rating): General Information, Health Inspection Rating with number of deficiencies, Staffing number of hours per resident per day, Quality Measures, Penalties, status as a Special Focus Facility*** ▪ ***State Enforcement Action/Citations (A, AA and B) for the past year, including any violations of the State minimum 3.2 direct nursing hours per patient per day standard,*** ▪ ***OSHPD: latest available direct caregiver turnover rates*** ▪ ***Ownership of the NF/SCF: a list of any and all companies and people who have 5% or more ownership in the NF/SCF licensee and or operating company***

Comment Template

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Page	Section Title	Existing Text	Comment or Suggested Edit
1	Preamble		The preamble notes that 'fragmentation' is the biggest problem; this ignores problems of lack of capacity and unmet need. The caps o all of the HCBS waiver programs have resulted in large numbers of people on waiting lists. A recognition of the lack of capacity and the unmet needs/waiting lists needs to be added to the preamble and must be addressed in the document.
4	Plan Approach to Certain Home- and Community-Based Efforts		We object to the Department's decision not to include the additional HCBS benefits currently available through waivers as required elements of the covered benefit package, which form the basis for capitated rates paid to plans. Benefits including respite, nutritional assessment, counseling, supplements, home or environmental adaptations, habilitation, transition assistance, supplemental home health and personal care, and other services MUST be required elements of the covered benefit package. Similarly, Community Care Transitions (CCT) services must be included in the covered benefit package. Failure to include these types of additional HCBS services as part of the covered benefit package sends a signal to plans that additional or supplemental HCBS are optional rather than mandatory, even for those who need them to avoid nursing home or other less-inclusive living arrangements.

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1, 3,	Preamble and throughout	References to plans' "incentives"	This Draft assumes that because managed care plans will have the financial incentive to avoid more costly institutional care, they will provide all waiver-level care to those who need it. If this financial incentive is truly sufficient, however, there is no reason *not* to formally include these services in the agreed-upon benefits package. Inclusion in the benefit package will ensure that plan rates are sufficient to provide the services; that plans establish a network of providers to deliver the services; and that plans actually offer these services to beneficiaries that need them to live in the community.
4	Readiness and Compliance	…and procedures to identify members that may need HCBS, and to refer members to community-based organizations and other entities that provide these services, such as California Community Transitions organizations, Area Agencies on Aging, Independent Living Centers, or ADRCs where available	It is not enough that managed care plans refer their members to entities that provide services. As noted above, there is a significant lack of capacity in the system not to respond to those referrals in a meaningful way (that is, in a way that provides the right services at the right time to avoid institutionalization). **Referral activities are in no way an adequate replacement for the HCBS waiver options that would n longer be available to people in the CCI county.**
4	Readiness and Compliance		We strongly urge the state to adopt policies similar to those described in Ohio's readiness document, requiring the plans to document disparity between need and services provided in order to build a profile that can be used to guide improvement and capacity building.

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	Document as a whole		California's Olmstead plan describes the purpose of the waivers as not merely avoidance of institutionalization, but "to ensure the provision of all services that are necessary to ensure successful community living." Yet nothing in the current draft document explains how managed care plans will be incentivized to meet this objective, or how their success at this objective will be measured.
	Flow Charts- Attachment E		People in CCI county who are currently in a waiver program and who opt to stay in the waiver program might, subsequently go off their waiver due to a nursing home stay or other temporary circumstance. These individuals should 1) be able to suspend their waiver and return to it, or 2) be able to reenroll in the waiver; both options allowing them to continue their care plans, rather than suffering the extreme disruption of not only losing their waiver but also being passively enrolled into a Duals Demonstration plan. This must be treated in the document as necessary consumer protection.

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Comment Template : HCBS Policy Paper

Organization: State Independent Living Council
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Page	Section Title	Existing Text	Comment or Suggested Edit
1	Introduction	The notion that these additional HCBS are only available through a waiver creates a situation where such services are trapped in a silo.	In proposing the movement of HCBS services from waivers to managed care health plans, individuals eligible for these services must retain as much right to them as they would under a waiver. Without protection of these rights, the notion that waivers will no longer be necessary for those involved in the demonstration may be wishful thinking. Giving plans the option to offer these services does not ensure they will. Within waiver, certain HCBS services become authorized benefits. Under this proposed policy, these services would only be optional for managed care plans. Providing flexibility to a plan is clearly different than assuring consumers get what they need and are authorized to receive. The introduction of this document should set the framework of the discussion. In this case, the *Olmstead* Decision and the Americans with Disabilities Act, should be the clear framework, emphasizing that these services exist to ensure that individuals are able to live in the community, in the least restrictive environment, with the ability to direct their own services according to their needs and preferences.

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2	Purpose of this paper	This particular guidance is focused on the provision of a limited number of additional HCBS that are listed in the authorizing legislation for the duals demonstration (goes on to list 6 additional types of services including "Other" as #6).	It is problematic to continually reference a finite number of 6 types of services when waivers carry with them access to more than 6 service categories. It is important to list out all categories associated with waivers since a stated goal of this policy is reducing service delivery through waivers by giving health plans the flexibility to offer like services. However, without specifically calling all service categories out, the category of "Other" has the effect of making additional types of services carry lower priority than services specifically stated. So as not to limit, the category of "Other" may be used after all types of waiver services spelled out.
3	Duals Demonstration Vision for HCBS	The demonstration plans' new authority to offer these services will eliminate the need for the waivers for those eligible for the Duals Demonstration. At the same time, demonstration plans will have the incentive to offer six additional HCBS discussed in this paper in order to keep persons in the home and community, resulting in a higher quality of life for their members and avoiding unnecessary and costly institution-based care.	The practical difference between a waiver and the authority it gives an individual to obtain and pay for needed services, and giving flexibility to health plan to deliver services needs to be addressed. This draft policy focuses on plan's flexibility to offer HCBS services, with their choice being guided by financial incentives. However, the rate structure that supposedly provides these incentives is not apparent to the public. How can consumers be assured that plans will have the incentive to offer all the services they need, especially if these services

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			are not included as essential benefits? People with disabilities and seniors with serious medical conditions cannot put their lives in the hands of vague incentives that rest on the business sense of plans to avoid high costs of institutionalization. While that may seem like the practical path for plans to take, we cannot be assured of the weight of incentives versus the cost of needed services. While *Olmstead* is law, the specifics of plan benefits need to support practical application of the law.
3-4	Preparing for the Demonstration	To achieve more efficient and effective HCBS system under the demonstration, DHCS will take the following steps: • *Engage with plans an providers about the vision, goals, operations and potential partners of the new system. …….* • *Offer Technical Assistance to HCBS Community Groups……*	We appreciate the mention of Independent Living Centers and others meeting with Plans to develop a shared understanding of roles. It would also be important for state representatives to play a key role facilitating this process and assisting in preparation: meeting separately with Independent Living Centers and like organizations to facilitate a discussion about practical implementation, role development, and interaction with Plans. In addition, there should be more specific policy language empowering the community organizations that provide these services in advance of any discussions with Plans.

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			We appreciate the offer of technical assistance to HCBS Community Groups. It is essential. This language appears to support the idea of Independent Living Centers and other community organizations being reimbursed by Plans for the services they provide. We would like to see a stronger, clearer commitment by the state to this practice, including mechanisms that both empower and protect community and peer-run organizations. Inclusive outreach and technical assistance needs to be scheduled soon and communicated clearly if this is to be a priority.
4	Plan Approach to Certain Home-and Community-Based Efforts	As a requirement for participating in the demonstration, and with regard to the six additional HCBS only, plans will: • Coordinate such services for beneficiaries who need them. • Refer beneficiaries to community providers to deliver services and to work with those providers as the plan deems appropriate. • Develop a care plan where the member has input into the services to be provided (for members requiring such a plan.)	When this draft policy references "the six additional HCBS only," it is misleading. This language treats these services as a finite number when the sixth service is actually the expansive category of "Other." There is no mention here of how needs for these additional services are assessed and how need will be defined within the Plans. We believe it is important for there to be a clear, system-wide definition to ensure a fair structure of assessment across all plans. Emphasis on coordination but not payment for needed

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		• Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion. Plans will have the financial incentive to provide these additional HCBS; however, there is n obligation to offer the six additional services.	services in this draft policy is problematic. This policy should make it clear that the plan would not only help coordinate, but pay for these services for those who need them. Why would someone eligible for a waiver willingly give it up to risk a relationship with a Plan who has "no obligation" to offer the services under the waiver? This policy should not move forward as is, with no outlined consumer protections in this regard.
4	Plan Approach to Certain Home-and Community-Based Efforts	Since the six additional services are not part of the core Medi-Cal program today, those services will not be subject to Medi-Cal grievance and appeals procedures if a plan chooses to offer them.	Barring these HCBS services from Medi-Cal grievance and appeals procedures is wrong. Anything now subject to Medi-Cal grievance and appeals (such as the services provided for under the Waivers) should continue to be covered under Medi-Cal grievance and appeals procedures. If and when these services transition to the Plans within their flexibility to offer them, they should also be subject to grievance and appeals processes under the law. Regardless of whether services provided are part of the mandatory benefits, it is essential for consumers to be protected by clear due process, especially when life, health, and quality of life are the central concern, as they are here.

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Page	Section Title	Existing Text	Comment or Suggested Edit
Care Coordination Standards 6	2. Health Risk Assessment	Community Care Transitions leads.	The name of the program is California Community Transitions.
HCBS policy page 1	CALIFORNIA DUALS DEMONSTRATION: Draft Policy for Demonstration Plans Offering Additional Home- and Community-Based Services (HCBS) January 24, 2013	Demonstration plans will have the incentive to offer additional HCBS in order to avoid costly institutional care.	Relying o financial incentives alone to get plans to provide HCBS places those with more costly care needs at risk of institutionalization. This contravenes the Olmstead decision.
HCBS Flow Chart	Attachment F – Not Enrolled: Beneficiary Seeks California Community Transitions	Plan may contract with CCT → Plan provides care management and plan benefits; May contract with CCT; Waiver slots are closed	"may" is not very strong. If "shall" is not possible", at least use "should strongly consider".

The IHSS Consumers Union Endorses the National Senior Citizens Law Center Comments on HCBS Waiver Policy

The IHSS Consumers Union is extremely grateful to the National Senior Citizens Law Center for Its vigilance regarding our Olmstead Rights and is in full support of their comments. In fact, we are in the process of developing a position paper on the establishment of a true Long-Term Care Continuum to recommend to the Long Term Care Commission, that relies heavily on these critical Home and Community-Based Services, so necessary to end the unconscionable practice of sending young people to nursing homes and cutting short their independent lives, and makes it possible for all Seniors and People with Disabilities to benefit from a health care delivery system that disincentivizes their "incarceration" in institutions and fulfills President Obama's commitment to Community Living.

The service gaps that made community living a bridge too far for some have been surpassed by using these HCBS benefits currently available through waivers. Services like the In-Home Waiver and Nursing Facility Waivers for those who need more than the IHSS maximum hours to stay out of nursing homes have been an excellent start to keeping people in the community. Community Care Transitions, to help people navigate from nursing homes to community living should be expanded and funded to help people transition to the community at the onset of a disabling condition as well!

It is a travesty that so many young people have been forced into nursing homes before they ever had a chance at independent living, and or that seniors who have a heart attack, a stroke or break a hip must say goodbye to their independent life in the community. Community Transitions specialists and MSSP Case Managers help them navigate the difficult gap between the acute onset of a disabling condition and finding an apartment, caregivers and other home and community waiver support services also mentioned. A few weeks in an acute hospital, and

far too little time in a rehabilitation center do not prepare people for community living -- they prepare people for nursing homes.

These HCB services have started the movement away from the institutional bias. If these services disappear in a vague cloud of unmandated services that managed care plans with their capitated models can choose to extend or not extend, then the Dual Demonstration pilots will not represent coordinated care, but will instead represent a dismantling of the true care continuum that was in the process of being cobbled together by these waivers that constructively filled in the gaps in the current health care continuum.

We have every reason to be concerned that if these Home and Community-Based services are not **mandated** as managed-care benefits, they will fall away. In this letter from the National Senior Citizens Law Center attached, a former health plan executive explains: **"The difference between covered and non-covered benefits in managed care is traditionally "a fairly bright line, and if it is not our service, if the service or product in question is not a benefit, then it is highly unlikely that managed care will provide it."**

If the Department of Health Care Services does not **mandate** that these Home and Community-Based waiver services continue in the Dual Demonstration Pilots, they will be dismantling the implementation of Olmstead in California, at the same time it uses our disability civil rights terminology to promote cost-cutting managed-care plans that have no contractual obligation to preserve those rights.

Most sincerely,

Nancy Becker Kennedy and Susan Kirk Chandler on behalf of the IHSS Consumers Union

Comment Template: HCBS Charts

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1	Introduction	central goal of the Coordinated Care Initiative (CCI) is to help beneficiaries to stay in their homes and communities for as long as possible	We believe an equally important goal is to ensure that individuals residing in institutional settings have the opportunity to return to the community, in accordance with their needs and preferences. We recommend adding language that acknowledges this goal. *Olmstead* Obligations*:* central tenant of the state's adherence to the Olmstead decision includes ensuring that individuals have the ability to reside in the least restrictive, most integrated setting possible. This policy applies to individuals residing in home and community-based setting who wish to avoid placement in an institutional setting as well as individuals residing in nursing homes who wish to transition to the community. To this end, health plans as contractual partners with the state should be required to provide access to the same range of services currently authorized under these waivers, in accordance with what is outlined the individual plan of care.
Attachment B	Not Enrolled: Beneficiary Seeks Multipurpose Senior Services Program		The flow chart is configured such that individuals who are not eligible for or opt-out of the demonstration and seek enrollment into MSSP (as part of the Medi-Cal managed LTSS benefit) would not be able to access this benefit unless and until a MSSP slot becomes available. If a slot is unavailable, we recommend that the health plan provide access to a comparable suite of MSSP-like services based on an individual's plan of care. Definition of MSSP-Contract Services: The flow chart indicates that if an individual is enrolled in the demonstration and seeks access to MSSP but no slot is available, the plan will contract for MSSP services. The current policy (see LTSS Readiness Standards, revised January 22, 2013) indicates, "If there is no capacity, plans must provide some level of MSSP-like services through a network of providers selected by the health plan" (page 4). We recommend that the state define the set of services they refer to as MSSP-contract

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			services (previously referred to as "MSSP-like" services).
Attachment D	Not Enrolled: Beneficiary Seeks NF/AH and AL Waiver		This flow chart signifies a change in state policy such that waivers will remain open in the demonstration counties (in addition to non-demo counties) with wait lists. Ultimately, we believe it is important for the health plans to provide access to the range of needed services and supports, in accordance with what is outlined in the individual plan-of-care. We suggest that the state revise its policy to ensure that individuals who need services similar to those offered in the waiver are instead provided these services through the health plan, reflecting a more integrated system of services and supports.
Attachment F	Not Enrolled: Beneficiary Seeks California Community Transitions		The graphic indicates that the health plans will be given the option to contract with a local California Community Transitions Lead Organization to assist individuals in transitioning from the institution to the community. The current policy assumes that beneficiaries are aware of the CCT program and their right to transition to community-based setting. We believe it is the responsibility of the health plan to ensure that all beneficiaries residing in institutional settings are informed of their rights and given the option to return to the community. We recommend that health plans be required to identify individuals in institutions who wish to transition to the community and consult with the proper entities to facilitate this transfer. Health plans should work in consultation with the CCT program's local Lead Organizations, and be provided access to the MDS 3.0 Section Q completed for residents in order to identify those who have expressed interest in transitioning from the nursing home. Furthermore, we recommend that resources should be made available to re-establish the individual's household needs, in order to successfully transition eligible beneficiaries in institutional settings back into the community.

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1	Introduction	By definition, additional HCBS are available only by waiving federal law, which otherwise does not allow for such services. The notion that these additional HCBS are only available through a waiver creates a situation where such services are trapped in a silo. As a result, the Long Term Services and Supports (LTSS) system is fragmented.	This section appropriately addresses the problems of fragmentation but does not address lack of capacity in the current system, an equally significant issue. Individuals are often placed on long waiting lists before receiving services because of under-funding for each particular HCBS program to appropriately meet the population's need. We recommend that this section be amended to acknowledge the unmet need in the current system and the goal of the demonstrations to use resources more effectively to expand services to meet the population's needs. Further, we recommend that this section acknowledge the importance of the *Olmstead* Decision and the Americans with Disabilities Act in ensuring that individuals have the ability to live in the least restrictive environment, according to their needs and preferences.
1	Introduction	Under the Duals Demonstration, the California Department of Health Care Services (DHCS) intends to expand the availability and use of HCBS by allowing demonstration plans to pay for these services out of the monthly payments they receive to provide care to their enrollees.	The issue is two-fold. First, individuals must be appropriately assessed for the range of health and functional needs, with an accompanying plan of care that ensures access to the necessary services and supports to maintain or achieve independence, consistent with individual need and preferences. To this end, health plans must develop and implement a plan of care for, and in consultation with, health plan members based an individualized health and functional assessment that clearly articulates the person's needs and preferences for care and support. Second, health plans should be required to provide services appropriate to the agreed-upon plan of care for members. The member should be given the opportunity to appeal the plan of care through formal grievance and appeals process.

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2	Purpose of this Paper	This particular guidance is focused on the provision of a limited number of additional HBCS that are listed in the authorizing legislation for the duals demonstration, which "may include": 1. Respite care: in home or out-of-home; 2. Additional Personal Care and Chore Type Services beyond those authorized by IHSS; 3. Habilitation ; 4. Nutrition: Nutritional assessment, supplements and home delivered meals; 5. Home maintenance and minor home or environmental adaptation; and, 6. Other services	We recommend the following services be included in the definition of "Other" services: • Communication services (e.g., devices, translation); • Community transition services; • Other housing assistance (e.g., restoring utilities, emergency move, non-medical home, temporary lodging;) • Transportation; • Private duty nursing; • Caregiver training and support; and • Supportive services provided in assisted living or publicly-subsidized housing. The assessment process should drive access to services and supports. This reinforces the need for standardized set of functional questions to be administered upon enrollment in the health plan, with guidelines established for LTSS assessment until adoption of the universal assessment tool. The assessment should reflect the individual's functional needs and preferences. The assessment should drive the individual plan of care, outlining how services can be structured to meet the individual's needs. The member should be given the opportunity to appeal the plan of care through a formal grievance and appeals process.
3	Duals Demonstration Vision for HCBS	The demonstration plans will be given flexibility to provide supports to enhance a member's care, allowing members to stay in their own homes safely, thereby preventing unnecessary hospitalization and prolonged care in institutional settings.	Incentives and Rate Structure: We recommend that the cost of the permissible HCBS be included in the methodology being used to determine the rates for health plans. The ability of health plans to keep people in the community and avoid institutionalization depends in large part upon an adequate rate structure and its ability to incentivize health plans to create meaningful access to HCBS.

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		The demonstration plans' new authority to offer these services will eliminate the need for the waivers for those eligible for the Duals Demonstration. At the same time, demonstration plans will have the incentive to offer the six additional HCBS discussed in this paper in order to keep persons in the home and community, resulting in a higher quality of life for their members and avoiding unnecessary and costly institution-based care.	
4	**Plan Approach to Certain Home- and Community-Based Efforts**	As a requirement for participating in the demonstration, and with regard to the six additional HCBS only, plans will: • Coordinate such services for beneficiaries who need them. • Refer beneficiaries to community providers to deliver services and to work with those providers as the plan deems appropriate. • Develop a care plan where the member has input into the services to be provided (for members requiring such a plan.) • Be authorized to deliver additional HCBS to beneficiaries at the plan's discretion. Plans will have the financial incentive to provide these additional HCBS; however, there is no obligation to offer the six additional services.	We recommend that the state provide clear guidance to the health plans regarding how "need" should be defined to ensure that there is equity across health plans in how these services may be offered. Further, we recommend that the first bullet in this section be revised to indicate that health plans will "Coordinate and, according to individual need identified in the functional assessment, *pay for* such services for beneficiaries who need them." The current wording of this statement could leave open the potential for the health plan to identify other services that the member would have to pay for out-of-pocket, which may place an undue burden on the individual.

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4	Plan Approach to Certain HCBS	Grievance and Appeals: Since the six additional services are not part of the core Medi-Cal program today, those services will not be subject to Medi-Cal grievance and appeals procedures if plan chooses to offer them. Plans will develop internal procedures as part of developing a care plan that is patient-centered.	We recommend that the existing grievance and appeals process apply to all services, regardless of whether such services are included as a required benefit. Individuals should be permitted to appeal any determinations regarding the plan of care, regardless of whether the services are specified as a required benefit.
4	Readiness and Compliance	The provision of these certain HCBS will be new function for many demonstration plans. As such, the state will require that plans take a number of steps to prepare for implementation. More specifically, for the services discussed in this document, demonstration plans must create: 1. Policies and procedures that guide the demonstration plans' care coordinators, Interdisciplinary Care Teams, and primary care physicians in assessing the appropriate authorization of these services and/or benefits, in addition to the required community-based LTSS (i.e. CBAS and IHSS), including but not limited to assessment tools and reassessment cycles.	We recommend that the state provide a minimum set of standards and requirements to which all health plans must adhere. We recommend that DHCS establish a clear process for LTSS assessment until the adoption of the universal assessment tool. The requirements in the existing text are vague as stated and provide too much discretion to health plans to determine how to assess and authorize for additional HCBS. This lack of standardization leaves room for too much variance in how the assessment is conducted, how information from the assessment is used to create a plan of care with beneficiary input, and which services and supports are provided based o the plan of care across health plans, without the assurance that all beneficiaries in the CCI will be provided equivalent access to range of services based o individual need.
4	Readiness and Compliance	2. Policies and procedures to identify members that may need HCBS, and to refer members to community-based organizations and other entities that	Due to variance in geographic capacity, there is potential for a member to be referred to a community-based organization (CBO) that must turn that individual away because they lack capacity to provide the service. We recommend that when a service is deemed

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		provide these services, such as California Community Transitions organizations, Area Agencies o Aging, Independent Living Centers, or ADRCs where available.	necessary and included in the care plan and the CBO plan refers the member to cannot serve the individual, that the state require health plans to purchase the service through other providers or to provide the service itself.
4	Readiness and Compliance	3. training curriculum and program for demonstration plan staff that provides for an orientation for all staff on the Americans with Disabilities Act, the Olmstead Decision and HCBS issues, and detailed training on community and county HCBS that maybe available.	We appreciate the suggestion for staff training o *Olmstead* the Americans with Disabilities Act and other HCBS issues. We recommend that a standardized training and curriculum be developed that outlines the significance of these issues, and provides health plans with a clear understanding of their roles and responsibilities in implementing these policies, and provides health plan staff with the tools and resources to most effectively ensure members appropriate access to all necessary HCBS.