# Duals Project – Proposed Readiness Criteria

Our respective organizations have previously testified and submitted our written concerns with respect to the Duals Demonstration – Coordinated Care Initiative, which would integrate Medicare and Medi-Cal services for persons who are dually eligible for those programs. For your convenience, we have developed the following "Readiness Criteria" to serve as a pre-implementation check-list of items that we believe are critical to ensuring that participating health plans and the State are prepared to serve the dual eligible population. The State should have the following completed six months prior to (unless otherwise noted) the commencement of enrollment of dual eligibles in the demonstration counties, and should submit to the Legislature, and post on the DHCS website, evidence that these tasks have been completed:

Outreach to Consumers:

1. Contract in place and funding for plan comparison and "choice counseling" by an independent entity (eg. HICAP or Health Consumer Center) that is adequately funded to assist the population of beneficiaries who will be asked to make decisions on their options to participate in the demonstration or to receive their care elsewhere.

2. Design of all enrollment-related notices, including summary of benefits, evidence of coverage, prescription formulary, provider directory, etc. as well as all appeals related notices produced in coordination with existing CMS guidelines. All notices will have been vetted by stakeholders.

3. Contracts are entered into with entities for the provision of enrollment information, other notifications, and personal health records in alternative formats (e.g., Braille, large font, CD), plain language, and Medi-Cal threshold languages to persons with various disabilities and Limited English-speaking (LEP) persons, and methodologies have been developed for the prior identification of individuals with these effective communication needs, as well as for meeting alternative format, LEP and plain language requests made after standard print materials have been sent.[1]

4. Establishment of marketing rules around the demonstrations, including rules about how non-demonstration plans market to potential demonstration participants and review of plan marketing materials.

5. Comprehensive outreach plan for beneficiary and provider outreach, including specific materials for persons in nursing and group homes and their families and nursing and group home providers.

Services and Benefits:

6. Finalized actuarially-sound rates and contracts between the Department and participating health plans so that plans can effectively plan to outreach and enroll network providers, and benefit packages can be established. The rating methodology,

[1] These criteria must be applied to all informing and educational materials to beneficiaries and therefore will not be repeated.

final rate amounts, and plan contracts must be posted on the DHCS website and readily available to the public.

7. Contracts in place between plans and providers (including agreements with county agencies).

8. Establishment of Network Adequacy Standards for medical care and long-term supports and services. For example, access to primary care, specialty care, and community-based services in the communities where duals reside.

9. Contract in place and funding for an independent ombudsman program with experience advocating for individual duals' access to Medicaid and Medicare medical services and LTSS, and which also includes a component for peer support.

10. Description of the benefits package of services (including vision and dental, behavioral health services and supports, and long term service and supports) that will be available to beneficiaries to assist in plan selection and how they may access services (through consumer-choice) in the pilot's assessment and care planning process.

11. Uniform and consumer-friendly materials and process to inform seniors and persons with disabilities of co-pays and covered services so that beneficiaries can make informed choices about plan selection.

<u>Network Adequacy, Care Continuity, and Enrollment:</u>

12. In non-COHS counties, description of the process to automatically assign beneficiaries (who do not self-select) into health plans, which will include a requirement to consider Medicare service utilization, provider data, and consideration of plan quality (aka: "algorithm for assignment" and "intelligent assignment").

13. Description of the processes that plans will use to assign individuals to primary care physicians and to identify persons as candidates for care coordination.

14. Enrollment process has been developed that accounts for all the unique potential outcomes for each individual including interaction with Medicare Advantage and Part D enrollment (i.e. enrollment system mapping); and enrollment computer systems and data exchanges have been programmed and tested.

15. Identification of dedicated State staff with adequate training and availability during extended business hours to trouble-shoot between health plans and beneficiaries, and a requirement that plans have similar points of contact and be required to respond to state inquiries when care continuity issues arise. There should also be a tracking mechanism for complaints for quality assessment purposes, with information posted publicly on types of issues arising and resolution.

16. Preparation of scripts and training of CMS, state and plan customer service representatives on all aspects of the demo; training of enrollment brokers and CBOs on rules of enrollment and how to counsel beneficiaries.

17. Effective care continuity process: A requirement for all plans to establish, before enrollment, a continuity of care (COC) process for all dual eligible enrollees that will be

automatically extended and will apply for the first 12 months that the dual eligible member is newly enrolled in a plan, with respect to primary, specialist, and critical ancillary providers (e.g., DME seating specialists) that are treating newly enrolled members as of the time of enrollment, as long as the treating physician will accept payment at his or her current rates from the plan and meets plan quality standards. As part of its COC process, the plan must establish procedures to facilitate in-plan specialist referrals, prescriptions, laboratory services, surgical facilities, and other service requests from out-of-plan providers who are treating members for COC purposes, and COC providers must be informed of these referral procedures. This must also include a process for the plans to notify members who receive COC of this fact, and be given plan information about how to see out-of-network providers, as well as information about how to make a Medical Exemption Request (MER).

Care Planning, Assessment, Coordination, Service Access, and Accessibility:

18. Standards developed and articulated for the assessment and care coordination process that will be required of all health plans to ensure consistency across health plans and across counties. This includes the development of standardized tools and processes as well as requirements for who can perform these tasks. The standards will explain the role of the health plan, county IHSS, Public Authorities, MSSP, Behavioral Health, and other LTSS providers in the process. The standards must also include minimum caseload requirements for health plans.

19. Policy developed for health plans to follow related to consumer choice in the care planning, assessment and care coordination process. These standards should affirm the rights of the consumer and his/her representative to accept and voluntarily participate in the care coordination/planning process (and the right to decline these services if desired by the consumer).

20. Clear policy guidelines that must be followed by the health plans to enforce beneficiary rights to determine their providers and care settings (e.g., home care, ADHC, nursing facility for NF eligible beneficiaries), with training curriculum for health plans and hearing officers to ensure that enrollees are informed of and can use these rights in accordance with civil rights laws, including the Olmstead decision.

21. Health Plan network standard which provides for discharge planning, and which provides for discharge planners who have been trained to understand LTSS and how to secure those services for beneficiaries (including how to work with county social workers and PA registries).

22. Requirement for plans to conduct physical and programmatic accessibility reviews of their provider networks, conduct staff trainings related to increasing disability and linguistic cultural awareness, and establish goals relating to increasing plan and provider capacity to provide reasonable accommodations and policy modifications.

Beneficiary Protections:

23. A unified notice, grievance and appeals process is defined and articulated to health plans 6 months prior to first enrollment, with training of administrative law judges, health plans, and ombudsmen completed within 30 days of first enrollment. Notices must include specific facts and reasons for any adverse determinations. Materials explaining

the appeals process to beneficiaries must be prepared and distributed to enrollees prior to enrollment.

24. For persons who are automatically enrolled (and who do not self-select into a plan or opt out), issuance of policy required to be followed by all plans that provides for the automatic approval of claims for COC outside of the plan with existing providers for 12 months.

25. Guidelines for health plans to allow for immediate disenrollment by the client due to lack of availability (including timeliness) of needed services or providers or based on other good cause. Guidelines must be developed with stakeholder input and be consistent with state and federal law.

Oversight and Evaluation:

26. An evaluation of the capacity of each potential participating plan and its ability to meet all program requirements completed 60 days prior to the first start date of enrollment, and provided to the Legislature no later than 30 days prior to enrollment.

27. Articulation of the various state agencies and the EQRO, and the resources required, in monitoring and oversight of the demonstrations, and a report to the Legislature in the Governor's proposed January State Budget of these roles and any additional resources that may be necessary.

28. Quality measures to be used to evaluate the demonstrations, including the measures to be used to distribute the amounts withheld from the capitated rate, and the triggering point for requiring protocols/remedies or other corrective action measures where one of the pilot plan participants fails to meet the outlined requirements. Quality measures must also be detailed enough to enable measurement of the impact of auto-plan selection on quality of care.

29. Development of plan reporting requirements including enrollment/disenrollment numbers, appeals/grievance information, data necessary to evaluate quality measures, care coordination models, and so forth. Reporting requirements must include provisions requiring all plan reports to be made available to the public, including the Legislature, and affirming that plans are subject to the California Public Records Act.

30. Data collected across plans must be compatible with each other and with DHCS data requirements, and DHCS must have the capability to gather, analyze and act on evaluation data in real time.

31. Plans for ongoing and appropriately incentivized stakeholder engagement.

Respectfully submitted by:

AARP

California Council of the Blind

California IHSS Consumer Alliance

Disability Rights California

Disability Rights Education and Defense Fund

National Health Law Program

National Senior Citizen Law Center

State Council on Developmental Disabilities

Western Center on Law and Poverty