

JUSTICE IN AGING

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Sarah Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Care Services
1501 West Capitol Avenue
Sacramento, CA 95814

Sent via email to: Sarah.Brooks@dhcs.ca.gov; calaim@dhcs.ca.gov

Subject: Expanding Access to Integrated Care for Dual Eligible Californians

January 31, 2020

Dear Ms. Brooks,

We, the undersigned organizations, write to provide comment on the Department of Health Care Services (“DHCS” or “the Department”)’s proposal entitled Expanding Access to Integrated Care for Dual Eligible Californians (“the proposal”). Our organizations regularly work with and advocate on behalf of California’s dual eligibles in California, for many of whom the promise of truly integrated care and meaningful access to home and community-based services remains unrealized. We thank you for the opportunity to comment on this important proposal and believe our comments will strengthen integrated care for this population.

The Department’s proposal will impact the lives of all 1.4 million dual eligibles in the state who today receive their care through eleven different delivery systems or combinations of systems. The Department’s proposal provides a significant opportunity to commit to integrated care that prioritizes care in the most appropriate and least restrictive setting by building upon the learnings of models and transitions California has implemented over the last decade.

In sum, we believe the new D-SNP system must:

- offer improved integrated person-centered care by building upon progress from past transitions,
- protect the rights of California’s dual eligibles,
- focus on equity and address disparities, and
- address all of a dual eligible’s healthcare needs and promote the delivery of care in the least restrictive setting by requiring robust care coordination across programs serving dual eligibles.

Below we outline fourteen key recommendations to strengthen the proposal to ensure that the delivery system for dual eligibles offers integrated care at the highest levels and builds on progress from the CCI.

WASHINGTON

1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES

3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND

1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

I. California’s Future Delivery System for Dual Eligibles Must Offer Integrated Care and Build on Progress from the Coordinated Care Initiative

For the past six years, DHCS has been implementing a vision of integrated care for dual eligibles through a Medicare-Medicaid Plan pilot known as Cal MediConnect (“CMC”) as part of the Coordinated Care Initiative (“CCI”). Cal MediConnect offers integrated care by combining Medicare and Medi-Cal benefits under one managed care plan. California has led the way with the largest enrollment in a Medicare-Medicaid type plan in the country with 102,359 duals enrolled in the program as of December 2019, and evaluation data demonstrates success in both improving quality and integration of care while reducing costs.¹ DHCS now proposes to terminate this integrated model in the seven CCI counties and transition to a statewide system of Dual-Special Needs Plans (D-SNPs) and Medi-Cal plans, with efforts to align those plans under the same parent company. As proposed, this design fails to capture the progress made to integrate care through the CCI and represents a significant step backwards in the delivery of integrated care.

Recommendation 1: DHCS must require as much integration and care coordination in the new D-SNP model as currently exist in Cal MediConnect.

Under the D-SNP model, DHCS has proposed mandating the bare minimum in care coordination from D-SNPs, requiring only that plans notify the state or another designated entity of hospital and skilled nursing facility admissions for a pre-identified sub-population of high-risk enrollees. This is a federal requirement that applies to all D-SNPs and is far from sufficient to accomplish coordinated and integrated care at levels anywhere close to Cal MediConnect.

The only way for DHCS to maintain progress from Cal MediConnect is to require as much integration as possible in the state D-SNP (MIPPA) contract.² This includes requiring D-SNPs to be responsible for providing and/or coordinating all Medi-Cal benefits, requiring additional care coordination and data-sharing requirements, and requiring the additional measures DHCS has put forth for consideration in the D-SNP proposal.

Medi-Cal Benefit Integration. To build on Cal MediConnect, D-SNP plans must be required to deliver essentially all Medi-Cal benefits and coordinate those benefits the Department has

¹ See Carrie Graham, et. al., [Assessing the Experiences of Dually Eligible Beneficiaries in Cal MediConnect: Results of a Longitudinal Survey](#), University of California, San Francisco (September 2018).

² The best vehicle most similar to Cal MediConnect to accomplish this is within a Fully-Integrated Dual Special Needs Plan (FIDE-SNP) model. Under federal rules, FIDE-SNPs must not only provide dual eligibles access to Medicare and Medicaid benefits under a single managed care organization, much like Cal MediConnect, but they are also required to coordinate the delivery of those benefits. However, given complexities with the level of integration of the state’s long-term services and supports, establishing formal FIDE-SNPs may not be feasible, and the ongoing carve out of behavioral health benefits may be a barrier to operating Highly-Integrated Dual Special Needs Plans (HIDE-SNPs). On a recent webinar [call](#) with the California Collaborative for Long-Term Services and Supports, DHCS expressed an openness to exploring with CMS whether the state could qualify for FIDE-SNPs or HIDE-SNPs through implementation of In-Lieu of Services, an idea we encourage. Regardless, DHCS should strive for integration at levels of a FIDE-SNP regardless of formal designation by CMS.

carved out or has proposed to carve out of Medi-Cal managed care including In-Home Supportive Services (IHSS), the Multi-Purpose Senior Service Program (MSSP), specialty mental health, and dental. The result will be a delivery system that both maintains and builds upon the benefit integration requirements of Cal MediConnect.

Care Coordination and Data Sharing. The integration of these benefits is not as meaningful without the additional extensive care coordination requirements we see in CalMediConnect. Accordingly, the contract should also require that D-SNP enrollees be assigned care coordinators to assist in their care, that care plans are created for enrollees, and that interdisciplinary care teams are established. Health risk assessments should be required as they are in Cal MediConnect, and DHCS should incorporate the LTSS referral questions that currently exist in the CMC HRAs. The care coordination requirements can be based on requirements that currently exist for Cal MediConnect plans.³

With regard to data sharing, Cal MediConnect made significant strides with respect to specialty mental health by creating an infrastructure to share information with county Departments of Mental Health. Likewise, prior to changes in 2018, data sharing with the County Departments of Social Services improved access to IHSS. Similar systems should be considered for other carved out services. We encourage DHCS to include these types of systems for both behavioral health and other carved out Medi-Cal services in the contract.⁴

Additional Care Coordination and Integration Measures. Finally, DHCS should require rather than just consider the following for inclusion in the D-SNP contract: integrated member materials; consumers in governance structure; quarterly contract management team meetings; dementia care specialists; and the coordination of audit timing. These all should be included in any new program to ensure promising practices from Cal MediConnect transition into the new D-SNP program.

DHCS has the ability and the authority to make these requirements possible through contracts it enters with Medicare Advantage plans wishing to offer a D-SNP.⁵

Recommendation 2: To ensure plan readiness, the Department should provide Medi-Cal plans more time to meet the requirements set forth in the proposal.

³ Cal MediConnect [Three-way contract](#), § 2.5.2.3; § 2.5.2.6.7; § 2.5.2.7; § 2.5.2.8; § 2.5.2.9; and § 2.5.2.13. We also note that Cal MediConnect has been successful in discharging and transitioning dual eligibles out of long-term care settings. This work should also be incorporated into the new D-SNP model. Carrie Graham, et. al., [The Impact of Cal MediConnect on Transitions from Institutional to Community-Based Settings](#), University of California, San Francisco (May 2017).

⁴ Some Medi-Cal benefits should not be carved out, and the CalAIM initiative provides the opportunity for DHCS to re-consider those carve-outs. For example, we believe that non-emergency medical transportation (NEMT) to carved out services should be carved in as a plan responsibility. See [APL 17-010](#), [DPL 18-001](#).

⁵ 42 C.F.R. § 422.501-504; 42 C.F.R. § 422, § 423, § 438, § 498.

As the Department has indicated, there may be some Medi-Cal plans whose inexperience with the Medicare Advantage program would mean that the development of a highly integrated D-SNP would be difficult. One of the most important lessons learned from the CCI transition was the importance of allowing sufficient time to plan for the transition. Giving the plans ample time to plan and undergo readiness review is key to enabling them to operate successful D-SNPs. This may mean that Cal MediConnect members do not transition to this new D-SNP structure until the plans have them operationalized, potentially past 2023. Alternatively, it may mean that the CCI counties transition first as those plans have deep knowledge of how to operate integrated Medicare-Medicaid plans. Likewise, plans outside of the CCI counties may need more than one year's time to prepare for the carve-in of Long-Term Care (LTC). We strongly suggest the state put forth a timeline for implementation that considers plan readiness.

Recommendation 3: In furtherance of integration, DHCS should implement all of its proposals regarding D-SNP look-alikes and ensure that strong continuity of care protections are in place when cross-walking duals from look-alikes to D-SNPs.

One ongoing challenge to integrated care in California is the growing problem of D-SNP look-alikes, standard Medicare Advantage plans that have no responsibility to coordinate care, but predominately market to and enroll dual eligibles. By one account, there are nearly as many dual eligibles enrolled in look-alikes products as there are in the Cal MediConnect program.⁶ As Justice in Aging has articulated in an issue brief on look-alikes, these plans pose a significant problem for dual eligibles as they are not subject to even minimal D-SNP requirements around the model of care and fail to offer any coordination with a dual eligible's Medi-Cal plan.⁷

We appreciate the proposal's attention to look-alikes. Creating a system of integrated care for dual eligibles in California inherently necessitates greatly limiting the availability of look-alikes in the Medicare Advantage market. Therefore, we are supportive of DHCS's proposal to (a) request CMS designate plans with a high percentage of dual eligibles enrolled as "look-alikes;" (b) request that CMS reject applications to offer non-D-SNP MA plans targeted to dual eligibles;⁸ and (c) request CMS cross-walk dual eligibles enrolled in look-alikes into D-SNP products offered by the same organization.

⁶ MedPAC, [Report to the Congress: Medicare and the Health Care Delivery System](#) (June 2018), p. 274.

⁷ Justice in Aging, [Dual Eligible Special Needs Plans \(D-SNP\) Look-Alikes: A Primer](#) (July 2019).

⁸ In the same area of the proposal, DHCS indicates it will limit coverage of D-SNPs to full benefit dual eligibles and will require a separate benefit package for partial dual eligibles. If the Department is truly committed to integrated care, it must enter into a Part A Buy-In agreement with the Social Security Administration. Such an agreement, which would be particularly important for older women and older immigrants, would prevent low-income beneficiaries from facing high costs and gaps in coverage. Perhaps more importantly in this context, a Part A Buy-In agreement would also allow more individuals to qualify as full-benefit dual eligibles and therefore to benefit by being able to enroll into integrated D-SNP plans for their care.

With respect to (c), we ask that the Department put in place very robust continuity of care protections when cross-walking duals to new plans. No dual eligible should be penalized by losing access to providers or benefits simply because they enrolled into a look-alike after an agent or broker marketed to them.

II. California’s Future Delivery System Must Also Protect All the Rights of Dual Eligibles

In addition to maintaining and expanding California’s integration efforts, California’s future delivery system must vigilantly protect the rights of dual eligibles. We are concerned that the proposal fails to (a) adequately protect a dual eligible’s enrollment rights; (b) ensure consumers are protected through a consumer ombudsman; (c) reduce instances of improper marketing activity; (d) protect duals who enroll in MLTSS; and (e) streamline notices during this transition.

Recommendation 4: In a commitment to maintaining a person-centered model, the Department should abandon efforts to implement default enrollment for new dual eligibles in the D-SNP model, continue to avoid use of passive enrollment, and maintain the current Special Enrollment Period (SEP).

Enrollment rights should also incorporate lessons from the CCI in another way: limit the use of enrollment mechanisms that limit choice and confuse consumers by prioritizing person-centered approaches. Anecdotal and evaluation data from Cal MediConnect clearly establish the harms of utilizing passive enrollment in a transition that affects a dual eligible’s access to Medicare providers.⁹ We appreciate and support the Department’s intention not to use passive enrollment for dual eligibles from Medicare fee-for-service into new Medicare plans. However, we oppose DHCS’s proposal to use default enrollment for D-SNPs to enroll existing Medi-Cal plan members into the D-SNP when they become eligible for Medicare.¹⁰ Although these new Medicare dual eligibles are unlikely to have developed relationships with Medicare fee-for-service providers, Medicare fee-for-service is the default enrollment system for virtually all new Medicare beneficiaries, and this should continue to be the case. Certainly, all dual eligibles deserve the opportunity to voluntarily consider whether it is in their best interests to join a Medicare plan, at what time, and under what conditions.

If DHCS is concerned about enrollment, the best path to appropriate and robust enrollment in integrated products is to design a program that provides person-centered, culturally competent, and coordinated and integrated care.

⁹ Carrie Graham, et. al., [Evaluation of Cal MediConnect: Results of Focus Groups with Beneficiaries](#), University of California, San Francisco (March 2016).

¹⁰ Should the Department move forward with default enrollment, it must address questions around aligned enrollment and delegation. For example, to achieve aligned enrollment, will a Medi-Cal member aging into Medicare whose Medi-Cal plan is delegated be default enrolled into the delegated Medi-Cal plan’s D-SNP or the prime Medi-Cal plan’s D-SNP?

Finally, although we applaud the Department’s decision to jettison the proposed Medi-Cal annual enrollment period, healthcare works better for dual eligibles who traditionally have had and need flexibility in trying different plans. Therefore, DHCS should continue to seek an enrollment waiver to maintain a monthly special enrollment period (SEP) in the new D-SNP model.

Recommendation 5: DHCS should continue with and expand on the consumer ombudsman program originally piloted through the Cal MediConnect program and ensure it is well resourced during this transition and moving forward.

Throughout the proposal, DHCS disappointingly fails to incorporate important consumer protections from the CCI. One of the most critical consumer protections is the availability of a robust ombudsman program, powered by legal aid attorneys across the seven counties, who help consumers take on disruptions in care, fight improper medical bills, and identify and resolve systemic issues in the program. Even today, years after passive enrollment has concluded, the ombudsman continues to provide consumers with holistic services, where they can go to resolve issues with services, eligibility, and more.

DHCS intends to work with the Medi-Cal Long-Term Care (“LTC”) Ombudsman program to support the transition to the new D-SNP model. Although the LTC ombudsman is an important program that helps protect the rights of beneficiaries in LTC, it is wholly insufficient to assist all dual eligibles with the potential challenges associated with transitions outlined in the proposal, including the mandatory enrollment of dual eligibles in Medi-Cal managed care and crosswalk enrollment, and accessing services post-enrollment.

The size of the transition also necessitates the presence of a consumer ombudsman service. Assuming similar enrollment numbers now for 2023, the crosswalk population itself will likely constitute over 100,000 dual eligibles. Per the state’s proposed timeline, thousands of additional dual eligibles will transition at the same time as the crosswalkers from fee-for-service Medi-Cal to Medi-Cal managed care. Accordingly, a consumer ombudsman program, similar to the one implemented in the CCI counties, must be available statewide to assist consumers during this new transition and afterward.

Recommendation 6: DHCS should incorporate strengthened CCI consumer protections in the D-SNP model including a six-month period of deemed eligibility; robust continuity of care protections; aid paid pending; integrated Medicare-Medicaid appeals and grievances; and integrated consumer materials.

There were several consumer protections that were part of the CCI that are either not mentioned at all or not fully detailed in the proposal. These protections must be incorporated into the Department’s strategy for expanding integration throughout the state.

Deeming. In Cal MediConnect, the Department recognized the importance of allowing consumers adequate time to resolve underlying Medi-Cal eligibility issues through a generous period of deemed eligibility (otherwise known as “deeming”) and, in recognition of how helpful deeming is, expanded the deeming period to two months several years into implementation. Prior to the CCI, some D-SNPs allowed members to stay enrolled for up to six months as they addressed Medi-Cal eligibility issues, and advocates have spoken to how even the two-month deeming period in Cal MediConnect is not always enough time to resolve complicated eligibility issues. In a D-SNP model, failure to cure Medi-Cal eligibility issues presents the same risk of disenrollment as in Cal MediConnect, and thus, given the importance of this consumer protection, we recommend a period of up to six months of deeming in this new D-SNP model.

Continuity of Care. During periods of transition in healthcare delivery systems, ensuring consumers have continuity of care protections is critical. This was an important lesson learned from the CCI. Continuity of care rules must be simple and easy to administer; too many beneficiaries experienced major disruptions in services because providers, bogged down by rules and administrative burdens, refused to enter into continuity of care agreements with plans. Eventually, the rules were tweaked so they were more streamlined.¹¹ In this D-SNP transition, we recommend the Department carry over the existing continuity of care protections from the CCI and work to make them simpler to administer so more beneficiaries can experience a seamless transition.

Other critical protections. In addition to deeming and continuity of care, Cal MediConnect included an aid paid pending protection, made significant progress toward integrated Medicare-Medicaid appeals and grievances, and utilized integrated consumer materials. We believe that the Department must, when possible, include these as well as part of the D-SNP contract with the state.¹²

Recommendation 7: To protect dual eligibles from nefarious marketing practices, the Department should restrict brokers and agents from marketing the new D-SNP model to dual eligibles, and DHCS should ask CMS to implement a ban on marketing all Medicare products for dual eligibles in California and put more resources toward HICAP counseling during the transition.

DHCS indicates that it will ensure consumer protections are standardized across the state and require D-SNPs to target marketing materials only to enrollees in Medi-Cal plans owned by the same parent company. It proposes requiring brokers to explain the value of enrolling into an integrated product and how to work with managed care, and that brokers receive training on

¹¹ [DPL 16-002](#), [APL 18-008](#).

¹² We note that the D-SNP contract should also require that D-SNP plans send vital documents in all Medi-Cal threshold languages, a current requirement under the Cal MediConnect three-way contract. Cal MediConnect [Three-way contract](#), § 2.8.4.1.8; § 2.11.5.5.2; § 2.12.1.13; § 2.14.2.1.3.5.2; § 2.15.2.1; § 2.17.2.3; and § 2.17.5.9.

how to work with limited English proficient (LEP) dual eligibles. Unfortunately, we believe that the Department's support of agents and brokers for integrated plans is misplaced.

We ask that the Department work with CMS to implement a ban on marketing all Medicare products, including the new D-SNP product, for dual eligibles. As Justice in Aging and 54 partner organizations expressed in a comment letter dated May 25, 2018, to DHCS regarding a then-proposal to create a broker pilot within Cal MediConnect, dual eligibles face tremendous pressure to enroll in a marketed product when interacting with brokers and agents, and broker misconduct exacerbates the problem.¹³ Existing Medicare marketing rules, sometimes vague and difficult to enforce, fail to always curb broker misconduct. The CMC broker pilot authorized one Cal MediConnect plan, L.A. Care, to use brokers beginning plan year 2019. However, the broker pilot actually resulted in a net decrease in the number of dual eligibles enrolled.¹⁴ At the same time, consumer advocates have encountered instances where these brokers have failed to properly identify network providers and provided incorrect explanations about member benefits.

Therefore, brokers and agents neither contribute positively to a dual eligible's experience when enrolling in a plan, nor do they seem to help plans enroll and retain duals in those plans. In fact, recognizing the potential harm of brokers and agents to dual eligibles, the CCI began with a commitment to not allow marketing activity of CMC plans. DHCS should return that commitment in the new D-SNP model.

As consumer advocates, we believe the best outcomes come from consumers engaging with unbiased enrollment counseling. During the CCI transition, Health Insurance Counseling and Advocacy Programs (HICAP) in the seven counties worked tirelessly to explain enrollment options to consumers. Due to resource limitations, HICAPs were constrained in the number of dual eligibles they could serve during the peak of passive enrollment. HICAPs are also important community-based resources who can assist consumers when they have encountered a Medicare marketing issue. In this transition, instead of focusing on how best to market the new D-SNP model, the Department should provide more resources to HICAPs so they can ensure dual eligibles understand their enrollment options and minimize disruptions in care.

Recommendation 8: To ensure a smooth transition for duals newly enrolling into Medi-Cal managed care, DHCS must ensure Medi-Cal plans are compliant with automatic crossover billing requirements and that Medi-Cal plan enrollment and onboarding materials are adequately targeted to duals.

We note that with respect to the mandatory enrollment of dual eligibles in MLTSS plans statewide, the Department proposes updating education and enrollment materials from the

¹³ Justice in Aging and partner organizations, [Comments on Proposed CMC Broker Policy](#) (May 2018).

¹⁴ LA Care's Cal MediConnect plan had 16,027 enrollees in Dec. 2018 compared to 15,800 in Dec. 2019. Data taken from the California Health and Human Services Open Data Portal's [Medi-Cal Managed Care Enrollment Report](#).

CCI, educating providers about proper billing practices, and providing technical assistance around new plan requirement. While these measures are appreciated, they are insufficient.

As demonstrated with the CCI, dual eligibles who opted out of Cal MediConnect still faced significant challenges accessing both Medicare and Medi-Cal benefits. A significant number were improperly billed by their Medicare doctors who were confused about how to work with their new Medi-Cal plan, and others encountered difficulty accessing their Medi-Cal benefits from the new managed care plan.

Provider education is not enough; DHCS must also conduct oversight over Medi-Cal plans to ensure they are meeting the automatic crossover billing requirements.¹⁵ Automatic crossover billing can help to greatly reduce instances of improper billing from Medicare providers. In addition, DHCS must require that the enrollment and onboarding materials that Medi-Cal plans send newly enrolled dual eligibles are tailored to them and their dual eligible status. In the CCI, many confused dual eligibles sought help when their plan member materials discussed primary care physicians and other details that are largely not applicable to dual eligibles, given their Medicare enrollment.

Recommendation 9: DHCS should streamline and simplify noticing for all populations during this transition and ensure not one population is receiving too many notices in a short period of time.

We also encourage DHCS to think intentionally about noticing of consumers. Although we advocate for proper notice for consumers and appreciate the Department's commitment to review notices and ensure that they are compliance with marketing rules, yet another lesson learned from the CCI is that too many notices – a result of too many transitions – over a short period of time can spell confusion, and worse yet, disaster for dual eligibles. Under the state's proposed timeline, for example, dual eligibles in non-CCI counties would receive likely three notices about enrollment into Medi-Cal managed care in 2022 and 2023. If they are in long-term care, they would receive an additional notice about their long-term care benefit being added to their Medi-Cal plan benefit package. They might get additional notices and communications from their Medi-Cal plan about joining a D-SNP operated by the Medi-Cal plan's parent company, for a grand total of at least five notices in under one year. We encourage the Department to plan carefully and integrate notices to the extent possible and also adjust the timeline so multiple transitions do not occur for the same population in a short period of time.

Controlling the volume of notices sent is not simply in the interests of mitigating consumer confusion; it also is in the interests of DHCS's ability to administer the transition. During the height of passive enrollment in the CCI, DHCS's mailing vendor actually failed to send all CCI enrollment notices timely because it could not feasibly mail all the notices in time, resulting in

¹⁵ Under federal law, Medicaid plans must have automatic crossover billing processes in place. 42 C.F.R. § 438.3(t).

delayed receipt by beneficiaries, exacerbating confusion and frustration. DHCS should create a timeline that reduces the number of transitions that dual eligibles experience in a short period of time and correspondingly reduces the number of notices they receive in this transition, focusing specifically on those dual eligibles in non-CCI counties who access LTC.

III. California’s Future Delivery System for Dual Eligibles Must Focus on Equity and Addressing Disparities

California’s dual eligible population is diverse and requires a person-centered approach to care based on equity. In the CCI, when the state largely ignored the diversity of this population and employed a one-size-fits-all approach, disparities perpetuated with respect to enrollment, assessment, and access to care.

Recommendation 10: The Department should develop a culturally competent outreach and education plan for the D-SNP transition, re-examine state and health plan algorithms for racial bias, and develop an equity plan for the D-SNP transition informed by attempts to address disparities in the demonstration.

Evidence of the need for culturally competent outreach and the creation of an equity plan is clear from the CCI passive enrollment data. Over 90% of Armenian-speaking dual eligibles opted out in San Bernardino.¹⁶ Meanwhile, less than 30% Latino dual eligibles opted out in Orange.¹⁷ Access to integrated care should not depend on one’s demographic characteristics.

Upon enrollment, all Cal MediConnect enrollees are assigned into certain risk stratifications using algorithms that look at a dual eligible’s previous history of care. However, social scientists have established that these algorithms are fraught with racial bias, such that patients of color who are sicker and need more care than white patients are stratified in the same level.¹⁸

After they are enrolled and assessed, identity continues to play a significant role in how dual eligibles access care when enrolled. Latino dual eligibles in Cal MediConnect report the lowest satisfaction with doctors and hospital choices with only one out of four indicating they are very satisfied.¹⁹ Asian American and Pacific Islander dual eligible enrollees are most likely to report language access issues, transportation problems, and unmet personal care need.²⁰ Meanwhile,

¹⁶ DHCS, [Cal MediConnect Monthly Enrollment Dashboard](#) (October 2016).

¹⁷ *Id.*

¹⁸ Ziad Obermeyer, et. al., [Dissecting racial bias in an algorithm used to manage the health of populations](#), *Science* Vol. 366, Issue 6464 (October 2019).

¹⁹ University of California, San Francisco, [2019 Findings from the Cal MediConnect Rapid Cycle Polling Project](#) (May 2019).

²⁰ *Id.*

over half of Limited English Proficient dual eligibles enrolled in Cal MediConnect reported that they were *never* able to get a professional interpreter to speak to their doctor.²¹

The transition to the new D-SNP model provides DHCS a chance to examine these inequities more closely and intentionally plan to address them in the D-SNP model. The Department must consider its outreach plan for the transition carefully, developing messaging tailored to communities on the ground, and work with trusted community leaders who can help DHCS educate and outreach.²² In addition, the Department must also examine any algorithm it intends to use to mitigate for possible racial bias.²³ Finally, DHCS should address known disparities reported in Cal MediConnect and use learnings about those disparities to develop an equity plan for the D-SNP transition.

IV. A Successful Transition Must Address All of A Dual Eligible’s Healthcare Needs and Promote The Delivery of Care in The Least Restrictive Setting

We strongly believe that the success of DHCS’s proposed transition depends in part on whether the Department offers a complete proposal that addresses all parts of the healthcare delivery system and all parts of a dual eligible’s healthcare needs. Unfortunately, the proposal is missing a number of important components. We identify several here, but in no way attempt to be exhaustive.

Recommendation 11: DHCS should align the D-SNP proposal with broader Medi-Cal Healthier California for All and CCI goals and coordinate with the Master Plan for Aging planning and development.

The CCI focused on integrating care with an aim to provide dual eligibles person-centered care and promote access to home and community-based services (HCBS). As the proposal intended to replace the CCI, there should be some consistency between the goals of the CCI and the new D-SNP model. However, the proposal does not make any mention of HCBS or person-centered care. We encourage DHCS not to abandon these important principles and offer a proposal that continues to champion them. For example, DHCS needs to create a plan that continues integrating and coordinating existing LTSS services like IHSS and MSSP, instead of relying on solely on In-Lieu of Services and Enhanced Case Management

²¹ Carrie Graham, et. al., [Assessing the Experiences of Dually Eligible Beneficiaries in Cal MediConnect: Results of a Longitudinal Survey](#), University of California, San Francisco (September 2018); *see also* Theodora Yu, [Many enrolled in California healthplan lack interpretation services, surveys show](#), The Sacramento Bee (Nov. 26, 2019).

²² For example, DHCS could consider partnering with local community organizations to better educate dual eligibles about their options. *See, for example*, Justice in Aging and Advocates for African American Elders, [Thinking Outside the Box: Creative and Culturally Competent Outreach Strategies in Health Care Transitions](#) (March 2015).

²³ We imagine that algorithms will continue to have a significant role in the transition, including in the risk stratification for dual eligibles transitioning into the D-SNPs as well as in how the Department intends to identify the high-risk population for whom it will develop a notification mechanism for regarding hospital and nursing facility admissions.

Similarly, the broader Medi-Cal Healthier California for All goals are to (a) promote whole person care approaches and address social determinants of health; (b) move Medi-Cal to a consistent and seamless system, reducing complexity and increasing flexibility; and (c) improve quality and transform delivery systems through value based initiatives, modernization of systems, and payment reform.²⁴ In contrast, the D-SNP proposal appears to be written in a vacuum, failing to identify how any of its contents would advance these three goals. The Department should better align the proposal with the Medi-Cal Healthier California for All goals.

As the state has been working to plan around the Medi-Cal Healthier California for All initiative, it has also been engaged in a process to create a Master Plan for Aging, a result of Governor Gavin Newsom’s Executive Order N-14-19. The process, supported by key stakeholders and several committees – one of which is particularly focused on Long-Term Services and Supports – is completely absent from the D-SNP proposal and the larger Medi-Cal Healthier California for All proposal. The state’s efforts to plan for the future of LTSS through Medi-Cal Healthier California for All and the Master Plan must be coordinated and in alignment to offer California one united vision for the future of health care delivery to older adults.

Recommendation 12: DHCS should release more information regarding its intentions to transition LTC and MSSP as soon as possible, and set forth how it intends to continue improving Cal MediConnect for those enrollees, focusing on known problem areas like language access, LTSS, and transportation.

In addition to ensuring consistency with the goals of Medi-Cal Healthier California for All and the CCI, the proposal must better spell out the transition details regarding the carve-in of LTC and the removal of MSSP from managed care. Although these components are identified on the Department’s timeline, there is very little explanation of how the Department will implement these transitions.²⁵ Details are necessary, especially since DHCS proposes both of these changes to occur as early as 2021.²⁶

DHCS must plan for this transition while contemporaneously concentrating on the current delivery system in the CCI. A portion of the proposal discusses the Cal MediConnect transition, indicating that DHCS will work with CMS to ensure that Cal MediConnect plans continue to

²⁴ DHCS, [Medi-Cal Healthier California for All Proposal](#) (October 28, 2019).

²⁵ We appreciate the Department’s release of the [Frequently Asked Questions: DHCS Long-Term Care Carve-In](#) document, but believe it does not fully address all details necessary as part of the transition.

²⁶ With respect to the MSSP transition, we strongly believe that DHCS should commit to ensuring beneficiaries are not harmed as a result. Specifically, MSSP has successfully integrated into the Health Plan of San Mateo (HPSM), and as a result, beneficiaries in HPSM may be receiving MSSP-like services even though they are not in a MSSP waiver slot. This was exactly one of the benefits to integrating MSSP as a benefit under the health plans, so we recommend keeping the integration in San Mateo. At a minimum, should the Department decide to carve out MSSP including in San Mateo, beneficiaries who are receiving MSSP-like services in that county should be protected by continuity of care.

provide high quality care to members during the transition. However, assurances from the Department without greater specificity as to the actions DHCS intends to take are unacceptable and insufficient. DHCS and Cal MediConnect may soon begin to feel disinclined to make improvements to the program, but DHCS cannot stop working to improve Cal MediConnect for the over 100,000 dual eligibles currently enrolled simply because it has proposed a transition scheduled to take effect several years from now. This is especially true when a rich bedrock of evaluation data from a variety of sources indicate that enrollees may be struggling in certain areas, like obtaining Durable Medical Equipment (DME), finding a provider or interpreter for LEP enrollees (discussed above), accessing LTSS, and issues with transportation.²⁷

Furthermore, progress in these areas can also inform contracting provisions for the new D-SNP model. For these reasons, we appreciate DHCS's decision to employ a workgroup to examine issues with DME access, but more must be done. DHCS must identify, with greater specificity, the actions it will take to continue to improve the program as it prepares for this transition, paying particular attention to language access, LTSS, and transportation.

Recommendation 13: DHCS should revisit the D-SNP proposal to address PACE, IHSS, and palliative care.

The D-SNP proposal fails to make *any* mention to the Program of All Inclusive Care for the Elderly (PACE) and IHSS, two vital programs for the delivery of care to older adults and people with disabilities in California. While these programs and proposals are complicated, DHCS must consider the impact of its proposal on programs like IHSS and PACE and clearly articulate how the proposal will work with these existing programs to promote integrated care. The Department cannot build a MLTSS program that ignores one of the largest HCBS programs in the country and the care of over 500,000 dual eligibles who receive IHSS across the state.

The proposal also fails to mention palliative care, a benefit Medi-Cal managed care plans started delivering as of January 1, 2018. To date, DHCS has not required Medi-Cal managed care plans to deliver the benefit to duals despite duals representing a population who would be both eligible for and would greatly benefit from palliative care. DHCS should address palliative care in its proposal since an integrated delivery model is one in which palliative care for duals can most easily be implemented.

Recommendation 14: DHCS should carefully plan the rollout of In-Lieu of Services with an eye toward lessons learned with Care Plan Options.

A complete proposal further requires DHCS to examine creative ways outside of the traditional benefit package that can support dual eligibles. We applaud the Department's efforts to implement In-Lieu of Services (ILOS) and appreciate the Department's clarification on a recent webinar call that ILOS will be mandatory for plans beginning in 2026. Data from Cal

²⁷ Graham, *supra* note 21.

MediConnect illustrates that when Care Plan Options (CPO) services were optional and financial incentives were not in place, beneficiaries largely did not benefit from these services.²⁸ This time, DHCS should take those learnings into account and ensure that the provision of ILOS ultimately is mandatory and that the financial incentives are in place, both with respect to dual eligibles in aligned D-SNP and Medi-Cal plans as well as those in Original Medicare. Successful implementation of ILOS helps the Department achieve its commitment to deliver care in the most appropriate, least restrictive setting.

In conclusion, we believe that if the Department implements these 14 recommendations, the new D-SNP system will offer improved, integrated, person-centered care; protect the rights of the state's dual eligibles; focus on equity and address disparities; and address all of a dual eligible's healthcare needs by promoting the delivery of care in the least restrictive setting. We appreciate the opportunity to provide comment. If there are questions regarding this letter, please contact Denny Chan at Justice in Aging, dchan@justiceinaging.org.

Sincerely,

Justice in Aging
Alzheimer's Association
Alzheimer's Los Angeles
Asian Americans Advancing Justice - Los Angeles
Bay Area Community Services
Bay Area Legal Aid
California Association for Adult Day Services
California Association of Public Authorities for IHSS (CAPA)
California Health Advocates
California IHSS Consumer Alliance
CCI Ombudsman
Center for Health Care Rights
Choice in Aging
Disability Rights California
Disability Rights Education and Defense Fund (DREDF)
Health Consumer Alliance
Homeless Action Center
Jewish Family Service of Los Angeles
Legal Aid Society of San Diego, Inc.
Legal Aid Society of San Mateo County
LifeLong Medical Care

²⁸ Justice in Aging, [Cal MediConnect: Unmet Need and Great Opportunity in California's Dual Eligible Demonstration](#) (February 2019).

Little Tokyo Service Center
National Health Law Program
Neighborhood Legal Services of Los Angeles County, Health Consumer Center
Partners in Care Foundation
Personal Assistance Services Council, Los Angeles
Saint Barnabas Senior Services
The California Pan-Ethnic Health Network
Western Center on Law & Poverty

CC: Tim Engelhardt, Medicare-Medicaid Coordination Office (MMCO),
tim.engelhardt@cms.hhs.gov; mmcocomments@cms.hhs.gov
Kerry Branick, MMCO, kerry.branick@cms.hhs.gov
Gretchen Nye, MMCO, gretchen.nye1@cms.hhs.gov
Jacey Cooper, DHCS, Jacey.Cooper@dhcs.ca.gov
Dr. Mark Ghaly, CHHS, Mark.Ghaly@chhs.ca.gov