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 with disabilities[2] are apparently required to give up their entitlement to establish

[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.

[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

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.

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

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people with disabilities who would not qualify for the MSSP waiver, despite needing a nursing facility level of care.

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

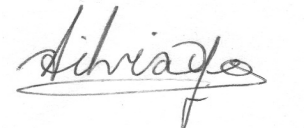
- The Additional HCBS policy must clarify that additional HCBS services encompass the full gamut of AL and NF/AH waiver services.
- Plan Assessments, LTSS assessment tools, and HCBS recommendations must operate on the basis that the full gamut of HCBS services is available to all member beneficiaries 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,



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