LTSS Network Adequacy Standards
December 10, 2012

Organization: AARP California
Contact Name: Casey Young
E-Mail: cyoung@aarp.org

Page	Section Title	Existing Text	Comment or Suggested Edit
General Comments	N/A		There is trade-off between standards that are prescriptive, providing plans, providers and beneficiaries certainty as to what is expected, and standards that provide more flexibility for plans to fashion policies and procedures that mesh well with their existing culture and operations. These proposed standards are too flexible, leaving considerable uncertainty for all impacted parties as to how the state will view the adequacy of the plans' required policies and procedures. Where the proposed standards are implementing a statutory, regulatory, or contract requirement or other authority, it should be cited in the document. In order to make this set of standards work effectively, there needs to be a strong incentive for plans to determine the appropriate services, and expeditiously resolve disputes over the level of care and services needed. They should not be allowed to terminate services in the current setting until a final determination is made that a change is warranted.

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Page	Section Title	Existing Text	Comment or Suggested Edit
Page 2	Provider Network and Contracting	"3. Policies and procedures to receive consent from IHSS recipients or their authorized representatives…"	This should be stated in more neutral terms. The point of the statute was that it should be the choice of the recipient. This reads as if the duty of the plan is to obtain consent. It should instead read something like: " to determine whether the recipient desires to have their IHSS provider involved in care planning or coordination, and if so, obtain express consent from the recipient or his or her authorized representative."
Page 2	Provider Network and Contracting	5. Policies and procedures for an expedited referral..	This is an example of where more specificity is appropriate. There should be uniform expectation of when an expedited referral is appropriate and what should be done in what time frame.
Page 2	Provider Network and Contracting	1. Policies and procedures to evaluate and document, on an annual basis, the amount of time…"	This is another example of where more specificity is appropriate. There should be a uniform expectation communicated to the regulated public and beneficiaries as to how quickly referrals are made and services received.
Page 3	Provider Network and Contracting	6. "…when such services are available in the county.	This is an inappropriate qualifier. County lines should not bar such services if reasonably available in the area.
Page 5	Provider Network and Contracting	5. "…sufficient number of facilities…"	This should be amended to specify that there should be a sufficient number of both post-acute and long term care facilities, and to require that the plans provide their analysis of

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			how they determined how many of each type of facility is needed to determine sufficiency. Even better would be if the standards specified how the analysis is to be done.
Page 5	Provider Network and Contracting	5." …outside of their target service areas."	This should be amended to read: "…outside of their target service areas or contracted network."
Page 6	Provider Network and Contracting	"…shall have a process to train care coordination staff…"	This is another example of where more specificity is appropriate. The effective training of care coordinators on LTSS issues is key to the success of this entire demonstration, and is something that the participating health plans have n real experience doing. There should be considerably more specificity to this requirement.
Page 6	Financial Information/Claims Processing	2. "…within a defined time frame…"	This is another example of where more specificity is appropriate. There should be a uniform expectation communicated by the state as to how long it should take to resolve these disputed claims, and should include an effective enforcement mechanism.
Page 8	Provider Relations	1. "…for securing authorization…"	This should be stated in more neutral terms. The point of the statute was that it should be the choice of the recipient. This reads as if the duty of the plan is to obtain authorization. It should instead read something like: " to determine whether the recipient desires to have

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			their IHSS provider included as part of the Interdisciplinary Care Team, and if so, obtain express consent from the recipient or his or her authorized representative."

Comment Template for LTSS Network Adequacy Standards
Due December 10, 2012

Organization: Aging Services of CA
Contact Name: Jack Christy
E-Mail: Jchristy@aging.org

Page	Section Title	Existing Text	Comment or Suggested Edit
General Comment			Thank you for the opportunity to comment on the draft LTSS Network Adequacy Standards. These standards are not clear and they are incomplete. Much more work needs to focus on how Plans intend to provide the services people need to stay safely in their homes.
1.	1st paragraph	In addition, the State is developing policy guidance on Home- and Community-Based Services (HCBS) "In-Lieu of" Benefits, as outlined in Welfare and Institutions Code Section (WIC) 14186.1(c); that guidance will supplement the standards below.	The promised policy guidance: HCBS In Lieu of Benefits must be available in order to develop LTSS Standards. Further comment on these standards must be able to consider the HCBS policy guidance before promulgating elucidating standards.

Comment Template for LTSS Network Adequacy Standards
Due December 10, 2012

Organization: Aging Services of CA
Contact Name: Jack Christy
E-Mail: Jchristy@aging.org

Page	Section Title	Existing Text	Comment or Suggested Edit
5.	Provider Network and Contracting – Nursing Facility/Sub-Acute Care Facilities	Policies and procedures to ensure members have opportunities to transition from nursing facility to community settings, as specified in the Care Coordination Standards.	Should be clear that Plans are ultimately responsible for transitioning members from nursing facility to community settings. If such a transition is not possible for whatever reason, the Plan is responsible for paying the cost of care where the member is, not where the member ought to be. Moreover, resources must be available to clean apartments, turn on water and electricity, etc. to make transition to the community possible.

Comment Template for LTSS Network Adequacy Standards
Due Dec 10, 2012

Organization: Alzheimer's Association
Contact Name: Theresa M. Renken
E-Mail: theresarenken@caalz.org

Page	Section Title	Existing Text	Comment or Suggested Edit
General Comment			We sincerely appreciate the opportunity to provide comments on the proposed Care Coordination Standards. Yet like many other organizations, we believe more time is needed to provide the appropriate level of input for such important public policy.
1	Provider Network and Contracting	"For IHSS, Health Plans shall meet the following: 1. Effective February 1, 2013, an executed Memorandum of Understanding (MOU) with county agencies that reflects an agreement between the Health Plan and 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."	As written, this requirement is unclear. What happens at the end of the first year? Does the MOU become obsolete, or do Health Plans and county agencies build upon the MOU in years two and three?
3	Provider Network and Contracting	"For CBAS, Health Plans shall meet the following: Policies and procedures to arrange, and show availability of providers for, unbundled services for Health Plan 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' cultural and linguistic needs."	Suggested language change: "Policies and procedures to arrange, and show availability of providers for, unbundled services for Health Plan 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." (emphasis added)
3	Provider Network and Contracting	"For CBAS, Health Plans shall meet the following:	This seems to suggest that if linguistically and culturally competent CBAS services are not

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Organization: Alzheimer's Association
Contact Name: Theresa M. Renken
E-Mail: theresarenken@caalz.org

Page	Section Title	Existing Text	Comment or Suggested Edit
		6. Policies and procedures that Health Plans are able to provide linguistically and culturally competent CBAS services when such services are available in the county."	available in the county, than Health Plans are ***not*** required to provide such services to Members. Is this the intent of the language? Also, we would suggest the following change to language: "Policies and procedures that Health Plans are able to provide *cognitively*, linguistically and culturally competent CBAS services when such services are available in the county." (emphasis added)
3-4	Provider Network and Contracting	"Such training shall include the components of medical and social services care planning for members needing LTSS, 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 the Health Plan's policy and procedures for referring members to MSSP for assessment and eligibility determination."	None of the readiness criteria ask the plans to provide dementia-capable care management to beneficiaries. Yet, there is literature that supports "dementia care management" as a standard of care for quality care. Furthermore, there is some evidence that dementia care management reduces the use of more expensive hospital and nursing home services. Reference to this readiness criterion could be integrated into the item on training. We would suggest the following change to language: Such training shall include the components of medical and social services care planning for members needing LTSS, an overview of the characteristics and needs of MSSP's target population, MSSP's eligibility criteria,

Page	Section Title	Existing Text	Comment or Suggested Edit
			assessment and reassessment processes, services, and service authorization process, and the Health Plan's policy and procedures for referring members to MSSP for assessment and eligibility determination. *Due to the growing number of patients who will have cognitive impairment and due to their special needs, care managers shall have training in dementia care management including but not limited to: understanding dementia, its symptoms and progression; understanding and managing challenging behaviors and communication problems caused by dementia, caregiver stress and its management; and community resources for patient and caregiver.*" (emphasis added)
5	Provider Network and Contracting	"For NF/SCF, Health Plans shall meet the following: 3. Evidence of orientation and training programs for registered nurses, other clinical personnel, and appropriate Health Plan staff, directly employed or contracted, to conduct utilization management and community care transition for plan members. This training shall include, but not be limited to incorporating the core concepts of the Olmstead Decision, i.e. serving members in the least restrictive settings as appropriate, as well as criteria for safe transitions, transition planning, and care plans after transitioning."	Considering their complex medical needs, we believe this section should include language that requires training for understanding the needs of people with dementia and Alzheimer's disease, as well as criteria for safe transitions for this population.

Comment Template for LTSS Network Adequacy Standards
Due Dec 10, 2012

Organization: Alzheimer's Association
Contact Name: Theresa M. Renken
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Comment Template for Long-Term Services and Supports Standards

Organization: Alzheimer's Advisory Committee (DHSS)

Due December 10, 2012

Contact Name: Sherrie Matza
E-Mail: shermatza@aol.com

Page	Section Title	Existing Text	Comment or Suggested Edit
3	CBAS	#3 Policies and procedures to arrange, and show availability of providers for, unbundled services for Health Plan 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' cultural and linguistic needs.	"…or cannot meet members' cultural and linguistic needs, or unique needs of an Alzheimer's or other dementia member."
3	CBAS	#6 Policies and procedures that Health Plans are able to provide linguistically and culturally competent CBAS services when such services are available in the county.	."…. Health Plans are able to provide linguistically, culturally and dementia competent CBAS services when such services are available in the county.
4	MSSP	#2 Documentation that Health Plans have developed and will conduct a benefit orientation and training program specific to MSSP for staff or contractors to act as care managers for members. The Health Plan also provides documentation that they have trained personnel of	….The Health Plan also provides documentation that they have trained personnel of MSSP organizations to the Health Plan's covered benefits and policies and procedures to access services and coordinate care, as well as training in needed services for persons with Alzheimer's or other dementias.

Comment Template for Long-Term Services and Supports Standards

Organization: Alzheimer's Advisory Committee (DHSS)

Due December 10, 2012

Contact Name: Sherrie Matza
E-Mail: shermatza@aol.com

Page	Section Title	Existing Text	Comment or Suggested Edit
4	MSSP	#6 Health Plans shall provide documentation of having developed policies and procedures governing MSSP assessment and eligibility determination as part of the Health Plan's care coordination.	…governing MSSP assessment and eligibility determination as part of the Health Plan's care coordination. Such assessment must include assessment for cognitive function.
5	NF/SCF	#3. Evidence of orientation and training programs for registered nurses, other clinical personnel, and appropriate Health Plan staff, directly employed or contracted, to conduct utilization management and community care transition for plan members. This training shall include, but not be limited to incorporating the core concepts of the Olmstead Decision, i.e. serving members in the least restrictive settings as appropriate, as well as criteria for safe transitions, transition planning, and care plans after transitioning.	There shall also be specific training on the unique needs of the Alzheimer's/dementia population and what is required in a variety of settings – e.g. determination if delayed egress is necessary.
7	Management Info. Sys.		ADD: Ensure records and systems have method to code member with Alzheimer's/dementia if that is not the primary diagnosis.

Comment Template for Long-Term Services and Supports Standards

Due December 10, 2012

Organization: Alzheimer's Advisory Committee (DHSS)

Contact Name: Sherrie Matza

E-Mail: shermatza@aol.com

Angela Gardner

This is my public comment regarding the proposed long term services and supports network standards. Thank you for your consideration.

1. I am glad that CMS is overseeing the DHCS Health Plan Readiness review plan and that these standards will be included. However, will this plan be ready and all Health Plans be thoroughly reviewed before the demostration start date: March 2013? I am concerned it will not.

2. **IHSS Standards**

How will IHSS be prepared for an increase in workload for dealing will multiple Health Plans?

Will more case workers be hired? Will each county office have a Health Plan Coordinator to assist staff to integrate multiple health plans into their existing programs and services? The standards need to be more specific and clear about that.

I am concerned about the proposed standards allowing each Health Plan develope separate policies and procedures with IHSS. The DCHS should be more specific in their standards with the policies and procedures Health Plans should have. It should be one set of policies and procedures for all Health Plans.

3. These standards add more bureaucracy to CBAS and LTSS not make it simpler the way the original demostration proposal claimed it would.

4.**CBAS**

The Eligibility Standard should be one standard developed by DHCS for Health Plans for contracting with CBAS Centers. The current proposed standard gives Health Plans too much freedom to delay and deny services to members. It leaves it up to Health Plans to regulate themselves. How will CBAS center staff be able to track each Health Plan's policies and procedures as well as provide their services as well to dual eligilbles?

5. **Zip code standards for CBAS and MSSP**

What happens if Health Plan zip codes do not match MSSP and CBAS zip codes? I hope this standard includes members zip codes and not only the Health Plan regional offices. This is not clear in the standards.

6. **MSSP Care Coordination Standard**

MSSP may have a different care coordination program for every health plan. DHCS should establish the Care Coordination Model and instuctions for Health Plans and MSSP's. This current standard is not good for dual eligibles or MSSP staff because it increases their workload.

7. **Member Services Standard**

The current proposed standard is very non specific and health plans could give agencies with contracts and members the run around. It's not enough to just have a Health Plan available to answer questions if they do not have specific information contractors and members need in one place.

Comment Template for LTSS Standards
Due December 10, 2012

Organization: Anthem/CareMore
Contact Name: Kathryn Duarte
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Page	Section Title	Existing Text	Comment or Suggested Edit
2	Provider Network and Contracting	5. Policies and procedures for an expedited referral, when appropriate, to county social services agencies for a member who is at risk for out-of-home placement, and may qualify for IHSS services.	Will the state will also require that the county social services agencies have an expedited process for determination and authorization of IHSS hours when a member is at risk of out of home placement?
2	Provider Network and Contracting	j Continuing to perform other functions as necessary, as defined by statue and California Department of Social Services (CDSS) regulation, for the administration of the IHSS program.	Suggested edit: "j. 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."
6	Financial Information/ Claims Processing	For IHSS, the details of claims processing and funding sources and mechanisms will be detailed in a contact between DHCS, CDSS, and Health Plans.	Suggested edit: "For IHSS, the details of claims processing and funding sources and mechanisms will be detailed in a *contract* between DHCS, CDSS, and Health Plans."
6	Financial Information/ Claims Processing	Provide assurance that, through December 31, 2014, they shall allocate to their contracted MSSP organization(s) the same level of funding as those organizations otherwise would have been allocated under their MSSP contract with the California Department of Aging (CDA).	DHCS should clarify basis for "level of funding" – assume this refers to rates per hour/unit/service, fee schedule, or PMPM rates. The concern is that it could be interpreted as meaning a guarantee of the MSPP organization's historic annual level of funding. And how does DHCS believe these arrangements will change beginning in 2015?
7	Quality Improvement System	3. Demonstrate, at minimum, contracts with all CBAS centers that meet State licensure requirements for adult day health care centers and Medi-Cal certification requirements for CBAS providers, without any encumbering sanctions or citations.	Suggested edit: 3. Demonstrate, at minimum, contracts with all CBAS centers that *accept the state fee schedule*, meet State licensure requirements for adult day health care centers and Medi-Cal certification requirements for CBAS providers, without any encumbering sanctions or citations.

Comment Template for Care Coordination Standards Organization: Bet Tzedek legal
Due Dec 10, 2012 Contact Name: Kim Williams
E-Mail: kwilliams@bettzedek.org

Page	Section Title	Existing Text	Comment or Suggested Edit
4	MSSP		Use of MSSP waiver institutional deeming rules and how consumer can access this.
4.	No section on NF subacut and hospital waiver		Concerned that there is n section o Nursing Facility Waivers. Why not?

Comment Template for Care Coordination Standards

Due Dec 10, 2012

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

Page	Section Title	Existing Text	Comment or Suggested Edit

Comment Template for Care Coordination Standards Organization: Congress of California Seniors
Due November 27, 2012 Contact Name: Gary Passmore
E-Mail: garyp@seniors.org

Page	Section Title	Existing Text	Comment or Suggested Edit
General			Some sections that implement legislation refer to the statutory section but others do not. It would be helpful if that was done consistently in both documents.
General			Do these provisions cover only contracted plans, or d they cover the subcontracted plans in LA County? Please include clarifying language.
General			Why are provisions for each of the LTSS so different? We believe where similar processes are being described for IHSS, MSSP, and CBAS, the wording should be identical.
1	Provider network and Contracting	Effective February 1…	This covers the first year. What about years two and three when the current structure is still in place. Does this need to be renegotiated three times?
2	Same section; item 3	Policies and procedures…	Policies and procedures to determine whether IHSS recipients want themselves or representatives involved in care planning. If so, policies and procedures to engage recipients or their authorized representatives. To include providers in care planning or coordination.
2	Same section; item5	Policies and procedures…	Is there a citation for this? An all-county letter? How does this work? Are policies and procedures o a plan-by-plan basis or should they be statewide?
2	Same section; item 6	Policies and procedures…	The wording is cumbersome. Do you mean lack of sufficient authorized hours to allow provider to get to recipient who is geographically isolated? Is this only for agencies and not other caregivers on the registry?

Comment Template for Care Coordination Standards Organization: Congress of California Seniors
Due November 27, 2012 Contact Name: Gary Passmore
E-Mail: garyp@seniors.org

Page	Section Title	Existing Text	Comment or Suggested Edit
3	For CBAS; item 2	Policies and procedures	Does WIC 14550(h) allow more than 60 minutes?
3	For CBAS; item 3	Policies and procedures	What are these providers (examples)? Where do they exist?
4	For CBAS; item 4	When establishing…	Does this reflect changes being developed to create new procedures for medical necessity?
3	For CBAS; item 5	Documentation of having…	Reference should be to "willing" CBAS centers
3	For CBAS; item 6	Policies and procedures	Just in the same county? Why is this different from item 5 on page 5?
3	For CBAS; item 7	Documentation of having…	"to collaborate with CBAS centers is a poor phrase. Just leave it out: Policies and procedures to conduct annual reviews…
3	For CBAS; general		Should there be section directing plans to share authorizations and records between plans when an individual switches?
3	For MSSP; general		Some of these items are vaguely worded.
3	For MSSP; item 1	Effective May 1…	What happens when there are eligible people but n more MSSP slots? Are the number of slots increased (there is room for more under existing waiver)?
4	For MSSP; item 3	Documentation that the plan…	What is meant by "appropriate referral"?
4	For MSSP; item 4	Policies and procedures…	This is poorly worded. What is meant by "establishing and convening…recommendations of MSSP organizations"?

Comment Template for Care Coordination Standards Organization: Congress of California Seniors
Due November 27, 2012 Contact Name: Gary Passmore
E-Mail: garyp@seniors.org

Page	Section Title	Existing Text	Comment or Suggested Edit
4	For MSSP; item 7	Health Plans…	Isn't this the same as item 1 on page 3? If not re-word to clarify the distinction.
5	For NF/SCF; General		Should plans have roster of who seeks to transition out of a snf in their county?
5			Should plans be expected to make resources available to establish an individual's household to allow discharge?
5	For NF/SCF; item 2	Policies and procedures…	Insert the words "to develop a plan" after Policies and procedures and to ensure.
5	For NF/SCF; item 3	Evidence of orientation…	Include training on state elder abuse liability laws governing snf patients and existing state procedures for oversight/reporting for snfs.
5	For NF/SCF; item 5	In contracting with…	Should there be distinction between types of facilities? Some are providing post acute transitional care and some are providing long term care. Do you want just those who do both? What is meant by "a sufficient number of facilities"?
5	For NF/SCF; item 7	When contracting with…	How do these mesh with existing standards and requirements for oversight by the state and federal governments? Are these separate? You should include reference to relevant sections of state law on oversight and reporting by snfs.
6	For all LTSS	Health Plans shall…	The Massachusetts readiness tool has good statement in care coordination section that could be incorporated here.
6	For all LTSS		The sentence would be stronger by inserting the words "person centered" after on and before LTSS.

Comment Template for Care Coordination Standards Organization: Congress of California Seniors
Due November 27, 2012 Contact Name: Gary Passmore
E-Mail: garyp@seniors.org

Page	Section Title	Existing Text	Comment or Suggested Edit
6	Financial Information/Claims Processing; item1	Documentation that they have…	Is there a 45 day timeline in statute, not just "timely fashion"? Should that be here with citation?
6	Financial Information/Claims Processing; item2	Policies and procedures	Why not MSSP and other providers?
6	Financial Information/Claims Processing; item4	Documentation of the…	Will this apply to all providers? Cite statute.
6	Financial Information/Claims Processing; general		Will all plans be expected to have capacity for electronic funds transfers for payment, not just paper?
7	Quality Improvement System; For IHSS	Policies and procedures…	Does this apply to Year 1 or all three years? Should you include details of requirements of CDSS?
7	Quality Improvement System; For CBAS	General	Would it be better for state to handle quality assurance to avoid conflicts of interest or skewed reporting by plans?
7	Management Information For MSSP; item 2	Evidence of having…	What, exactly, is the reference to "clinical data"? Is this medical and not functional. It should include both and be so stated.
8	Quality Improvement System; For NF/SCF and 2	Evidence of…	How does this work with existing monitoring and oversight by state and federal agencies?
9	Member Services; item 2	Policies and procedures…	This needs to be amplified. Will plans be expected to have an ombudsman function? Will they have member advisory groups? Will they make public complaints? Do they have timely resolution standards? Will they be required to inform members about state Medi-Cal Ombudsman or DMHC call center?

Comment Template for LTSS Readiness Standards
Due December 10, 2012

Organization: California Association for Adult Day Services
Contact Name: Lydia Missaelides
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GENERAL COMMENTS	
Thank you for the opportunity to provide input and comments on the proposed network readiness standards. Our comments are intended to help the department improve the clarity, consistency and readability of the standards. As the only LTSS provider already mandated as a CCI benefit and working with Plans in advance of the CCI, the experience of the CBAS community should be instructive in understanding and identifying key elements of readiness.	
SCAN Fndn	*We support the comments provided by the SCAN Foundation.*
Cite to law and regulations	*Provide citation to law or regulation. Sometimes the source is referenced and most often, not. This would help connect the standards to the source requirement. Perhaps this could be an index rather than included in the document itself.*
Order of statements	*Re-order the lists in a more logical flow/sequence.*
State Readiness	*CMS should provide oversight to determine state readiness and capacity of Managed Care enrollment contractor, Ombudsman call center; beneficiary enrollment and counseling systems, data sharing systems (TAR, payment etc.), CCI specific websites, rapid problem resolution teams, to name a few.* *The known problems experienced by CBAS eligibles, who are in Medi-Cal managed care but retain Medicare Fee for Service will be multiplied by tens of thousands beneficiaries as they move in and out of the Demonstration with their Medicare benefit. Continuity of care problems experienced by the CBAS beneficiaries in 2012 need to be understood and systems put in place to ameliorate these problems prior to launch of the CCI.*
Continuity of Care	*Strengthen continuity of care problem solving during the transition or as people move their Medicare benefit into and out of the demonstration, and identify a rapid resolution team at each Plan to resolve problems created by enrollment, assignment to a Plan doctor or IPA for those who remain in Medicare Fee for Service, resistance by non-contracted providers to coordinate benefits, and other problems affecting the health and safety of the Member, whether in or out of the Demonstration.*
Statewide Consistency	*Identify areas where statewide policy and procedures are beneficial and convene small working groups to design.*

Comment Template for LTSS Readiness Standards Organization: California Association for Adult Day Services
Due December 10, 2012 Contact Name: Lydia Missaelides
E-Mail: lmissaelides@caads.org

Page	Section Title	Existing Text	Comment or Suggested Edit
2	**Provider Network and Contracting CBAS**	1. Policies and procedures to evaluate and document, on an annual basis, the amount of time that elapses between when a member is referred for CBAS services, and when those services are received.	***This section overlaps with #4. Combine and clarify wording. We recommend the following edits:*** 1. Policies and procedures to evaluate and document, on an annual basis, the amount of time that elapses between when a member is referred for CBAS services through self-referral, family members, CBAS Centers, physicians, other Health Plan staff and providers, health care and social services providers, or other community-based organizations and when those services are ~~received~~ authorized by the Plan. (moved from #4)
3	**Provider Network and Contracting CBAS**	2. Policies and procedures to ensure that Health Plan members' total one-way transportation time between home and the CBAS centers does not exceed 60 minutes each way, to ensure compliance with WIC 14550(h).	***The statement is in error. WIC 14550(h) permits more than 60 minutes travel time. However, intent is unclear. Why is this one rule highlighted among all the rules that CBAS has to follow? Recommend striking section as it is not apparent why this is necessary in this document, conflicts with law, and does not further advance readiness of the plans.*** ~~2. Policies and procedures to ensure that Health Plan members' total one-way transportation time between home and the CBAS centers does not exceed 60 minutes each way, unless more time is necessary to ensure regular and planned attendance and there is documentation in the participant's record that there is no medical contraindication, to ensure compliance with WIC~~

Page	Section Title	Existing Text	Comment or Suggested Edit
			~~14550(h).~~
3	**Provider Network and Contracting CBAS**	4. When establishing eligibility for CBAS services, the Health Plan follows all regulatory timelines for intake, assessment, and authorization of services. Policies and procedures to ensure compliance with designated time-frames for completing determinations of members' eligibility for CBAS center services, upon referrals by members themselves, family members, CBAS Centers, physicians and other Health Plan staff and providers, health care and social services providers, or other community-based organizations.	***Accuracy, clarity and redundancy. First sentence is redundant of existing requirement, and does not follow the pattern for all other sections. The document asks for evidence of policies and procedures. Last sentence is not necessary here. We recommend the following edits and moving the stricken language to #1 (see edit for #1)*** ~~4. When establishing eligibility for CBAS services, the Health Plan follows all regulatory timelines for intake, assessment, and authorization of services.~~ Policies and procedures to ensure compliance with designated <u>contracted</u> time-frames for completing determinations of members' eligibility for CBAS center services, and authorizing or denying services. ~~upon referrals by members themselves, family members, CBAS Centers, physicians and other Health Plan staff and providers, health care and social services providers, or other community-based organizations.~~
3	**Provider Network and Contracting CBAS**	5. Documentation of having contracted with all CBAS centers within the Health Plan's covered zip code areas and in adjacent zip codes accessible to members.	***Clarity. Some centers may not be willing to contract and the edit clarifies that the requirement is for the centers to be licensed <u>and</u> certified. Also need policy for how to address loss of contracted center capacity to serve members. We recommend the following edits:***

Page	Section Title	Existing Text	Comment or Suggested Edit
			5. Documentation of having contracted 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	**Provider Network and Contracting CBAS**	6. Policies and procedures that Health Plans are able to provide linguistically and culturally competent CBAS services when such services are available in the county.	***Clarity. This sentence is confusing as written so the intent is not clear. The Plan does not provide CBAS services but it offers and authorizes CBAS to its members, so re-write makes clear the intent is to be able to identify the centers within the Plan's area and make them available by referral/authorization. Suggest that the plans' also inventory the other specialty services offered such as DD, Alzheimer's, Behavioral Health, Stroke, etc. We recommend the following edits:*** 6. Policies and procedures demonstrating that Health Plans are able to identify and ~~provide~~ offer to the Member linguistically and culturally competent CBAS services ~~when~~ where such services are available ~~in the county.~~ within the Health Plan's covered zip code areas and in adjacent zip codes accessible to members.
3	**Provider Network and Contracting**	7. Documentation of having established policies and procedures to collaborate with	***Clarity and duplication. Mixes up L&C status and sanctions, under state control, with identification of areas of improvement that the Plan and Centers can identify and***

Page	Section Title	Existing Text	Comment or Suggested Edit
	CBAS	CBAS centers to conduct annual reviews of their contract arrangements, licensing and credentialing status, and areas of collaboration and improvement.	***collaborate to enact. The state should design a system for notifying Plans when a center has had their license or certification revoked since it happens rarely, the Plans should not have to track down this information. The plans may want to ask for annual updates in status of Center key staff, Board members etc or ask the state to provide such information since the centers need to provide to the state.*** 7. ~~Documentation of having established~~ Policies and procedures ~~to collaborate with CBAS centers to conduct annual reviews of their~~ for establishing, convening, and considering the recommendations of CBAS organizations and providers during the annual reviews of their contract arrangements, ~~licensing and credentialing status~~, and for the purpose of identifying additional areas ~~of~~ for collaboration and improvement.
New	**Provider Network and Contracting CBAS**	New #8	***The CBAS experience did not include a readiness review and many plans were not able to sufficiently and timely train all staff on the new program and internal systems that were being adapted to accommodate CBAS providers and members. This led to delays in obtaining accurate answers or, worse, Plan members being provided inaccurate information about being assigned to a Plan doctor, for example. Training is a key component of readiness. We recommend the following new language***

Page	Section Title	Existing Text	Comment or Suggested Edit
			8. Documentation that Health Plans have developed and regularly conduct CBAS specific orientation and training programs for Plan staff and contractors who are responsible for CBAS eligibility, authorization and claims processes, member and provider services. Training shall include the Health Plan's policy and procedures for screening and referring members to CBAS, components of the CBAS Eligibility Determination Tool, an overview of the characteristics and needs of CBAS target population, eligibility criteria, service authorization process, assessment and reassessment process, coordination of benefits for the dually eligible, the CBAS 3-day assessment process, CBAS Individual Plan of Care and how the Plan will coordinate with the CBAS MDT, especially for those CBAS patients for whom the Plan is responsible for convening an ICT to develop an Individual Care Plan.
New	**Provider Network and Contracting CBAS**	New #9	***Title 22 requires CBAS centers to develop individualized plans of care (IPCs) after the members of the multi-disciplinary team conduct a thorough 3-day assessment. This effort must rely, in part, on information obtained by the Plan in determining eligibility and medical necessity for the shared member. It is critical that there are P&Ps in place***

Page	Section Title	Existing Text	Comment or Suggested Edit
			to define how communication will occur on behalf of the member and how care will be coordinated between the Plan and the CBAS center, with clarity of roles and responsibilities of each to avoid duplication of effort or working at cross-purposes. Clear and timely communication is critical. We recommend the following language: 1. Documentation of policies and procedures governing how the Health Plan will make referrals to CBAS, definition of the channels of communication, and how the Member's health information will be shared and coordinated between the Plan and the CBAS center. 2. Documentation of how the Plan has worked in collaboration with CBAS organizations and contracted providers to develop protocols for coordinating the Member's ICT with the CBAS Multi-Disciplinary Team, and delineating roles and responsibilities among the entities.
New	**New**	New #10	***The Darling v Douglas settlement requires plans to have in place a mechanism to authorize CBAS on an expedited basis for those who are currently in a hospital or nursing facility or who are at immediate risk for admission to a nursing facility. Suggest adding the following language that similar to that found in the IHSS section.***

Page	Section Title	Existing Text	Comment or Suggested Edit
			1. Policies and procedures for an expedited authorization for CBAS admission for a member who may qualify for CBAS services and who is currently in a hospital or nursing facility or is at immediate risk for out-of-home placement.
6	**Financial Information/ Claims Processing**	1. Documentation that they have incorporated mechanisms into their claims processing systems to pay contracted CBAS centers and NF/SCFs in a timely fashion; consistent with regulatory timeframes established for all other contracted Health Plan providers.	***The CBAS experience demonstrated inadequate readiness on the part of both CBAS providers and Plans to submit and process claims, respectively. Insufficient or no testing of claims systems was done in advance of the launch date. Training was not conducted in a timely manner. LTSS providers generally are not accustomed to billing multiple payors, each with differing standards. The complexities of the duals population and interaction of managed care with Medi-Cal managed care created many problems that should have been anticipated had the state provided clearer directions about readiness expectations.*** ***There also needs to be an alternative way to issue advance payments to LTSS providers if claims cannot be paid in a timely manner and the LTSS provider is experiencing a cash flow situation that could lead to closure or non-compliance. We recommend the following edits:*** 1. Documentation that ~~they~~ Plans have ~~incorporated mechanisms into their~~ designed, tested, modified and implemented LTSS claims processing systems to pay contracted CBAS centers and NF/SCFs in a timely and accurate manner

Page	Section Title	Existing Text	Comment or Suggested Edit
			~~fashion~~; consistent with regulatory timeframes established for all other contracted Health Plan providers. Readiness means evidence of claims testing with a 95% successful paid claims for each LTSS type. 2. Policy and procedures for providing advance payments or emergency payments to LTSS providers to avoid disruption in care to Plan members due to closure, reduced hours or days or other consequences of non-payment of claims.
6	**Financial Information/ Claims Processing**	3. Policies and procedures for resolving, within a defined time frame, any disputed claims for CBAS or NF/SCF reimbursement and to avoid disruption in care to Health Plan members.	***This is not a new requirement, but what is needed is a requirement for the Plans to pay advances to providers experiencing a hardship that arises because of time required to fix errors arising from the Plan or the provider or delays in payment due to the transition. CBAS providers experienced a steep learning curve to comply with plans' various claims processing idiosyncrasies and centers' inexperience submitting claims to multiple health plans.*** 3. Policies and procedures for resolving, within a defined time frame, any disputed claims for CBAS or NF/SCF reimbursement and to avoid disruption in care to Health Plan members. 4. Policies and procedures for providing expedited or advance payment to a contracted provider when delays in payment will result in inability to meet payroll, closure, or disruption in the ability to

Page	Section Title	Existing Text	Comment or Suggested Edit
			provide care to Members.
6	**Financial Information/ Claims Processing**	5. Policies, procedures, and mechanisms for reporting individual encounter, claims, and quality data to DHCS for their members' utilization of facilities and services, and admissions to hospitals from facilities.	***Clarity and intent. Since claims and encounter data is already collected by the Plans, the intent of this section is unclear. The term "quality data" is not defined and the use of the term "facilities" is not clear. Which facilities and services? Admission to hospitals from which facilities? Why limited to facilities?***
6	**Financial Information/ Claims Processing**	6. Documentation of the readiness of electronic claims processing systems to pay claims submitted by contracted providers in accordance with current law and regulations.	***Should be #2 in the sequence. The Plans should show evidence of having tested claims submissions and successful payment, along with procedures to be used by contracted providers specifying the required claims form, fields to be populated, the availability of electronic fund transfer, and a point person for solving claims submission system problems or errors. Recommend the following new language:*** 6. Documentation of the readiness of electronic claims processing systems to pay claims submitted by contracted providers in accordance with current law and regulations, as evidenced by testing of claims submissions and successful payment; instructions and training for contracted providers on the claims submission process, including the use of required claim forms; required fields; availability of electronic fund transfer, and a Plan contact for resolving claims

Page	Section Title	Existing Text	Comment or Suggested Edit
			submission problems or errors.
	Financial Information/ Claims Processing	New #6 *Should be #1 in order.*	***CBAS and the Plans experienced challenges in obtaining timely and accurate TAR data from the state and reconciling the state's data with the data from the field. These systems need to be improved and tested to assure readiness.*** 7. Documentation and testing of systems designed to accept and reconcile authorized TARs from Medi-Cal in a timely manner.
7	**Management Information System**	None	***CBAS has specific reporting requirements in the 1115 waiver related to reporting of annual health status measures that should be included either here or under MIS. It is not known how the plans will comply with this waiver requirement but the operational plan for collecting these measures should be developed in a collaborative manner between the plans, the CBAS community and the state.***

Page	Section Title	Existing Text	Comment or Suggested Edit
7	**Quality Improvement System**	1. Demonstrate that their Quality Assurance and Improvement Plans will include targeted, focused protocols for CBAS centers.	***There should be statewide protocols for quality assurance and Improvement to comply with CBAS specific requirements within the 1115 waiver document approved by CMS in 2011. These standards should be developed in collaboration with CBAS experts. Recommend the following edits:*** 1. Demonstrate that their Quality Assurance and Improvement Plans will include targeted, focused protocols for CBAS centers, developed in collaboration with CBAS community leaders.
7	**Quality Improvement System**	2. Policies and procedures detailing how their contracted CBAS centers will adhere to Plan-established quality assurance provisions and any other applicable State and federal standards and requirements. Health Plans will seek technical assistance from the State as is necessary.	***Duplication and clarity. This section mixes regulatory compliance with new, yet to be determined quality measures. The center is the entity that must adhere to established quality assurance provisions, and laws and regulations, not the plan. The plan should have a policy and procedure for reporting suspected non-compliance with laws and regulations of a substantive nature, to the Department of Public Health, Department of Health Care Services or Department of Aging, as appropriate, to assure adherence with CBAS laws and regulations. In addition, the plan should have a Policy and Procedures for how it will deal with substantive contractual non-compliance up to and including contract termination.*** ***This section should be separated from compliance with quality assurance provisions above and beyond L&C. See #4 below for suggested language.***

Page	Section Title	Existing Text	Comment or Suggested Edit
			~~2. Policies and procedures detailing how their contracted CBAS centers will adhere to Plan-established quality assurance provisions and any other applicable State and federal standards and requirements. Health Plans will seek technical assistance from the State as is necessary.~~
7	**Quality Improvement System**	3. Demonstrate, at a minimum, contracts with all CBAS centers that meet State licensure requirements for adult day health care centers and Medi-Cal certification requirements for CBAS providers, without any encumbering sanctions or citations.	***Clarity and Duplication. This provision is both unclear in how it is written and also exists under Provider Network and Contracting and does not need to be repeated here.*** ~~3. Demonstrate, at a minimum, contracts with all CBAS centers that meet State licensure requirements for adult day health care centers and Medi-Cal certification requirements for CBAS providers, without any encumbering sanctions or citations.~~
8	**Quality Improvement System**	4. Policies and procedures for sharing the findings, and coordination of any subsequent follow up, from Health Plan/CBAS center quality assurance activities with CDA and the California Department of Public Health (CDPH).	***There state is responsible for L&C activities and the Plan is responsible for quality assurance activities. If the state desires reports from the plans regarding their quality findings, there needs to be a uniform regulation across the state for what level of findings are to be provided to the state and what the state's responsibility is for receiving such findings. Early experience indicates that the state does not have mechanisms in place to accept findings from the Plans, so this is a readiness issue for the state to resolve prior to asking Plans to develop policies and procedure***

Page	Section Title	Existing Text	Comment or Suggested Edit
			within a vacuum. This is not necessary for readiness and can be handled through a work group and issuance of an all plan and all provider letter in the future. 4. ~~Policies and procedures for sharing the findings, and coordination of any subsequent follow up, from Health Plan/CBAS center quality assurance activities with CDA and the California Department of Public Health (CDPH).~~
8	**Provider Relations**	1. Policies and procedures for securing authorization from members or their legal representative to include IHSS provider in the Interdisciplinary Care Team for that member.	***The intent of this requirement is confusing. Why does this only apply to IHSS and not all LTSS and caregivers. Especially for those with cognitive impairment, the presence of a caregiver may be crucial. Also does not seem to be consistent with the care coordination standards for Person-Centered Planning (see page 13) that ensures participation of any person of the member's choosing without a formal authorization. Recommend the following edits.*** 1. Policies and procedures for securing authorization from members or their legal representative to include <u>caregivers and</u> ~~IHSS~~ <u>LTSS</u> provider<u>s</u> <u>of their choosing</u> in the Interdisciplinary Care Team for that member.
8	**Provider Relations**	2. Documentation of having assigned and trained staff specifically to address and process complaints and	***Unless not addressed already in the plans' contracts with the state, separate out "grievance" which has a specific meaning, as compared to "problem solving," which is the***

Page	Section Title	Existing Text	Comment or Suggested Edit
		grievances from contracted CBAS centers, MSSP sites, and NF/SCF on issues including, but not limited to, claims, payments, coordination with the Health Plan, referrals of Health Plan members, and concerns about Health Plan members' service needs.	***step prior to filing a formal grievance. Recommend the following edits:*** 2. Documentation of having assigned and trained staff specifically to address and expeditiously process problems, complaints ~~and grievances~~ from contracted CBAS centers, MSSP sites, and NF/SCF on issues including, but not limited to, plan enrollment, timeliness in conducting assessments, authorizing services or level of care, claims, payments, coordination of benefits with the Health Plan and non-contracted or network providers, referrals of Health Plan members, and concerns about Health Plan members' coordination of benefits, or service needs.
8	**Provider Relations**	3. Develop and conduct orientation and training programs to familiarize contracted facilities with Health Plans' operations, members' rights, plan-specific policies and procedures, claims submission and payment, reporting requirements, and conflict resolution process.	***Demonstrated readiness to train LTSS providers, with sufficient lead time prior to launch of mandatory enrollment is critical. The CBAS experience ran the full gamut of decent preparation lead time and thoroughness of training to little lead time and training. The level of complexity is increasing not only for the beneficiaries but for the provider community so training is imperative. Recommend the following edits:*** 3. Develop and conduct initial and periodic orientation and training programs to familiarize contracted ~~facilities~~ LTSS providers with Health

Page	Section Title	Existing Text	Comment or Suggested Edit
			Plans' operations, methods for provider communications, members' rights, plan-specific policies and procedures, claims submission and payment, coordination of benefits for the various types (classes?) of beneficiaries, reporting requirements, and conflict resolution process, including how frequently such training will be conducted.
9	**Member Grievance System**	For CBAS, MSSP, and NF/SCF, Health Plans shall meet the following: Policies and procedures describing 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. Health Plans must also show documentation that these policies and procedures were developed in collaboration	***This section is confusing to read as written. Suggest breaking it into the following sections for clarity.*** For CBAS, MSSP, and NF/SCF, Health Plans shall meet the following: ~~1)~~ Policies and procedures describing how Health Plan members' grievances regarding eligibility determinations, initial assessments for services, and authorization for services ~~and care~~ delivered by the Plan's contracted CBAS centers, MSSP sites, or NF/SCF should be submitted and will be adjudicated. ~~Health Plans must also show documentation that these policies and procedures were developed in collaboration with their contracted CBAS centers, MSSP sites, and NF/SCF.~~ 2) Policies and procedures describing how a member may submit a grievance to the plan

Page	Section Title	Existing Text	Comment or Suggested Edit
		with their contracted CBAS centers, MSSP sites, and NF/SCF. Additionally, the policies shall include a process for referral of complaints to state licensing representatives.	regarding a contracted LTSS provider, ~~submitting a Additionally, the policies shall include~~ including a process for when referral of a member complaint~~s~~ to state licensing and certification personnel ~~representatives~~ is necessary. 3) Health Plans must also show documentation that these policies and procedures were developed in collaboration with their contracted CBAS centers, MSSP sites, and NF/SCF.
99	**Member Services**	For IHSS, CBAS, MSSP and NF/SCF, Health Plans shall meet the following: 1. Policies and procedures for the training of Health Plan staff to answer any service related questions or direct members to appropriate agency.	***It is critical that all plan personnel who interact with providers and members are trained and demonstrate understanding of the various Medi-Medi insurance interactions in order to be able to ask the member the right questions so the right answer is provided.*** For IHSS, CBAS, MSSP and NF/SCF, Health Plans shall meet the following: 1. Policies and procedures for the training of Health Plan staff to ensure their ability to answer ~~any~~ service related questions, as pertinent to insurance status of a dually eligible member who may be Medi-only, full dual or partial dual, and, as needed, ~~or~~ direct members to the appropriate Plan department or government agency for further assistance.

Page	Section Title	Existing Text	Comment or Suggested Edit
9		2. Policies and procedures ensuring that all Health Plan members and/or authorized representatives are fully aware and informed of their rights, and that those rights are not violated.	***Which rights are intended to be included here?*** 2. Policies and procedures ensuring that all Health Plan members and/or authorized representatives are fully aware and informed of their rights, and that those rights are not violated.
9		For CBAS	***In areas with more than one plan, it is in the member and plan's interest to have agreements in place to honor each other's authorization for CBAS services, since the authorization period spans six months and members may change plans at any time. Suggest the following:*** Policies and procedures demonstrating how authorizations and Individual Plans of Care will be transferred from one plan to another plan when a member dis-enrolls from one plan and enrolls in another to ensure no interruption in services to the member and no interruption in reimbursement to the CBAS provider responsible for the transferring member's care.
9	**Health Insurance Portability and Accountability Act (~~HIPPA~~) (HIPAA)**	For IHSS, CBAS, MSSP and NF/SCF, Health Plans shall meet the following: 1. Policies and procedures to ensure compliance with the Health Insurance Portability and Accountability Act of	***This is covered in the boilerplate contract so does not seem necessary here. If retained, recommend that in situations where the CBAS provider is the primary entity providing care, that a specific policy that includes MSSP or CBAS or the primary family caregiver to serve as an authorized representative be developed. Recommend the following edits:***

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		1996. 2. For IHSS, policies and procedures consistent with HIPAA to allow IHSS providers to speak on behalf of member, if so authorized.	For IHSS, CBAS, MSSP and NF/SCF, Health Plans shall meet the following: 1. Policies and procedures to ensure compliance with the Health Insurance Portability and Accountability Act of 1996. 2. For IHSS, policies and procedures consistent with HIPAA to allow IHSS providers, member's caregiver, CBAS or MSSP authorized representative to speak on behalf of member, if so authorized by the member.

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Page	Section Title	Existing Text	Comment or Suggested Edit
Page: 4-5	**Section:** 1	**Text:** *Policies and procedures for authorization of NF/SCF for members. Such policies and procedures shall cover criteria and authorization/reauthorization for placement in contracted facilities. These policies and procedures should include, but not be limited to utilizing current Medicare criteria for Medicare skilled nursing facility placement or Medicaid criteria for Medi-Cal skilled nursing facility placement.*	**Comment or Suggestion:** SB 1008 provides that the criteria to be employed must be that established by the Medicare and Medi-Cal programs. By stating that plans are to develop policies and procedures that should "include but not be limited" to utilizing Medicare and Medicaid criteria implies that the health plans have the ability to make the criteria more restrictive than what is required by SB 1008 and the Medicare and Medicaid programs. This is contrary to law. The term "include but not be limited" must be deleted. We also suggest that plans be required to give members options for admission to multiple nursing facilities, which would include facilities closest to their home and/or family members.

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Page: 5	**Section:** 5	**Text:** *In contracting with NF/SCFs pursuant to these standards, Health Plans shall contract with licensed and certified nursing facilities that provide all levels of care. Health Plans must contract with a sufficient number of facilities located in the Health Plans' covered zip code areas and, to the extent necessary, in adjacent zip code areas accessible to Health Plans members.*	**Comment or Suggestion:** A "sufficient number of facilities" for network participation are not a defined standard. How are plans to determine such sufficiency? CAHF suggests the following revision: If a facility is in the covered Zip codes and/or adjacent Zip code and has Medi-Cal patients residing in their facility, the health plan must execute a contract with the facility if requested. This provision is necessary to assure continuity of care for all Medi-Cal beneficiaries and to assure continued payment to the facility for providing Medi-Cal services to residents. Given the health plan coordination requirements, it will be much easier to coordinate care if the facility and the health plan have an existing relationship. Without such a requirement, if a health plan refuses to execute a contract when requested, facilities will have to execute separate individual agreements when a resident is enrolled in a health plan. This is not an acceptable alternative. AB 1008 provides that health plans recognize Medi-Cal authorizations for skilled nursing facility services for new enrollees. Consequently, all nursing facilities must be able to contract with the health plans to assure continuity of care.

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Page	Section Title	Existing Text	Comment or Suggested Edit
Page: 5	**Section:** 6	**Text:** *Health Plans shall have policies and procedures to facilitate nursing facility compliance with state and federal requirements regarding readmission to a nursing facility after hospitalization in an acute care hospital.*	**Comment or suggestion:** This is not clear. If DHCS is referring to Medi-Cal bedhold and leave-of-absence requirements, then it should clarify. Suggested language: Health plans must have policies and procedures to reimburse NF/SCFs for bed holds and leave of absences consistent with federal and state requirements.
Page: 5	**Section:** 7	**Text:** *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.*	**Comment or suggestion:** There are a number of additional facility requirements that are imbedded in this section that exceed current regulatory requirements. For example, there is state regulation on the reporting of unusual occurrences to the local health officer and CDPH (Title 22, Section 72541) but the regulation does not utilize the term "sentinel events and quality issues" as triggers. Further, the additional reporting requirements represent new mandates and DHCS will need to provide a reimbursement add-on in the event that this provision is adopted. We have previously provided comments on this reporting issue, and DHCS has failed to consider our prior comments. The section should be deleted in its entirety.

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		• *Provisions on how the Health Plan will address change of ownership, loss of licensure, or any expected or unexpected closure of a contracted NF/SCF.*	**Comment or suggestion:** This is not clear. This bullet should be rewritten to clarify that health plans must adopt policies that are consistent with CDPH requirements regarding closure and loss of licensure for skilled nursing facilities.
		• *Policies and procedures that address the management of the nursing facility benefit.*	**Comment or suggestion:** This is not clear. Is DHCS requiring the provider **or** the health plan to have specific policies and procedures? If it is the provider, then this represents a new mandate and should not be included in the contract. If this is a health plan requirement, it is not a contract provision and should be included elsewhere in this document. This bullet should be deleted.
		• *Provider training curriculum for newly contracted NF/SCF providers.*	**Comment or suggestion:** This is not a contract provision, but a readiness standard that should be identified elsewhere in this document. The plan needs to provide multiple training opportunities prior to CCI implementation on prior authorization, continuity of care, immediate access to case managers for urgent ancillary services (pharmacy, labs, dialysis, etc.), and claims processing procedures, including testing of claims submission by facilities. Further,

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			testing of claims to ensure accurate processing and payment needs to be validated prior to going live. This is absolutely necessary in order to prevent erroneous payment or claim rejections resulting in significant cash flow and related problems for providers.
		• *Staff curriculum for training on how to manage the benefit including:* ▪ *Sign in sheets for the staff training on how to manage the benefit.* ▪ *Care coordination for members in nursing facilities.* ▪ *Required notices for members in nursing facilities.* ▪ *How to provide notices to members in nursing facilities.* ▪ *Relevant state and federal standards on the benefit.* ▪ *Relevant state and federal standards on consumer rights and*	**Comment or suggestion:** This text is not clear. Who is getting the training? If this is an outline for training of health plan employees, it does not belong in the section regarding contracting with skilled nursing facilities. If this is the case, the section should be deleted or moved. If DHCS is requiring specific training for skilled nursing facility staff, then this represents a significant cost to the facility and a mandate that DHCS must reimburse in the AB 1629 rates. Skilled nursing facilities provide the benefit and the health plans are responsible for paying for it. If DHCS is requiring that the skilled nursing facilities provided notice to the residents for health plan issues, it does not have that authority to require such notices. This would represent a new cost to the facility and AB 1629 rate would need to be increased. Further, as

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		protections. ▪ *Sentinel events-quality reporting* ▪ *How to pay claims* ▪ *Encounter data submissions*	stated previously, the "sentinel event reporting" is problematic and should be deleted. Also, DHCS may require that health plans submit encounter data submissions based on claims payment data. However, skilled nursing facilities should not be required to submit any further data beyond claims-related information unless DHCS plans on increasing AB 1629 reimbursement rates. The following items are issues that we think should be included in the contracts between the health plans and skilled nursing facilities: • Prompt Payment--discussed elsewhere. • Payment of RUGs and Medi-Cal rates, consistent with SB 1008. • The provider have access to a claims payment system with the ability to pay RUGs and facility-specific AB 1629 rates, including any retroactive rates because of appeals and/or DHCS delayed publishing of rates, consistent with SB 1008. • The plans recognizes that AB

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			1629 rates are not all-inclusive and that therapy and ancillary services are NOT included in the rate and are separately payable by the health plan. • Payment of bedholds and leave of absence. • Payment of Medicare deductibles and copayments. • Recognition of Johnson vs. Rank, which includes a beneficiary's right to spend their share of cost on non-covered services as specified in the Medi-Cal Long Term Care Provider Manual. • The plans have a claims processing system that pay claims with adjustments for SOC for non-covered services. • Authorization procedures, including a provision requiring the health plan to recognize existing Medi-Cal authorizations for new enrollees to assure continuity of care, consistent with SB

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			1008. The health plan should demonstrate to DHCS that they can upload Medi-Cal prior authorization data to their claims system, otherwise claims cannot be processed electronically. (Recall that Gold Coast Health Plan required providers to submit boxes of paper copies of Medi-Cal treatment authorization requests before they would pay claims, which is unacceptable.) • Electronic claims system tied to the payment system. Electronic prior authorizations that are obtained from subcontractors and delegates must be linked to the health plan payment system to allow claims to be processed in a timely manner. • The health plan has the ability to make payments by electronic fund transfers, consistent with SB 1008.

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Page	Section Title	Existing Text	Comment or Suggested Edit
Page: 6	**Section**: 1 and 4	**Text:** *Documentation that they have incorporated mechanisms into their claims processing systems to pay contracted CBAS centers and NF/SCFs in a timely fashion; consistent with regulatory timeframes established for all other contracted Health Plan providers.* *Documentation of the readiness of electronic claims processing systems to pay claims submitted by contracted providers in accordance with current law and regulations.*	**Comment or suggestion:** DHCS is requiring that plan payment to skilled nursing facilities must be made within "regulatory timeframes established for all other contracted providers." What are those timeframes? SB 1008 requires DHCS to establish timeframes, which DHCS has repeatedly ignored. Prompt payment to skilled nursing facilities services, consistent with the current timeframes for Medi-Cal and Medicare reimbursement, is CAHF's highest priority. DHCS failure to require these payment timeframes for the health plan represents a significant cost to skilled nursing facilities because they will have to execute line for credit and pay interest to bridge the cash flow delays. The interest costs represent a new mandate, which DHCS is required to include in the AB 1629 reimbursement rates. Similarly, the plans are to pay electronically "in accordance with current law and regulations." This should expanded to include specific electronic claims processing requirements, such as the ones outlined in the contracting section above (prompt payment, electronic funds transfers, electronic prior authorization, copayment

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			and deductibles, share-of-cost, Johnson v. Rank, etc.)
Page: 6	**Section:** 3	**Text:** *Policies, procedures, and mechanisms for reporting individual encounter, claims, and quality data to DHCS for their members' utilization of facilities and services, and admissions to hospitals from facilities.*	**Comment or suggestion**: This section requires plans to have mechanisms to collect, among other things, quality data from the utilization of facilities. This is unclear. Is DHCS requiring skilled nursing facilities to submit data to the health plan? What data are they requiring to be submitted? Quality measures for skilled nursing facilities are collected and reported by CMS based on MDS 3.0 submissions. If DHCS and the health plans expect access to MDS 3.0 data, they should access through CMS through a data-user agreement. This provision has nothing to do with network adequacy and should be deleted.

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Page	Section Title	Existing Text	Comment or Suggested Edit
Page: 8	**Section:** 1 and 2	**Text:** *For NF/SCF, Health Plans shall meet the following:* 1. *Evidence of quality standards for NF/SCF services provided to members, and policies and procedures for health plans to monitor quality and the process to address any deficiencies identified by Health Plans.* 2. *Evidence that Quality Assurance and Improvement Plans include quality improvement activities for contracted facilities. These Plans should include monitoring for the effectiveness of care transitions.*	**Comment or suggestion:** This is another example of DHCS establishing new mandates. Health plans are to establish "quality standards" for skilled nursing facilities that are to be monitored and "deficiencies" are to be identified. Then, the plans are to implement "quality improvement activities" for these facilities and monitor the "effectiveness of care transitions." Please provide DHCS' legal authority to establish new facility requirements through the CCI. CAHF provided detailed comments on this issue in our August 23, 2012, letter to Jane Ogle, which we will not repeat in this document. The plan should focus on outcomes for its enrollees and should not be responsible for the quality improvement plans of the facility or monitoring of corrective action plans by facilities. Oversight belongs with the California Department of Public Health (CDPH) and represents a duplication of effort without the health plans having the proper authority or training to provide oversight. This section should be deleted.

CAHF Comments for Long-Term Services and Supports
December 10, 2012

Organization: CAHF
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Page	Section Title	Existing Text	Comment or Suggested Edit
Page: 8	**Section:** 2	**Text:** *Documentation of having assigned and trained staff specifically to address and process complaints and grievances from contracted CBAS centers, MSSP sites, and NF/SCF on issues including, but not limited to, claims, payments, coordination with the Health Plan, referrals of Health Plan members, and concerns about Health Plan members' service needs.*	**Comment or suggestion:** DHCS should require that the health plan establish a complaint, grievance and appeal system for providers. There is a reference to a "member grievance system" but nothing specific as to providers. Given the magnitude of this endeavor DHCS must require that health plans have staff available to address provider issues that need to be resolved immediately that may endanger the health and safety of the member. For example, we are very concerned that there will be disruptions in dialysis, drugs regimes, expedited lab services, and other ancillary services for our residents because of health plan contractual requirements. There must be a venue to resolve these issues quickly. There are other areas of network readiness that should be addressed in this document. **Intermediate Care Facilities for the Developmentally Disabled—**Residents of these facilities will be excluded from enrollment in Medi-Cal managed care. Health plans needs to provide specific policies and procedures for assuring that enrollment in the health plan is reversed in the instance of erroneous enrollment. In

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			addition, they need to have policies and procedures in place for the payment of the month of admission and the following month for residents who are admitted to an ICF/DD while enrolled in the health plan. This issue has been confusing for both facilities and health plan for SPDs and must be rectified prior to CCI implementation. CAHF would also suggest that DHCS have a dedicated staff person that can expedite enrollment reversal. Facilities should not be expected to provide care without reimbursement for three to four months. They need to be able to bill Medi-Cal FFS quickly. **Ombudsman** This document does not contain a provision to assure providers access to health plans staff. We would like to see specific standards for health plans to report data to DHCS that would include the total number of calls, wait time on phone, number of dropped calls, topics, and other factors that could be used by DHCS to monitor the effectiveness of the health plan provider call center. Similar standards are included in the Medi-Cal fiscal intermediary contract. Policies and procedures are meaningless

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			without oversight to monitor their effectiveness. **Changes in Health Plans and Continuity of Care** Except for San Mateo and Orange, beneficiaries residing in the other six counties will have the ability to change health plans from month to month. This is a concern because of continuity of care issues in skilled nursing facilities. A new health plan may refuse to authorize services that were authorized by the prior health plan because of financial incentives—if they don't approve, they don't have to pay for it. This creates a continuity of care issue for the beneficiary and a high-cost financial risk for the skilled nursing facility. The Department should require that health plans honor authorizations from other Medi-Cal managed care plans for six months in the event that a beneficiary changes plans. Given that SB 1008 requires that authorization for services be consistent with established Medi-Cal and Medicare guidelines, requiring health plans to honor the prior plans authorization should not be a hardship. In addition, health plans should be required to continue authorization

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			and payment for Medicare Part A skilled nursing services that have been initiated under Medicare fee-for-service prior to enrollment in the health plan. These requirements would be similar to the one adopted in SB 1008, which required plans to honor Medi-Cal authorization for six months, and assures continuity of care. **Los Angeles County** We continue to have concerns about CCI implementation in Los Angeles County and the issue of subcontractors and delegates. We look forward meeting with DHCS and the health plans to discuss various issues.

Comment Template for Care Coordination Standards Organization: CAHSAH

Due December 10, 2012 Contact Name: Jennifer Gabales

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Page	Section Title	Existing Text	Comment or Suggested Edit
	General Comment		We appreciate the opportunity to comment o the proposed Care Coordination Standards. CAHSAH's comments focus on how licensed home health agencies can be used to allow beneficiaries to remain in the community. Home health agency services are currently used under the state's home-and community based waiver benefit for qualifying beneficiaries in their homes. Previous discussions regarding the continuation of existing waiver services after implementation of the CCI have indicated that managed care plans may incorporate these services as a benefit; however language in the care coordination standards is vague and should be more specific to ensure the inclusion of existing waiver benefits. Managed care plans may be more willing to include innovative services if these services are part of the care coordination and LTSS standards and illustrate how these services can be utilized. Home health services are currently provided in the Assisted Living Waiver Program, In-Home Medical Care, and the NF/AB waiver and sub-acute waivers. The use of home health as long term

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			service support (LTSS) must be included in care coordination standards as an option to help ensure the ingenuity of these waivers is not lost in the CCI transition for future beneficiary health needs. The use of home health is efficient when used to manage chronic conditions and slow the impact of debilitating diseases through the provision of nursing, therapies and aide services while beneficiaries remain in their homes.
3	CBAS, Health Plans shall meet the following:	3. Policies and procedures to arrange, and show availability of providers for, unbundled services for Health Plan members whose level of care needs correspond to the CBAS benefit eligibility requirements, when CBAS centers are unavailable, inaccessible, limited in capacity or cannot meet members' cultural and linguistic needs.	3. Policies and procedures to arrange, and show availability of providers , <u>especially and including home health (which may be bundled), or</u> unbundled <u>contracted</u> services for Health Plan members care whose level of care needs correspond to the CBAS benefit eligibility requirements, when CBAS centers are unavailable, inaccessible, limited in capacity or cannot meet members' cultural and linguistic needs.
10		14. ICPs shall facilitate a Member's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health and substance use disorder treatment services or home health for chronic conditions when CBAS is unavailable.	14. ICPs shall facilitate Member's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health and substance use disorder treatment <u>services or home health for chronic medical conditions</u> when CBAS is unavailable.

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Page	Section Title	Existing Text	Comment or Suggested Edit
10		15. IPCs shall include identification of appropriate providers, facilities, services and available community and social supports.	15. IPCs shall include identification of appropriate providers, facilities, services and available community and social supports <u>including home health.</u>
11		18. Plans shall consult with the Member, PCP, IHSS social worker, MSSP case managed, behavior health specialist, family and/or community supports and other providers, as appropriate in the development of the ICP.	18. Plans shall consult with the Member, PCP, IHSS social worker, MSSP case managed, behavior health specialist, family and/or community supports and other providers, <u>including home health</u>, as appropriate in the development of the ICP.
13		Plan should develop specific care coordination provisions for nursing facility residents. Plan must monitor nursing facility utilization and develop care transitions plans and programs that move beneficiaries back into the community to the extent possible. Such transition care planning shall include assessment of the need for home and Community-Based Services, and involve members , family, legal representatives, PCPs, nursing facility personnel, behavioral health representatives and other health care and community-based providers.	Plan should develop specific care coordination provisions for nursing facility residents. Plan must monitor nursing facility utilization and develop care transitions plans and programs that move beneficiaries back into the community to the extent possible. Such transition care planning shall include assessment of the need for home and Community-Based Services, and involve members , family, legal representatives, PCPs, nursing facility personnel, behavioral health representatives, <u>home health,</u> and other health care and community-based providers.
14-15		C. Services needed after discharge, setting preferred by the dual-eligible Member/representative of the dual-eligible Member and hospital/institution, setting agreed to by the dual-eligible Member/representative of the dual-eligible	Comment: What if the beneficiaries preferred provider does not have a contract with the managed care plan? How will their preference be accommodated?

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		Member, specific agency/home recommended by the hospital, specific agency/home agreed to by the dual-eligible Member/representative of the dual-eligible Member, and pre-discharge counseling recommended.	
15	E	Coordination with county agencies for IHSS and behavioral health services, MSSP providers and CBAS centers, CBOs such as Area Agencies o Aging, and nursing facilities as appropriate. For IHSS, the plan's coordination process should be developed jointly with county social service agencies and consider state requirements for counties regarding discharge planning.	Coordination with county agencies for IHSS and behavioral health services, MSSP providers and CBAS centers, CBOs such as Area Agencies o Aging, Home Health Agencies and nursing facilities as appropriate. For IHSS, the plan's coordination process should be developed jointly with county social service agencies and consider state requirements for counties regarding discharge planning.

Comment Template for Care Coordination Standards Organization: CAHSAH

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Comment Template for LTSS Network Adequacy
Due Dec 10, 2012

Organization: California Hospital Association
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General Comment			CHA applauds the efforts of the state to ensure that plans develop adequate networks to meet the needs of their members. However, we remain concerned that the document as currently written does not adequately address the need for plans to expand their provider networks to ensure an adequate number of types of facilities or range of services. CHA remains concerned that narrow networks will be implemented and beneficiaries will lose access to their primary and specialty providers after the continuity of care provisions are no longer in place. CHA members report that currently many plans will be using their existing networks rather than expanding them to meet the needs of this vulnerable population. These decisions will likely force beneficiaries to either change providers or opt out of the demonstration – neither of which is optimal.
General Comment			While these comments address standards relative to LTSS for the Plans, they do not include information regarding how the state will evaluate and monitor compliance, or how and when corrective action will be

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			implemented. **CHA urges DHCS to communicate its proposal for oversight, including evaluation and enforcement of the standards. Furthermore, the standards should include both qualitative and quantitative metrics to ensure the established standards are being met, and such metrics should be made publicly available.**
2	Provider Network and Contracting - CBAS	"For CBAS, Health Plans shall meet the following: 1. Policies and procedures to evaluate and document, on an annual basis, the amount of time that elapses when a member is referred for CBAS services, and when those services are received."	The ability to access the appropriate level of care o a timely basis is a critical factor in the Members' ability to achieve and maintain optimal health and functional independence. However, in the current standards document, this provision appears to apply only to CBAS and not to the other programs/services that may be included. Furthermore, the state is asking only that Plans monitor and document the time between referral and service commencement and does not provide a standard for timeliness or require the Plan to ensure timely access to necessary services. **CHA recommends that Plans be required to monitor the length of time between referral and commencement of services for all programs and levels of care and that the state b more prescriptive about the time interval that it deems acceptable**.

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			CHA further urges DHCS to expand on this portion of the standards to clarify the expectations of the Plans for transitions of care, including timely access to care at all levels, timely resolution of care denials, and to address financial responsibilities that result from a failure to provide timely access to care. CHA recommends that plans be required to maintain readily available (7 days/week) access to care coordination personnel who will be available to provide care authorizations and assistance in identifying and obtaining appropriate placements and necessary community resources. **In the event that a Member remains in any care setting longer than is required for their medical or functional condition while awaiting discharge or transition to the next level of care or home and community based service, the Plan will continue to reimburse the provider at the established rate for that provider level of care until the Member is able to transition.**

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5	Provider Network and Contracting: For NF/SNF	"…..Health Plans shall contract with licensed and certified nursing facilities that provide all levels of care. Health Plans must contract with sufficient number of facilities "	The current document fails to distinguish between long term residential skilled nursing care and short term transitional or rehabilitative care that may be provided in the skilled nursing setting, as required by SB 1008. The newly added section of the Welfare & Institutions Code section 14132.276(b) 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." **CHA urges DHCS to expand the SNF standards to clearly identify post-acute transitional or rehabilitative care in a skilled nursing facility as a distinct level of care, and to differentiate it from long term residential care for the purposes of care coordination and reimbursement.**
5	Provider Network and Contracting: For NF/SNF	"…..Health Plans shall contract with licensed and certified nursing facilities that provide all levels of care. Health Plans must contract with sufficient number of facilities "	**CHA urges DHCS to clarify the standards to require health Plans to contract with skilled nursing facilities providing all levels of inpatient services, including facilities that serve more medically complex patients and those with behavioral needs.**

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			The level of care and types of services provided by skilled nursing facilities varies widely. While some skilled nursing facilities provide a range of medical and rehabilitative care, many are unable to admit and care for individuals with complex medical needs such as a need for dialysis, ventilator care, rehabilitative therapy or for those with behavioral issues or mental health needs. In particular, the critical role of the hospital based SNF should not be overlooked when reviewing the network of providers. Hospital-based skilled nursing facilities generally treat skilled nursing patients presenting more complex medical needs and generally have higher nursing-staffing levels compared to freestanding SNFs. The current Medi-Cal rate structure recognizes the unique role of hospital based skilled nursing providers, and consequently reimburses hospital based distinct part SNFs at higher levels than free-standing nursing facilities. While present DP/NF rates are already well below the cost of care provided, we urge DHCS to ensure that rates for care provided in hospital based skilled nursing facilities and subacute care units continue to support the unique role these facilities serve in the continuum of care, and do not erode further.

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			In addition, the "levels of care" and what would constitute a "sufficient" number of facilities is not defined in the present language. **CHA urges DHCS to establish and communicate clearer standards as to the number and types of skilled nursing facilities with whom plans are required to contract.**
5	Provider Network and Contracting: For NF/SNF	"…..Health Plans shall contract with licensed and certified nursing facilities that provide all levels of care. Health Plans must contract with sufficient number of facilities "	**CHA urges DHCS to revise the standards to require health Plans to contract with long-term care facilities that serve unique populations, and to provide adequate protections for culturally diverse skilled nursing facilities.** 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. As currently written, the standards do not ensure that individuals who desire to live "in community" as they define it, will continue to

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			have access to such care. 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

Comment Template for LTSS Standards
Due December 10, 2012

Organization: CalOptima
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		LTSS READINESS STANDARDS	
1	Provider Network Contracting: IHSS	Effective February 1, 2013, an executed Memorandum of Understanding (MOU) with county agencies	Contracting with the County Social Services Agency requires approval by the County Board of Supervisors. The approval process is quite lengthy, as it includes submission to County Counsel and others. Even with final approved language today, based on the county calendar, approval could not be obtained by 2/1/13.
2	Provider Network Contracting: IHSS	Policies and procedures to receive consent from IHSS recipient… to include IHSS providers in care planning or coordination	Will IHSS authorized tasks be revised to include IHHS provider participation in care planning or coordination? CalOptima's understanding is that this is not an authorized task today. How much time will be permitted for providers to participate? In what frequency will it be allowed (a designated number of hours each month? Each quarter? Etc.)?
2	Provider Network Contracting: IHHS	expedited referrals, when appropriate, to county SSA for members at risk of out of home placement	Please clarify how the State defines expedited reviews.
3	Provider Network and Contracting	members' total one-way transportation time between home and the CBAS centers does not exceed 60 minutes each way,	The draft RA requires CalOptima to ensure that members' total one-way transportation time between home and the CBAS center does not exceed 60 minutes each way. Our CBAS Policy GG.1130 allows members to choose a CBAS center based on "personal preference, cultural and linguistic, clinical condition, and/or geographic preference." This language was previously approved by the State. Given the preferences allowed, the one-way transportation timeframe may exceed 60 minutes. Please provide guidance on how we can meet this item given that members have the right to choose a CBAS center, as required by the State.
3.	Provider Network Contracting: CBAS	Documentation of having contracted with all CBAS centers …in adjacent zip codes accessible to members	Contracting with all CBAS providers within 60 minute drive for members seems unnecessary. CalOptima's recommendation for contracting requirements outside of covered zip codes be limited to more immediate surrounding communities with a requirement to offer contract to other CBAS providers, if so requested by the member.
3-4	Provider Network and Contracting	Bullets relating to MSSP contracting for example:	In Orange County, CalOptima is in a unique situation as we are already the MSSP provider. CalOptima recommends the we be required to establish policies and procedures rather than

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		Effective May 1, 2013, Health Plans will provide evidence… Policies and procedures for establishing, convening and considering recommendations from MSSP organizations, members and other stakeholders in implementation of the contract	execute a contract, as it does not make sense for us to contract with ourselves. Please clarify how CalOptima should provide evidence of compliance with this requirement at Readiness Review. Additionally, the draft requires documentation regarding orientation and training programs for contracted MSSP organizations. Since our MSSP is a unit within CalOptima and MSSP staff are CalOptima employees, is similar documentation necessary from CalOptima but from an internal staff training standpoint?
4	Provider Network Contracting: MSSP	Health Plans shall provide documentation of having developed policies and procedures governing MSSP assessment and eligibility determination as part of the Health Plan care coordination	Please clarify the role expected of health plan vs. role of MSSP program. Is this intended to supplant the MSSP program roles regarding assessment and eligibility determination?
5	Provider Networking Contracting: NF/SCF	Policies and procedures to ensure members have opportunities for transition from nursing facility to community settings, as specified in Care Coordination Standards	Please provide any information regarding the role of the Money-Follows-Person program and this requirement. Will the funding continue notwithstanding the Demonstration?
6	Financial Information/Claims Processing: MSSP	…allocate to their contracted MSSP organization(s) the same level of funding as those organizations otherwise would have been allocated…	Please expand on this requirement. Is it meant on a per member basis? What if there are changes in a specific member's condition? Same on an overall basis? What if there are changes in condition or number of members in the program? Will this funding level be a pass-through? CalOptima recommends qualifying language be added to allow for flexibility, for example "unless member needs change or enrollment fluctuates".
6	Financial Information/Claims Processing: MSSP	For IHSS, the details of claims processing and funding sources and mechanisms will be detailed in a contact between DHCS, CDSS, and Health Plans.	Revise "contact" to "contract".
7	Management Information Services: IHSS	Effective February 1, 2013, evidence of data sharing…	As noted in prior comment, contracting with the County requires approval by the County Board of Supervisors. The approval process is quite lengthy, as it includes submission to County Counsel and others. Even with final approved language today, based on the county calendar, approval could not be obtained by 2/1/13.

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7	Management Information Services: MSSP	MSSP Section, Bullets 1-3	As noted in prior comment, in Orange County, CalOptima is already the MSSP provider. Can this be satisfied by internal policies and procedures?
7	Management Information Systems	MSSP Section, Bullets 1-3	What evidence is DHCS requesting that CalOptima provide to satisfy Management Information System, items 1-3?
9	Member Grievance System	requirements for CBAS, MSSP, and NC/SCF	What documentation will the State accept to demonstrate compliance with this requirement?
	General Comment: There are many references to providers outside the network.		Please provide clear guidance around the requirements for payment to non-participating providers.

age 5 item 2 includes "opportunities for transition from nursing facilities to to community living, as specified in the Care Coordin Standards".

In Care Coord Standards, I see language about process (case planning and review of needs). Is there a mandate for NF/SCFs to assess if resident can live in community, and, if so determined, to educate resident about options and to create and implement a plan to do so, OR is there just an "opportunity" to move into community if resident requests that? Some residents, esp those who have resided for years in NF/SCFs, may not know or believe they can live in community, may not know what resources/supports are available, so may not initiate relocation or may be reticent to agree.

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Comments for LTSS Network Adequacy Standards

Organization: County of San Diego,
Aging & Independence Services (AIS)
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Page	Section Title	Existing Text	Comment or Suggested Edit
2	Provider Network and Contracting	(g) Performing quality assurance activities.	Including Program Integrity activities (pursuant to new State standards).
2	Provider Network and Contracting	#2: Evidence of Health Plan policies that 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.	Policies should be standard across all participating health plans and should be developed through the health plans Advisory Committee.
2	Provider Network and Contracting	#3: Policies and procedures to receive consent from IHSS recipients or their authorized representatives to include IHSS providers in care planning or coordination.	Policies should be standard across all participating health plans and should be developed through the health plans Advisory Committee. The consent form that will be used should also be standardized across all health plans.
2	Provider Network and Contracting	#4: Policies and procedures to 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.	Policies should be standard across all participating health plans.
2	Provider Network and Contracting	#5: Policies and procedures for an expedited referral, when appropriate, to county social services agencies for a member who is at risk for out-of-home placement, and may qualify for IHSS services.	1) These policies and procedures need to be developed locally and collaboratively between the health plans and the County IHSS Program. In San Diego, these policies and procedures must be the same across all health plans. 2) What is the expectation for response time for IHSS?

Comments for LTSS Network Adequacy Standards

Organization: County of San Diego,
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2	Provider Network and Contracting	#6: Policies and procedures to 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-u services, as necessary, or it has been **determined** that the recipient is unable to function as the employer of the provider due to dementia, cognitive impairment, or is unable to retain a provider due to geographic isolation and distance, authorized hours.	1) These policies and procedures need to be developed locally and collaboratively between the health plans and the County IHSS Program. In San Diego, these policies and procedures must be the same across all health plans. 2) Who will make this determination?
3	Provider Network and Contracting	(For MSSP, Health Plans shall…) #2: Documentation that Health Plans have developed and will conduct a benefit orientation and training program specific to MSSP for staff or contractors to act as care managers for members.	1) What about training of the health plans about MSSP? Should there not be a requirement that the health plans undergo a through training o MSSP? 2) Why aren't these same training requirements in place for IHSS/PA and contract providers? This section really needs work. 3) "contractors"- Whose staff does this refer to? MSSP staff or other staff hired to perform care management?
& 4	Provider Network and Contracting	(For MSSP, Health Plans shall…) #2, 2nd paragraph: Such training shall include the components of medical and social services care planning for members needing LTSS, an overview of the characteristics and	Are the eligibility criteria, assessment and reassessment processes for MSSP changing? If not, why would the health plans provide training to MSSP providers on these? The MSSP providers are the subject matter experts.

Comments for LTSS Network Adequacy Standards

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		needs of MSSP's target population**, MSSP's eligibility criteria, assessment and reassessment processes,** services, and service authorization process, and the Health **Plan's policy and procedures for referring members to MSSP for assessment and eligibility determination.**	These policies and procedures need to be developed locally and collaboratively between the health plans and the MSSP provider.
4	Provider Network and Contracting	#4: Policies and procedures for establishing, convening, and considering the recommendations of MSSP organizations, Health Plan members and other stakeholders in the implementation of the MSSP contract.	The health plans Advisory Committee should be involved as well in the development of these policies and procedures.
4	Provider Network and Contracting	#5: Plans shall provide documentation of having developed policies and procedures governing how the Health Plan will make referrals to MSSP and defining the respective care management roles and duties of the Health Plan's Interdisciplinary Care Team (ICT) and MSSP care managers.	The first part of this sentence seems redundant with Section 3.
4	Provider Network and Contracting	#6: Health Plans shall provide documentation of having developed policies and procedures governing MSSP assessment and eligibility determination as part of the Health Plan's care coordination.	This is confusing – is saying something different then Section 3?

Comments for LTSS Network Adequacy Standards

Organization: County of San Diego,
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4	Provider Network and Contracting	#8: At the discretion of Health Plans and MSSP sites, policies and procedures on using MSSP sites to manage additional services outside of the scope of the MSSP waiver.	The potential additional services that are outside of the scope of the MSSP waiver need to be defined.
7	Management Information System	Effective February 1, 2013, evidence of data sharing agreements with counties and county Public Authorities.	Need to consider standards for all counties for data sharing and need to indicate that the State will share the necessary IHSS data rather than have each county d so.
7	Management Information System	#2: Evidence of having executed data sharing agreements (to include sharing of clinical data, utilization of plan benefits and MSSP waiver services) with their contracted MSSP organization(s).	Need similar language for IHSS.
8	Quality Improvement System	(For MSSP, Health Plans shall…) #1: Policies and procedures detailing how their contracted MSSP organization(s) will adhere to quality assurance provisions and any other applicable State and federal standards and requirements.	These policies and procedures need to be developed locally and collaboratively between the health plans and the MSSP provider.
8	Quality Improvement System	(For MSSP, Health Plans shall…) #2: Policies and procedures documenting how Health Plans will report the findings and coordination of any subsequent follow up, from MSSP quality assurance activities with CDA and DHCS.	These policies and procedures need to be developed locally and collaboratively between the health plans and the MSSP provider.

Comments for LTSS Network Adequacy Standards
Due December 10, 2012

Organization: CWDA
Contact Name: Diana Boyer
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Page	Section Title	Existing Text	Comment or Suggested Edit
all	ALL DOCUMENT	Throughout document	**General recommendation**: some statements begin with "Evidence of having…" while others begin with "Policies and procedures…" "Health Plans shall have policies and procedures…" "Health plans shall provide documentation…" or "Documentation that…" For consistency and clarity, recommend that all statements begin the same way
1	1st paragraph	which will assess whether the plan is compliant	Clarify which plan; the "Health Plan" or the "Readiness Review Plan?"
1	2nd paragraph	The State will also require 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), CBAS, MSSP, NF/SCF…"	WIC 14186 states "(a) It is the intent of the Legislature that long-term services and supports (LTSS) be covered through managed care health plans in counties participating in the demonstration project authorized under Section 14132.275." Since LTSS will only be integrated into managed care plans in the dual demonstration counties, it's unclear to us what this statement means?
1	Provider Network and Contracting	#1 "for the first year of the demonstration"	Why is this limited to a one year MOU? Counties and health plans should have the option of longer-term MOU's.
1	Provider Network and Contracting	#1 "the MOU shall maintain the role of county social service (or health service) agencies and Public	Insert "as appropriate" or some other term after Public Authorities, as per WIC 14186.35 the demonstration counties

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		Authorities in IHSS for:"	may chose to take PA functions in house or contract with another entity.
1 & 2	Provider Network and Contracting	each current and new member's; maintain the consumer	General Comment/Recommendation: Too many terms used: "recipient", "member", "consumer", "beneficiary", "enrollee", etc. It is understood that each program has its own term. However, a single term, for all, is recommended.
2	Provider Network and Contracting	the county agencies	General Comment/Recommendation: Several terms used: "county agencies" and "counties" use just one for consistency
2	Provider Network and Contracting #6.	regarding **agencies**, approved by CDSS, that provide IHSS personal care	Clarify which "agencies" are being referred to as providing IHSS personal care, is this not county IHSS?
2	Provider Network and Contracting #6.	or it has been determined that the recipient is unable to function as the employer of the provider due to dementia, cognitive impairment, or is unable to retain a provider due to geographic isolation and distance, authorized hours.	This statement is confusing, not sure how it applies to rest of #6
2	Provider Network and Contracting	None	WIC 14186 requires health plans to develop care coordination standards with specified entities, specifically it states: "(3) Managed care health plans shall, in coordination with LTSS care management providers, develop

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			and expand care coordination practices in consultation with counties, nursing facilities, area agencies on aging, and other home- and community-based providers, and share best practices." We suggest adding a statement in this section that says "*Evidences that health plans have developed care coordination standards in coordination with IHSS, and policies and procedures that articulate the roles and responsibilities of the health plan and IHSS staff in the care coordination process.*"
2	Provider Network and Contracting	6. policies and procedures to ensure compliance with WIC 12302.6"	We do not have a concern with this statement specifically. However we suggest adding a statement above that in the county MOU section, as follows: "If applicable, IHSS services for clients as specified under WIC 12302.6." That law specifies that if there is an existing contract between the county and an agency for emergency back-up services, etc., that the county may continue to provide these services and meet the "agency" requirements until such time that the contract expires, and the health plans must contract with the county to continue those services.

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3	For CBAS, Health Plans shall meet the following (3.):	**unbundled** services	Clarify what these services are
3	For CBAS, Health Plans shall meet the following (4.):	Health Plan staff and **providers,** health care and social services **providers**	Clarify which, if any are actually referencing IHSS providers
3	For CBAS, Health Plans shall meet the following (7).	Licensing and credentialing status, and areas of collaboration and improvement.	Clarify what is meant by "areas of collaboration and improvement."
4	For NF/SCF (1)	Medicare skilled **nursing facility** placement	**Clarify** if the term "nursing facility" in this context applies to both NFs and SCFs. If so, **replace** "nursing facility" with "NFs/SCFs"
5	For NF/SCF (2)	Policies and procedures to ensure members have opportunities to transition from **nursing facility**	**Clarify** if the term "nursing facility" in this context applies to both NFs and SCFs. If so, **replace** "nursing facility" with "NFs/SCFs"
5	For NF/SCF (3)	This training shall include, but not be limited to incorporating the core concepts of the Olmstead Decision, …"	We support this statement and believe this should be an overarching LTSS readiness standard given its importance to the overall success of the demonstration. We suggest a section be added to this document devoted to the topic of "Training" and a requirement that health plans produce evidence of cross-training on the concepts of the Olmstead Decision, as well as culturally-competent services, and how to access those services through the health plan. Health plan staff and their non-LTSS

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			providers (in addition to SNF staff) should receive such training. This should include written materials for health care staff as well as nursing facility staff, and evidence that training has been delivered or will be delivered and available as needed (via in-person, webinar or other outreach), and that when possible such training is delivered jointly with LTSS contractors (i.e. CBAS, IHSS and consumer representatives of LTSS). Page 6, "for all LTSS" concerns training on care coordination, and that statement should also be placed in the new training section, and strengthened (per comments submitted by the SCAN Foundation).
5	For NF/SCF (4)	Policies and procedures to provide Health Plan members **post transition care coordination**, as specified in the Care Coordination Standards.	#4 appears to state the same thing that is stated in #3 regarding "post transition." #3 states: "as well as criteria for safe transitions, transition planning, and **care plans after transitioning** (Is this not the same as "post-transition?)
5	For NF/SCF (7)	A comprehensive policy on **occurrence reporting**, including, but not limited to **sentinel events** and **quality issues**.	Clarify what "occurrence reporting," "sentinel events," and "quality issues" mean; consider using plain language to avoid confusion
5	For NF/SCF (7)	Provider **training curriculum** for newly contracted NF/SCF providers.	Appears that these two may be one in the same; consider using plain language

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		Staff **curriculum for training** on how to manage the benefit including:	and consolidating into one as follows: "NF/SCF provider/staff training on how to manage health plan members"
6	For NF/SCF (7)	**Sentinel events**-quality reporting **Encounter data** submissions	Clarify what these mean or use plain language
6	Financial Information/Claims Processing	For IHSS, the details of claims processing and funding sources and mechanisms will be detailed in a **contact** between DHCS, CDSS, and Health Plans.	Should this be "*contract*"?
	Management Information System	Effective February 1, 2013, evidence of data sharing agreements with counties and county Public Authorities.	The statement is very unclear, and currently the State's Data Sharing Workgroup is in the process of developing data sharing procedures. Note that is impossible to have these agreements executed by February 1, 2012 until we understand what can and cannot be shared between health plans and counties (i.e. it is unclear the extent to which IHSS Provider data may be shared). Therefore, this may need to be a placeholder until that work is completed. However, WIC 14186(b)(6)(A) states, "County agency assessments shall be shared with care coordination teams, when applicable. The county agency thereafter may receive and consider additional input from the care coordination team."

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			While page 2, (h) captures the idea of confidential data sharing, this section could be amended to add, "Policies and procedures for sharing confidential client data, including IHSS assessments, and other information between the health plans and counties for purposes of care coordination."
7	Quality Improvement System	For IHSS…"Policies and procedures defining 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)."	The statement is consistent with the code cited, but we haven't yet seen any policies on this from CDSS, so it's difficult to understand what the health plans will need to comply with, and since we have no information, it's unclear how health plans will meet the February 1, 2013 deadline. Note that County IHSS could be impacted by these policies, given that counties will continue to operate local Quality Assurance programs, so it would be helpful to understand what standards the health plans will be required to meet and how this might impact County IHSS QA efforts.

Comment Template for Care Coordination Standards
Due December 10, 2012

Organization: Inland Empire Health Plan
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7	Quality Improvement System 3	Demonstrate, at a minimum, contracts with all CBAS centers that meet State licensure requirements for adult day health care centers and Medi-Cal certification requirements for CBAS providers, without any encumbering sanctions or citations.	Would modify statement to read as follows (additions highlighted): Demonstrate, at a minimum, contracts with all CBAS centers in the plan's respective service area, that meet State licensure requirements for adult day health care centers and Medi-Cal certification requirements for CBAS providers, without any encumbering sanctions or citations.

Comment Template for LTSS Network Adequacy Standards
Due December 10, 2012

Organization: LA. Care Health Plan
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Page	Section Title	Existing Text	Comment or Suggested Edit
All	All	Regarding network adequacy and the requirement to contract with SNFs, IHSS, CBAS, MSSP	Is the requirement that health plans have a network contracted by the time of readiness review or that health plans can demonstrate a process or plan to contract the networks?
1	Provider Network and Contracting: IHSS	Effective Feb. 1st an executed MOU…	Will this be delayed if implementation is pushed to June 1st?
1	Provider Network and Contracting: IHSS		Should add requirement similar to bullet 2 under the MSSP section. "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 they have trained personnel of IHSS organizations to the Health Plan's covered benefits and policies and procedures to access services and coordinate care."
2	IHSS - 5	Policies and procedures for expedited referral for IHSS	What are the required time frames for expedited referral? Are these standards described somewhere? Do referrals have to be made to the County for IHSS or can we use other vendors for IHSS when it is added for members who do not have it already?
2	IHSS- 6	or it has been determined that the recipient is unable to function as the employer of the provider due to dementia ...	Unclear. Is the standard for P&Ps regarding two things: 1) What agencies can provide emergency back u care? and 2) What happens when beneficiary has an impairment that prevents them from employing the provider?

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2	CBAS -1	Evaluate and document the amount of time that elapses between when a member is referred to CBAS services and when those services are received.	This is not an appropriate measurement for the Health Plan since it is entirely a function of how long the CBAS center takes to engage the beneficiary. Health Plan has n control over this. It would be more appropriate to measure the amount of time from learning that the beneficiary has a CBAS need to referral to CBAS.
2	Provider Network and Contracting	3. Policies and procedures to receive consent from IHSS recipients or their authorized representatives to include IHSS providers in care planning or coordination.	Whose policy? Health plan, DPSS or both? Perhaps the consent could be included in a universal consent upo enrollment in the DDP.
2	Provider Network and Contracting	4. Policies and procedures to 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))	Whose policy?
2	Provider Network and Contracting	5. Policies and procedures for an expedited referral, when appropriate, to county social services agencies for a member who is at risk for out-of-home placement, and may qualify for IHSS services.	Whose policy?
2	Provider Network and Contracting	6. Policies and procedures to 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-u services, as necessary, or it has been	Whose policy?

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		determined that the recipient is unable to function as the employer of the provider due to dementia, cognitive impairment, or is unable to retain a provider due to geographic isolation and distance, authorized hours.	
3	Provider Network and Contracting	4. When establishing eligibility for CBAS services, the Health Plan follows all regulatory timelines for intake, assessment, and authorization of services. Policies and procedures to ensure compliance with designated time-frames for completing determinations of members' eligibility for CBAS center services, upon referrals by members themselves, family members, CBAS Centers, physicians and other Health Plan staff and providers, health care and social services providers, or other community-based organizations.	These functions are dependent on MSSP (fact to face vendor) and the CBAS centers themselves for CDET Assessments and the preparation of an Individual Plan of Care and Treatment Authorization Request. How can the Health Plans be held to timelines when they are dependent o others over which they have no control of performance?
3	Provider Network and Contracting	5. Documentation of having contracted with all CBAS centers within the Health Plan's covered zip code areas and in adjacent zip codes accessible to members	LA Care only offers a contract. Define adjacent zip codes. Is there a distance from the boundary of the County that is applicable? Do we really have to contract with each and every CBAS center in our territory? What if they don't meet standards of quality, customer service, etc? What if we wanted an appropriate but more confined network?

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3	Provider Network and Contracting	7. Documentation of having established policies and procedures to collaborate with CBAS centers to conduct annual reviews of their contract arrangements, licensing and credentialing status, and areas of collaboration and improvement	LA Care does license facilities
3	Provider Network and Contracting	1. Effective May 1, 2013, Health Plans will provide evidence of having executed contracts 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.	What is the purpose of this contract? Health plans need guidance on this issue.
3	CBAS -2	Ensure that members' one-way transportation time between home and CBAS centers does not exceed 60 minutes.	How is the transportation time measured since it can vary by day, time of day, season, etc.? Are there exceptions when the closest CBAS center is more than 60 minutes from the home of the member?
4	MSSP -8	Plans shall have policies and procedures to refer MSSP eligible members to MSSP sites, if there is availability.	Must the plan refer members for assessments and services after year 2 or just for services?
4	Provider Network and Contracting	3. Documentation that the Health Plan has worked… 4. Policies and procedures for establishing… 5. Plans shall provide documentation on having…	What about member consent? (see comment to page 2 item number 3)
4	Provider Network and Contracting	7. Health Plans shall have contracts with MSSP sites/organizations to provide Plan	What is the difference between this and number 2 (MSSP)? What is in the contract?

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		members who are MSSP waiver participants, MSSP case management services, and if needed, receive MSSP waiver services (supplemental personal care, respite, ramp, nutrition services maintenance type, etc.);	
4	Provider Network and Contracting	8. Documentation that the Health Plan has incorporated the use of MSSP services and other LTSS into their policies and procedures: • Use of MSSP waiver resources for plan members:	Limited availability
5	Provider Network and Contracting	5. In contracting with NF/SCFs pursuant to these standards, Health Plans shall contract with licensed and certified nursing facilities that provide all levels of care…	Suggests that we are prohibited from contracting with NF/SCFs that do not provide all levels of care Define adjacent zip codes. Is there a distance from the boundary of the County that is applicable? Is it necessary that Health Plans have contracted with all of the nursing facilities at the time of review or evidence that they are in the process of contracting? Is the Health Plan allowed to deny coverage for nursing facilities outside the County and adjacent zip codes or does the beneficiary have the right to select any facility in any geography?
5	Provider Network and Contracting	7. When contracting with NF/SCFs… - Provisions on how the Health Plan will	Health plans do not license facilities

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		address change of ownership, loss of licensure, or any expected or unexpected closure of a contracted NF/SCF.	
5	NF/SCF – bullet point three	P&Ps that address the management of the nursing facility benefit.	Not clear what this means. Whose P&P is this? How does it need to be reflected in the contract? What specifically is meant by management of the nursing facility benefit?
5	NF/SCF – bullet point five	Staff curriculum for training on how to manage the benefit…	Training for whose staff (the provider or the plans')? How is this to be reflected in the contract? If for the Plan's staff, why would it be addressed in the contract with nursing facility?
6	Financial Information/Claims Processing, Paragraph #1	pay contracted CBAS centers and NF/SCFs in a timely fashion; consistent with regulatory timeframes established for all other contracted HP Providers.	Is there only one regulatory standard for timely payment or does it depend o the type of provider? What type of provider is the health plan required to be consistent with?
6	Provider Network and Contracting	7. When contracting with NF/SCFs… - Staff curriculum for training on how to manage the benefit including: Relevant state and federal standards on the benefit.	Not a health plan responsibility
6	Provider Network and Contracting	7. When contracting with NF/SCFs… - Staff curriculum for training on how to manage the benefit including: Relevant state and federal standards on consumer rights and protections.	Not a health plan responsibility
6	Provider Network and Contracting	7. When contracting with NF/SCFs… - Staff curriculum for training on how to manage the benefit including: How to pay claims	What claims do NF/SCFs need to pay?

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6	Financial Information/Claims Processing	Provide assurance that, through December 31, 2014, they shall allocate to their contracted MSSP organization(s) the same level of funding as those organizations otherwise would have been allocated under their MSSP contract with the California Department of Aging (CDA).	How will a health plan know what that is? Has MSSP funding been determined through December 2014? The same funding as was provided by CDA in what time period? Do the Health Plans need to commit to keeping each and every MSSP organization whole or does the sum total of expenditures to MSSPs need to match that of the CDA? How will this work when the census of each MSSP will change over time through deaths, additions and changes in service levels?
6	Financial Information/Claims Processing	1. Documentation that they have incorporated mechanisms into their claims processing systems to pay contracted CBAS centers and NF/SCFs in a timely fashion; consistent with regulatory timeframes established for all other contracted Health Plan providers.	Health plans do not need a special provision indentifying these facilities as providers subject to requirements applicable to any other provider
6	Financial Information/Claims Processing	2. Policies and procedures for resolving, within a defined time frame, any disputed claims for CBAS or NF/SCF reimbursement and to avoid disruption in care to Health Plan members.	No special G&A or P&P should be necessary for these providers
6	Financial Information/Claims Processing	3. Policies, procedures, and mechanisms for reporting individual encounter, claims, and quality data to DHCS for their members' utilization of facilities and services, and admissions to hospitals from	No extra reporting requirements should be necessary

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Page	Section Title	Existing Text	Comment or Suggested Edit
		facilities.	
7	Quality Improvement System	Policies and procedures defining 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))	The referenced WIC only states that that the standards and requirements will be defined by CDSS. It is imperative that CDSS provide this definition as quickly as possible so that health plans can prepare the necessary policies.
7	Management Information System	2. Evidence of having executed data sharing agreements (to include sharing of clinical data, utilization of plan benefits and MSSP waiver services) with their contracted MSSP organization(s).	Is member consent needed?
7	Quality Improvement System	1. Demonstrate that their Quality Assurance and Improvement Plans will include targeted, focused protocols for CBAS centers	There are no changes to IHSS so there should not be a QA provision for IHSS services for which the health plan has no responsibility
7	Quality Improvement System	2. Policies and procedures detailing how their contracted CBAS centers will adhere to Plan-established quality assurance provisions and any other applicable State and federal standards and requirements. Health Plans will seek technical assistance from the State as is necessary.	Health plans do not regulate facilities
8	Quality Improvement System	1. Policies and procedures detailing how their contracted MSSP organization(s) will adhere to quality assurance provisions and any other applicable State and federal standards and requirements.	Health plans do not regulate MSSPs

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8	Provider Relations	1. Policies and procedures for securing authorization from members or their legal representative to include IHSS provider in the Interdisciplinary Care Team for that member	What about the DPSS social worker?
8	Provider Relations	3. Develop and conduct orientation and training programs to familiarize contracted facilities with Health Plans' operations, members' rights, plan-specific policies and procedures, claims submission and payment, reporting requirements, and conflict resolution process	Health plans are not responsible for IHSS grievances and appeals.
9	Member Grievance System	Policies and procedures describing 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. Health Plans must also show documentation that these policies and procedures were developed in collaboration with their contracted CBAS centers, MSSP sites, and NF/SCF. Additionally, the policies shall include a process for referral of complaints to state licensing representatives.	Who determines eligibility for MSSP? Is that the health plan responsibility?
9	Health Insurance Portability and Accountability Act	2. For IHSS, policies and procedures consistent with HIPAA to allow IHSS providers to speak o behalf of member, if so authorized.	This does not appear to be health plan policy, but one of the public authority which is the employer of record

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The California Elder Justice Coalition (CEJC) would like to offer some comments and recommendations to help build in assurances into the standards to ensure victims of elder abuse d not fall through cracks. Some of the specific areas we identified in need of additional protections include: Coordination of care, assessments, training, and stakeholder involvement (in development of assessments and plans).

While the recommendations below specifically reference the Coordinated Care Initiative DRAFT Assessment and Care Coordination Standards dated November 20, 2012, CEJC's intent applies to the LTSS readiness standards as well:

1. Care Coordination General Requirements (pages 4 & 5; section 9.d). Maybe add a section 9.e or sentence to the end of 9.d.

   PLANS should include protocols to assess and coordinate care for Members who lack capacity to self-direct their own care and who are at high risk for elder abuse. PLANS should consider cases where "authorized representatives" responsible for determining Member's interest in "self-directing their Care" are the abusers.

   Both LTSS and Care Coordination Standards should include mandated reporting protocols and training for care coordination providers across multiple entities, including providers outside the provider network.
2. Page & (Health Risk Assessment – HRAs). HRAs should include assessment indicators to assess for abuse and neglect.
3. Individual Care Plan. Page 9. Section 1 & 14.

   Recommendation: Section could include paragraph that require that Plans and ICPs (Individual Care Plans) consider elder abuse needs of Members and coordinate those services with the county APS departments and Victim Services as part of the Member's care management plan when appropriate. Same could be done for members who have dementia…..could add another section specific to "Alzheimer's and dementia care" or add to the list following behavioral services.
4. Page 10, Section 9: The draft standards need clarification to specify the roles and responsibilities for care coordination across multiple entities to ensure high risk members do not fall through the cracks. For example, it is not clear who is responsible for what coordination tasks and roles for Members who are hospitalized in medical hospital settings or specialty mental health/acute psychiatric hospital institution settings. It is not clear what is expected of discharge planners, or the Health Plan Coordinators, or the Community Care Service Providers. Also, will there be assurances that Health Plans will cover the cost of hospital stays in complex cases where additional time is needed to ensure safe discharge and appropriate placement and services are in place. There are concerns in regards to cases where "level of acuity" is not approved for reimbursements, yet critical and necessary coordination of care steps need to be made prior to discharge.
5. On page 13-14 of the document, we recommend adding the following to the section Discharge Planning and Care Coordination:

   Recommendation: Elder and Dependent Adult Abuse/Self Neglect Screening

   At the time of discharge from a transitional care situation, Plan entities should screen elder and dependent adult patients for possible abuse or self-neglect. Any suspected instance of abuse or self-neglect shall be reported to the local APS jurisdiction where the patient resides. Any instance of abuse in Skilled Nursing Facilities or Licensed Residential Care Facilities should be reported to the local Long Term Care Ombudsman in the jurisdiction where the patient resides.

6. The standards require training for hospital staff, discharge planners, service providers, MSSP, CBAS, IHSS providers, etc. Recommendation: Training should incorporate mandated reporter training as well as identification of elder abuse.
7. Stakeholders, HCBS providers listed do not appear to consider Members other needs i.e. legal, elder abuse victim services. For instance, SAFE DISCHARGE from hospital and mental health specialty hospitals may require referrals and immediate linkage to legal service providers, victim services, etc.
8. We recommend that any stakeholder involvement include participation from representatives from the Elder Abuse network (i.e. Adult Protective Services, Long Term Care Ombudsman, Legal Service Providers, CEJC and others. Reason why this is important is because when Members fall out or individuals fall through the cracks, it is often the Elder Abuse network of providers who will be responsible for responding to cases and coordinating care. We suggest stakeholder involvement in all stages of development and implementation of Standards, Health Risk and Universal assessments, and training components.

   On behalf of the California Elder Justice Coalition, thank you for your consideration and the opportunity to provide input and recommendations.

Draft comments: ("READINESS) for health plans AND IHSS + Public Authorities + Information sharing, case notes, assessments across all platforms must be in accessible formats so members can review should there be a need for a member or IHSS recipients go before a hearing. Should include all matter related to consumer/beneficiaries.

"Readiness" ALL MEDICAL FACILITIES have public transportation to/from including but not limited to:
Para transit, public bus lines with bus stops immediately outside the medical facility, ambulance an "Ambul-cabs"/wheelchair transport 24/7 at no-cost-to member provided through a 24/7 "Medical Coordinator".

ALL Dual Health Plans must be fully compliant for persons who have vision impairments providing them with "Alternative Formats to Printed Material" by offering them their choice of one of these alternates...all three must be available: 1) Large Print, 2) Braille, or 3) Audio at the choice of the Dual Eligible member...INCLUDING but not limited to when requested by member and so noted on front of in-patient charting, in-patient/out-patient member should be identified by health plans so that the member should not have to ask every time for alternate formats to print. Notations on all computerized patient information shared within the health plan, "Alternative Formats Required: LP (Large Print), B (Braille), A (Audio); membership, any form a patient may be requested to fill out (under no circumstance should a visually impaired person have to depend on someone else to assist them!). This is equally as important as a person's name, address, telephone, age and other kept statistics. Any "Permission Forms" a patient signs must be available in Alternative Formats" (LP, B or A) in addition, when a legal document is used for a member to sign, the document(s) must be available in alternative format selected by the Dual Eligible member.
- Any drugs ordered for member should be offered in alternative formats including: Large Print, Braille and Audio chosen by member. All prescriptions containers must have full name of person, dosage, how to take directions, what the medication is for and the expiration date of the drug. If a member is disabled AND non-English speaking label information should be in their own language (this is already available technology. If a patient is required to break a pill in half the label must so state...and patient should have the medication prepared by the pharmacy to ensure that the medication is halved or quartered when a patient is vision impaired to ensure that the proper dose is dispensed. (Note: This should also be offered to those with with limited hand or strength function) PILL CUTTERS GIVEN TO PATIENTS DO NOT ALWAYS WORK LEAVING DUST AND INADEQUATE PIECES THEREFORE NOT A FULL

DOSAGE TOWARD THE END OF THE MEDICATION. ALWAYS ASK PATIENT IF THEY WANT PHARMACY STAFF TO PREPARE DOSAGE PROVIDED BY SYRINGE. Medication containers should be in containers easiest for patient and so noted on the member's record in the pharmacy.

PROVIDE ELECTRONIC MEDICATION DISPENSING EQUIPMENT IF CRITICAL DOSAGE MUST BE GIVEN AT SPECIFIED TIMES. DISPENSERS HAVE AUDIO SPEAKING AND ALARMS. THIS SHOULD ALSO APPLY TO ANY BREATHING APPARATUS, FLOW RATE, ETC. FOR ACCURACY...AND SHOULD INCLUDE AUDIO ELECTRONIC INTRAVENOUS DISPENSER FOR A MEMBER'S HOME USE. THIS NEED SHOULD NOT HAVE TO BE ORDERED EACH AND EVERY TIME IF A PERSON REQUIRES IV. MACHINES SHOULD BE KEPT RUNNING, IN GOOD CONDITION...MAKE AVAILABLE A PERSON-TO-PERSON CONTACT TO OPERATE EQUIPMENT UNTIL THEY UNDERSTAND OR THEIR HOME CARE PROVIDER UNDERSTANDS ITS USE.

A PERSON SHOULD NOT HAVE TO BE IN A NURSING FACILITY OR HOSPITAL TO HAVE IV THERAPY! BY LAW, A PERSON HAS THE RIGHT TO LIVE AT HOME AND EVERY EFFORT SHOULD BE MADE AVAILABLE TO DO SO. DOCTORS SHOULD BE TRAINED THAT NURSING FACILITIES WILL **NOT** BE THE MEMBER'S FIRST CHOICE; MEDICAL SERVICES MUST BE PROVIDED AS THEY ARE IN FEE-FOR-SERVICE - BY USING HOME HEALTH CARE COVERAGE VISITS, RATHER THAN PLACING THE MEMBER IN A NURSING FACILITIES. PHYSICAL AND OCCUPATIONAL THERAPY CAN BE DONE IN THE HOME ENVIRONMENT...THIS SHOULD BE A MEMBER'S CHOICE. THE SINGLE MOST IMPORTANT THING IS ***INDEPENDENT LIVING***

MEDICINES PRESCRIBED TO A MEMBER LEAVING EITHER ACUTE CARE OR A SNF SHOULD BE DISPENSED FOR SEVERAL DAYS GIVING THE MEMBER AN OPPORTUNITY TO GET A FULL PRESCRIPTION(S)...AND BE SURE THAT THE PHARMACY CAN/WILL DISPENSE FORMULA AND/OR NON-FORMULA MEDICATIONS, EQUIPMENT GOES WITH MEMBER WHEN RELEASED TO THEIR HOME. IF A MEMBER WILL NEED A WHEELCHAIR LONG TERM, AN OCCUPATIONAL THERAPIST SHOULD DO AN ASSESSMENT **PRIOR** TO DISCHARGE. THE WHEELCHAIR SHOULD GO HOME WITH THE MEMBER OR A TEMPORARY APPROPRIATE WHEELCHAIR UNTIL THE CUSTOMIZED WHEELCHAIR IS READY FOR THE MEMBER. ***never*** ***never*** DISCHARGE A MEMBER FROM ANY MEDICAL FACILITY WITHOUT APPROPRIATE DURABLE MEDICAL

EQUIPMENT FOR LONG TERM USE--**EVER**; THIS SHOULD INCLUDE APPROPRIATE SEATING SYSTEM TO AVOID PRESSURE SOARS. "ROHO SEATING SYSTEM" IS AMONG THE BEST BUT OTHER SEATING SYSTEMS MAY BE NECESSARY. A WHEELCHAIR MUST LAST AT LEAST SEVEN YEARS PRIOR TO AUTHORIZING A NEW CHAIR AND THE CHAIR CAN NOT BE FIXED FOR CONTINUE USE--IT WOULD COST AS MUCH AS A NEW CHAIR OR MORE...REQUIRED BY MEDICARE.

ALL DISCHARGES SHOULD BE DONE **WITH** THE PATIENT! NOT FOR THE PATIENT. THE PATIENT'S WISHES MUST BE THE ULTIMATE DIRECTION TAKEN. IF THE PHYSICIAN IS NOT FAMILIAR WITH THE "COMMUNITY-BASED SERVICES" IN CONTRA COSTA COUNTY THEN HE/SHE MAY NOT BE FAMILIAR WITH THE CONCEPT OF INDEPENDENT LIVING.

TRAINING OF MEDICAL STAFF, INCLUDING DISCHARGE PLANNERS, PHYSICIANS AND OTHER KEY MEDICAL STAFF ABOUT THE DEPTHS OF INDEPENDENT LIVING

Deaf and hearing impaired members - "Readiness"

- American Sign Language signer on staff on ALL shifts and on ALL days of the week, 365 days a year!
- Make CART available to the deaf if a patient conference is held so the person who is deaf can fully participate in their own determination of health care in their health plan
- Teach **all** patient/staff personnel basic Sign Language like but not limited to: "Just a minute, I will call an interpreter to assist." "Pain?" carefully find words and phrases which are basic informational. Once a year test medical staff of their knowledge in basic Sign Language so all hospital staff, in all departments can use basic Sign Language pertinent to their department work with a patient.

Mobility Impaired, para/quad "Readiness"

- Lifting teams required every day, all shifts. Take directions from members because the wrong kind of lifting could further hurt the member. ALWAYS ASK!

- Service Animals should ALWAYS be allowed to enter member's room. Change whatever hospital regulations your have in your acute or transition facility to accommodate a Service Animal. Service Animals are legally

allowed **anywhere** at any time.

- If a special bed is used at home, "Readiness" means that the same kind of bed must be available to order or have in the facility. For a person with fragile conditions, specialty hospital beds are available like a "First Step Advantage" air bed. This can make a huge difference in a member's outcome both in the home and medical facility (acute and SNF) with many differing conditions, pressure sores, para/quad-related conditions, bowel and bladder management, circulation, breathing and respiratory treatment...etc. Not having this kind of bed is abusive.

- "Readiness" can mean many different things to different people. All matters above are essential to good "Quality" care as "Communication" is an essential element of "Readiness". Since the majority of those moving into managed care are different than the average Medi-Cal member; we are more fragile as Duals, we are not to be admitted into a medical facility and treated for the presenting medical issue but must be treated for the ENTIRE body. Not to fully meet the needs of a person with a disability who may have multiple needs, you will not have good outcomes which you seek...face re-admissions...face members requesting "Against Medical Advise" discharges with possible re-admission, something which is frowned upon. Or worst, challenged by a legal action.

- Hearing Impaired and Deaf: Alternative
- Details of the plan, not a summary but the full document
- Any printed medical procedure explanation in alternative formats
- Any charting for in-patients both handwritten or computer generated
- Any/All medical procedures
- Any conferences designed for members of health plans or any other meetings for members of health plans must provide CART which is done by a CART stenographer who types out the speech/words spoken so the deaf/hearing impaired can read what is being said. CART must be requested so the equipment and the person typing the spoken words can be present with a trial run to ensure the equipment is working...this should be done the day before so if equipment needs to be changed. ALL deaf members should be told that CART if available at any/all meetings. Health Plans cannot expect that a family member or a friend sign on behalf of the member of health plans. The health plans must have **American Sign Language Signer**; depending on the time involved of meeting, seminar, member/patient meeting with doctors/medical professionals appointment(s) and have a TTD/TTY access to all departments/trained staff how to use the TTD/TTY. Some telephone companies have a disability department who might be helpful. There is also a telephone

special interpreters using voice for the caller who the deaf person can call through the operator PLUS for those with speech interpreters in "Speech-to-Speech" nation wide! The state and all health plans, IHSS, Public Authorities should all be accessible to the deaf and blind.

Questions on access standards call "Disability Rights, Education, Defense Fund" DREDF. They have put together a health care access guideline.

Margaret Dowling
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Pittsburg, CA 94565
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Comment Template for Care Coordination Standards

Organization: Motion Picture and Television Fund
Contact Name: Sharon Siefert, Vice President, Legal Affairs
E-Mail: Sharon.siefert@mptf.com

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.) Dual Demonstration Network Adequacy Standards should be clarified to require health plans to contract with long-term care facilities providing all levels of long-term care inpatient

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			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 community" as they define it, will continue to

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			have access to such care. The 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 LTSS Readiness Standards Organization:NAMI California

Due Dec 10, 2012 Contact Name:Bettie Reinhardt

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Page	Section Title	Existing Text	Comment or Suggested Edit
Pp 7,8	Quality Improvement Systems	QI is addressed in very cursory, proforma manner in this section.	Given that most QI has been developed for medical venues and programs, it seems that more guidance should be provided here. At the least, include the important elements of a good QI system: process, system, and outcomes.

December 12, 2012

Jane Ogle
California Department of Health Care Services
Delivered via e-mail to: info@CalDuals.org

Re: Comments on California Duals Demonstration Long –Term Services and Supports Network Adequacy Standards

Dear Ms. Ogle,

Attached and below are comments on the Department of Health Care Services LTSS Network Adequacy Standards (hereafter "LTSS Standards") from the National Senior Citizens Law Center and Disability Rights California. We greatly appreciate the opportunity to provide these comments and we applaud the Department for its efforts to solicit stakeholder feedback on this important public policy. NSCLC and DRC have been active participants in the Department's stakeholder process to date and we look forward to providing our expertise and perspective as planning for this significant change continues.

While the attached comments provide more detailed feedback on each section of the draft standards, we wanted to raise our concern in this cover letter that key elements of a robust long term services and support benefit package - specifically, the HCBS "in-lieu of" benefits, as outlined in WIC 13186.1(c) - are missing from these standards. The current draft includes reference to IHSS, CBAS, MSSP and NF placement in the array of covered LTSS. The document is silent regarding plan requirements to assess and provide additional HCBS benefits (such as home modifications, emergency response systems, respite, assisted living, in home nursing or additional attendant care hours above IHSS) which may be needed to keep or

transition members out of NF or other institutions or how a member might find out about or access such care.

While IHSS and CBAS are key components of LTSS, these options alone are not always appropriate or sufficient to meet members' needs. Further, the MSSP program is limited in the number of people and type of services it can provide due to limited slots, cost caps and geographic availability.

The exclusion of these services from these standards is especially concerning given the State's decision to phase out the waiver programs that currently make these services available.

The State and contracted Health Plans are required to provide LTSS in the most integrated settings under the Americans with Disabilities Act, Section 504 and the Olmstead decision. By failing to cover the full range and amount of services needed to keep members in the most integrated setting, this document fails to set standards that would ensure that the state and the plans will meet these obligations.

In addition to fulfilling its obligations under the ADA, Section 504 and the Olmstead decision, we note that California receives enhanced federal funding for its California Community Transitions grant, with a promise that those eligible for CCT services will be offered the full array of waiver services necessary to transition out of institutions. If the waivers no longer exist and plans are not required to provide these services, it is unclear how CCT eligible individuals will receive these services.

We welcome the opportunity to discuss these concerns further with the Department and other stakeholders and continue to encourage a thoughtful, cautious approach to such a major transition affecting so many lives.

Sincerely,

Deborah Doctor
Disability Rights California

Kevin Prindiville
National Senior Citizens Law Center

Comment Template for LTSS Standards
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Organization: DRC and NSCLC
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Page	Section Title	Existing Text	Comment or Suggested Edit
`1	**Provider Network and Contracting**		There should be an MOU between the HP and CMH or Behavioral Mental Health plan in all counties they serve -- which covers the list of items identified in the DHCS documents (referral, continuity of care, confidentiality, coordination, records, etc.).
1	**Provider Network and Contracting**	Memorandum of Understanding… for the first year	This implies that Items a-j are to be kept at the county level for one year only, which is not in statute. Should separate out the functions which change after one year – e.g. collective bargaining.
2	IHSS h.	Sharing confidential data as necessary	This section deals with sharing confidential data between the health plan and IHSS. Giving the counties, the Public Authorities or IHSS providers access to confidential medical information of member should not be granted without the informed consent of the participant or his/her authorized representative. Must follow HIPAA. Giving IHSS data to health plans requires same protections.
2	**Provider Network and Contracting #3**	"consent from IHSS recipients to include IHSS providers"	Consumers must be able to consent or not to including anybody they want – not just their IHSS home care worker/employee. Forms should not give preference to the employee, but should ask which if any person the consumer wants to include.
2	**Provider Network and Contracting , #3**	Policies and procedures for an expedited referral,	Define "expedited": we suggest 24 hours

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2	CBAS 1	Policies and procedures to evaluate and document, o an annual basis, the amount of time that elapses between when a member is referred for CBAS services, and when those services are received.	This section is unclear as to what the expectation is for an acceptable amount of elapsed time overall between referral for CBAS and receipt of services, as well as acceptable interval time for the various steps in the process. Annual reporting seems too long to be effective if plans are out of compliance with acceptable timelines; moreover, the *Darling* settlement also indicates quarterly reporting. Timelines for expedited enrollment should also be documented and reported. There should also be provisions for plans of correction for non-compliance with timelines, and quality assurance regarding outcomes for individuals who are not provided with CBAS in a timely manner. *This section overlaps with #4. Combine and clarify wording.* 1. Policies and procedures to evaluate and document, o an annual basis, the amount of time that elapses between when a member is referred for CBAS services <u>through self-referral, family members, CBAS Centers, physicians, other Health Plan staff and providers,</u>

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			health care and social services providers, or other community-based organizations and when those services are ~~received~~ authorized by the Plan. (moved from #4)
3	CBAS 2	Policies and procedures to ensure that Health Plan members' total one-way transportation time between home and the CBAS centers does not exceed 60 minutes each way, to ensure compliance with WIC 14550(h).	Plans should be required to report on compliance with transportation timeline requirements, on a quarterly basis.
3	CBAS 3	Policies and procedures to arrange, and show availability of providers for, unbundled services for Health Plan 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' cultural and linguistic needs.	Plans should be required to report, on a quarterly basis, the number of Plan members eligible for CBAS, the number receiving unbundled CBAS and the reason for receipt of unbundled services versus CBAS. Plans should also be required to report on the categories of types of unbundled CBAS providers, and the cost of unbundled CBAS services.
3	CBAS 4	When establishing eligibility for CBAS services, the Health Plan follows all regulatory timelines for intake, assessment, and authorization of services. Policies and procedures to ensure compliance with designated time-frames	Timelines for CBAS eligibility determinations are not entirely set forth in regulation at this time; thus Plans must be required to comply with requirements in the *Darling* settlement, the Waiver, and State directives. Plans must explicitly be required to comply with the *Darling*

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		for completing determinations of members' eligibility for CBAS center services, upon referrals by members themselves, family members, CBAS Centers, physicians and other Health Plan staff and providers, health care and social services providers, or other community-based organizations.	settlement's requirement to conduct expedited enrollment as appropriate. In addition to timelines, Plans must be required to comply with eligibility requirements set forth in the settlement and in the Waiver.
3	CBAS 5	Documentation of having contracted with all CBAS centers within the Health Plan's covered zip code areas and in adjacent zip codes accessible to members.	In addition to contracting with all CBAS programs as described, Plans must be required to contract for sufficient slots within those programs to meet the CBAS provider capacity requirements of the *Darling* settlement, including an adequate number of slots, language and cultural competence, and program specialization.
3	CBAS 6	Policies and procedures that Health Plans are able to provide linguistically and culturally competent CBAS services when such services are available in the county.	The phrase "when such services are available in the county" is unclear." Under the Darling settlement, sufficient provider capacity is determined by having an adequate number of slots, language and cultural competence, and program specialization to meet the needs of the CBAS-eligible population in areas where ADHC existed in December 2011. Where there is not sufficient CBAS provider capacity, plans must provide unbundled CBAS to meet these same requirements.

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3	New 8		8. Documentation that Health Plans have developed and regularly conduct CBAS specific orientation and training programs for Plan staff and contractors who are responsible for CBAS eligibility, authorization and claims processes, member and provider services. Training shall include the Health Plan's policy and procedures for screening and referring members to CBAS, components of the CBAS Eligibility Determination Tool, an overview of the characteristics and needs of CBAS target population, eligibility criteria, service authorization process, assessment and reassessment process, coordination of benefits for the dually eligible, the CBAS 3-day assessment process, CBAS Individual Plan of Care and how the Plan will coordinate with the CBAS MDT, especially for those CBAS patients for whom the Plan is responsible for convening an ICT to develop an Individual Care Plan.

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Page	Section Title	Existing Text	Comment or Suggested Edit
3-4	New 9		1. Policies and procedures for an expedited authorization to CBAS for a member who may qualify for CBAS services and who is currently in a hospital or nursing facility or is at immediate risk for out-of-home placement.
3-4	MSSP 2	Components of training by HP to MSSP providers	Section is unclear. It seems to indicate that the HP will train MSSP on planning for LTSS and MSSP eligibility and services. It is the MSSP that has the expertise here and should be training the HP staff on those items. Reference to appropriate statutory standards for eligibility, assessment and service delivery should be incorporated here.
4	MSSP 3	Documentation that the HP has worked with MSSP to develop a care coordination and management model for MSSP referral and services	This is confusing. The HP has just contracted with the MSSP and has little time to complete this step. Is this the same as, in addition to or different from the coordinated care standards?
4	MSSP 4	P&P for considering recommendations of MSSP, members and stakeholders in implementation of the MSSP contract	Seems like this asks the wrong question. Why does the HP need P&P regarding implementation of an already executed contract with the MSSP? Seems like the useful stakeholder group would look at the accessibility, quality, transparency, choice, effectiveness of LTSS services, including MSSP

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			services, of the HP in general.
4	MSSP 5	P&P for referral to MSSP	Should include timelines; should include maintenance of a waitlist or documentation of need beyond the capped slots available to members
4	MSSP 6		
4	MSSP 7	Contracts with MSSP to provide MSSP waiver participants case management and, if needed, other services	This is the only place where flexible LTSS services might be provided under the current proposal. These services are capped and limited. The unmet need for services should be documented or provided elsewhere under the HP LTSS program.
4	MSSP 8	Incorporate use of MSSP services, at discretion provide additional services, incorporate features of MSSP care management, referral if slots available	This section is both unclear and problematic. Need a cite to the MSSP care management referenced here and information about how that will overlap with the CC standards which are contained elsewhere; referral only if slots are available does not deal with unmet needs, provision of alternatives or other problems that members might have with access to these services or ensuring that limited resources are fairly distributed between plans
4	NF/SCF 1	P&P for authorization of NF/SCF for members. Contracted facilities. Include but not be limited to	Authorization of NF services should be part of the larger LTSS assessment. Authorization of need for NF services must trigger offer of services delivered in the most integrated setting. Services offered must include HCBS in

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			lieu of (nursing facility) benefits. Se below.
5	NF/SCF 2	P7 to ensure members can transition to community settings, as specified in the CC Standards	The CC Standards do not adequately cover transition from NF, including assessment, inclusion of team members familiar with community options and transition efforts, community providers, flexible benefits, identification of specific services (frequency and duration and provider), a written plan, informed consent by the member or authorized representative and sign off, timelines, intensive care management, monitoring of actual community services, transition plan implementation and monitoring and emergency assistance upon discharge, reassessment, appeal rights.
5	NF 3	Evidence of orientation and training programs for clinical and HP staff to conduct utilization management and care transition. Training to include Olmstead, safe transition, transition planning and care plan after transition.	Se comment above. In addition, this is unclear as to why utilization management and Olmstead transition are included in the same section. Standards for utilization of NFs and LOC determinations versus options counseling and providing services in the community in the most integrated setting (MIS) are both larger topics that require separate sections and clear details o the obligations of HP.
5	NF 4	Refers to P&P for post transition care as specified in the CC standards	These need to be spelled out in the CC document. See separate comments.
5	NF 5	Requires contracts with NF/SCFs in sufficient numbers located within zip	1. This standard is sorely inadequate. To simply say 'sufficient' without defining how sufficiency

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		code or if necessary outside of zip code	is measured does not create a measurable standard to evaluate plan readiness by. 2. The standards are missing provisions for care continuity. During the transition to managed care, plans should contract with all NFs where a member is located to ensure continuity of care. The same should be true for any new member who is already in a facility when enrolling in a plan. HRA and care plans will not even occur for 9 days. Member care should not be disturbed in the interim if the member wants to stay in the facility. In addition, there are no provisions for contracting with higher quality facilities or measuring quality and no provisions for member choice. 3. Subacute facilities are not given sufficient attention here. All subacute level members need a contract for continuity of care and individual consideration if a transfer is desired by the member. Again quality indicators must be considered in contracting with providers. Standards regarding sufficiency should be required (numbers, choice, quality). 4. What happens to individuals who are on or would be eligible for HCBS under the Subacute waiver?

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6	All LTSS	HPs shall have a process to train care coordination staff on LTSS, eligibility and benefits	This doesn't approach being a standard. Having process, rather than demonstrating competence, is all this requires. This document is supposed to cover readiness standards for HP who are now responsible for all of the LTSS needs of members. With minor exceptions, these HP has never been responsible for these services. Standards regarding topics to cover, what LTSS is, and MIS obligations should be spelled out, including use of community providers and resources familiar with these services and concepts to assist in materials development, information for members and training to HP staff, and contracts with the HP if that's the best way to ensure that members have full access to LTSS. Staff must be trained o how to comply with the ADA and Olmstead in relation to providing services in the community rather than in an institution.
6	Financial Information/Claims Processing: CBAS and NF/SCF 1-4		We agree with CAADS on this.
7	Management Info Systems - IHSS	Data sharing agreements with counties and the public authorities	Please see comments above for Page 2.
7-8	Quality Improvement System--CBAS		Quality Assurance for CBAS must meet the requirements of the Darling settlement with respect to areas of evaluation, methods of conducting quality assurance, and sharing

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			outcomes with Class Counsel.
8	NF/SCF 1, 2	Evidence of quality standards for NF/SCF, monitoring and quality improvement	This section is unclear as to the role of licensing and other state oversight. Reference to model standards or more clarity regarding expectations would be helpful. Facilities and plans should be monitored for compliance with the Olmstead decision.
8	Provider Relations IHSS 1	P&P for securing authorization from members or legal representative to include IHSS provider in the ICT	Please see comments about this issue on Page 2. IHSS providers should not get preference. Any authorization form should be for anyone whom the member names.
9	Member Grievance System for CBAS, MSSP and NF/SCF	P&P describing how member grievances regarding eligibility assessment, care delivered by contracts CBAS, MSSP or NF/SCF.	Section under IHSS requires that members be informed that they will be able to utilize State Fair Hearing process to appeal. However, for CBAS, MSSP and NFs, only the grievance procedure is mentioned. There needs to provide clear instructions regarding internal plan grievance procedures and how members maintain their rights to notice and due process including their rights to appeal to a fair hearing any denials, terminations or reduction in benefits under LTSS. This is very important to members. We are happy to provide, and have provided in the past, more detailed recommendations on the appeal process, but the important point in this document seem to be providing clarity that plan processes must be

Comment Template for LTSS Standards
Due Dec 10, 2012

Organization: DRC and NSCLC
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Page	Section Title	Existing Text	Comment or Suggested Edit
			consistent with requirements under state and federal law.
9	Member services for all LTSS – 1, 2	P&P for training staff to answer LTSS questions; P&P ensuring that members are informed of rights and rights not violated	This section is inadequate. As to LTSS services, each plan should have specific designated and trained staff and a dedicated call in number for questions regarding LTSS (which is a complicated benefit that is not yet clearly defined by the State). Training needs to include community providers and resources as this is new area for many HPs. As to information about members rights, the state must provide specifics and guidance to plans. Requiring each plan to figure this out separately makes no sense; there is no local variation or flexibility allowed. State and federal laws govern.
9	Member services	P&P for training staff to answer LTSS questions; P&P ensuring that members are informed of rights and rights not violated	*In areas with more than one plan, it is in the member and plan's interest to have agreements in place to honor each other's authorization for CBAS services, since the authorization period spans six months and members may change plans at any time. Suggest the following:* Policies and procedures demonstrating 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

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			services to the member and no interruption in reimbursement to the CBAS provider responsible for the transferring member's care.
9	HIPAA IHSS 2	HIPAA compliance to allow IHSS providers to speak on behalf of member if authorized	Again, IHSS providers are not the default alternative; the consumers delegate the person or persons or their choice, if any. Therefore, any policies and procedures must be designed to allow anyone the member chooses to speak for them, without favoring the IHSS provider.

Comment Template for LTSS Network Standards
Due Dec 10, 2012

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Page	Section Title	Existing Text	Comment or Suggested Edit
Pages 4-5	Provider Network & Contracting, NF/SCF #1	For NF/SCF, Health Plans shall meet the following: Policies and procedures for authorization of NF/SCF for members. Such policies and procedures shall cover criteria and authorization/reauthorization for placement in contracted facilities. These policies and procedures should include, but not be limited to utilizing current Medicare criteria for Medicare skilled nursing facility placement or Medicaid criteria for Medi-Cal skilled nursing facility placement.	We recommend changing the language to state "utilizing current Medicare criteria for Medicare skilled nursing facility placement or Medicaid criteria for Medi-Cal custodial NF-A/NF-B placement." Skilled criteria for dual eligibles should be driven by Medicare standards while custodial levels of care should be driven by Medicaid standards.
Page 5	Provider Network & Contracting, NF/SCF #5	Health Plans must contract with sufficient number of facilities located in the Health Plans' covered zip code areas and, to the extent necessary, in adjacent zip code areas accessible to Health Plan members	Allow Health Plans to compensate non-contracted facilities at standard fee-for-service rates as a means to augment networks while contracts are finalized.
Page 7	Quality Improvement System, CBAS #3	Demonstrate, at a minimum, contracts with all CBAS centers that meet State licensure requirements for adult day health care centers and Medi-Cal certification requirements for CBAS providers, without any encumbering sanctions or citations.	Some CBAS centers may decide not to contract with one or more Health Plans, primarily due to capacity constraints and/or desire to work with fewer payers. We suggest modifying this language to say "offer contracts to all CBAS…."

Comment Template for LTSS Adequacy Standards
Due December 10, 2012

Organization: MSSP Site Association
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	LTSS Standards in General		While MSA appreciates the opportunity to provide our feedback, the stakeholder time allocation for feedback should be at least 30 days. This allows us more time to think through each aspect of the standards and work together to provide you meaningful and helpful feedback.
1	Intro paragraph 1	In addition, the State is developing policy guidance on Home- and Community-Based Services (HCBS) "In-Lieu of" Benefits, as outlined in Welfare and Institutions Code Section (WIC) 14186.1(c); that guidance will supplement the standards below.	This process should also include stakeholder and provider feedback to ensure it meets the needs of the population served by it. This guidance may change feedback provided on this document and should be revisited once developed. Additionally, please define "In-Lieu of" benefits.
1-6	Provider Network and Contracting	Entire Section	Vague, little detail and no accountability to the quality of policies and procedures and the standard to which these will be reviewed and validated to ensure: They do not conflict with CCI, they do not conflict with all existing program mandates, protect client rights and assure HIPAA compliance in interactions with LTSS community.
3	Provider Network and Contracting-MSSP	1. Effective May 1, 2013, Health Plans will provide evidence of having executed contracts with all MSSP organizations in the Health Plan's covered zip code areas for providing MSSP waiver services to eligible members, or have demonstrated	Contracts must be executed as the MSSP waiver services are mandated in the law, to be a part of the demonstration. Contracts already exist between MSSP providers and DHCS. The plan contract can mirror already approved contractual obligations. As identified by The

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		that they have negotiated, in good faith, to attempt to secure executed contracts.	SCAN Foundation in stakeholder comments it submitted to DHCS, we recommend that if MSSP-like services are permitted under the Demonstration when traditional waiver slots are filled, the Plans be required to adhere to the same services and standards provided under the MSSP waiver program and that this is reflected in the contracts between the Plans and MSSP organizations.
3	Provider Network and Contracting-MSSP	2. Documentation that Health Plans have developed and will conduct a benefit orientation and training program specific to MSSP for staff or contractors to act as care managers for members.	The wording on this section is unclear. Currently, it reads as if the Health Plan will train MSSP providers on what MSSP is, which may be an incorrect interpretation. If the intent is to educate the plans about MSSP, the language should read that CDA and MSA will provide joint training about MSSP to the plans. This can be accomplished through Webinars to reach all contracted plans.
3	Provider Network and Contracting-MSSP	2. (Second Paragraph) The Health Plan also provides documentation that they have trained personnel of MSSP organizations to the Health Plan's covered benefits and policies and procedures to access services and coordinate care.	The intent of this section is unclear. Is the goal of this training to have Plans rely on MSSP to educate consumers about the Plan's covered services or have MSSP aware of services to help with navigation? Possible suggested edit: "…to access services and coordinate care on behalf of a Member served by MSSP."
4	Provider Network and Contracting-MSSP	3. Documentation that the Health Plan has worked with their contracted MSSP organizations to develop a care	If a client is being discharged from a NF or hospital, the referral should be able to come through the NF or hospital and be expedited to

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		coordination and management model that supports appropriate referral of Health Plan members to the MSSP for assessment, eligibility determination, and services.	prevent readmission. Suggested edit: "…care coordination and care management model that supports appropriate and timely referral of Health Plan Members to the MSSP for assessment, eligibility determination, and services within 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	4. Policies and procedures for establishing, convening, and considering the recommendations of MSSP organizations, Health Plan members and other stakeholders in the implementation of the health plan's contract with the MSSP site.	As previously stated, a contract already exists between the MSSP sites and the state. This should be clarified to refer to the contract which covers the relationship between the Plan and the MSSP provider including how the communication occurs and transfer of data within HIPAA compliance, time frames, etc. and include input from the Plans, the State and MSSP sites.
4	Provider Network and Contracting-MSSP	5. Plans shall provide documentation of having developed policies and procedures governing how the Health Plan will make referrals to MSSP and defining the respective care management roles and duties of the Health Plan's Interdisciplinary Care Team (ICT) and MSSP care managers.	This seems a little broad in scope and does not address the issue of multiple plans in LA and having a uniform system for referrals. There should be some uniform standards including time frames for the referral process. This could be included in the contract addendum. Additionally, the role of the MSSP care manager is already defined in the waiver agreement with CMS; however the MSSP care coordinator's role in the ICT should be defined.

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4	Provider Network and Contracting-MSSP	6. Health Plans shall provide documentation of having developed policies and procedures governing MSSP assessment and eligibility determination as part of the Health Plan's care coordination.	Statutorily the MSSP waiver standards are still applied in the care provision including assessment and eligibility determination. Is the intent of this paragraph to ensure the Plans include this benefit as part of their menu of care coordination services?
4	Provider Network and Contracting-MSSP	7. Health Plans shall have contracts with MSSP sites/organizations to provide Plan members who are MSSP waiver participants, MSSP case management services, and if needed, receive MSSP waiver services (supplemental personal care, respite, ramp, nutrition services maintenance type, etc.);	Page 3 bullet point 1 needs to be adjusted to match this point. Additionally, "and if needed" should be changed to, "and **as** needed." MSSP can only provide these services as needed based on a need identified in the assessment and care plan process, after all informal and other formal resources are exhausted.
4	Provider Network and Contracting-MSSP	8. • Incorporation of features or elements of the MSSP care management approach.	This is unclear. Is this in cases where the member does not require the level of care management provided in MSSP? Is this referring to contracted cases with MSSP sites that aren't MSSP clients? It should be defined – what elements or features and in which cases?
4	Provider Network and Contracting-MSSP	8. • Plans shall have policies and procedures to refer MSSP eligible plan members to the MSSP sites, **if there is availability.**	Currently, potential MSSP clients are put on a waiting list if there are no waiver slot vacancies. Suggested edit:"…to refer MSSP eligible plan Members to the MSSP sites, if there is an open waiver slot available, and for how eligible plan Members will receive the needed benefits if there is no available waiver slot."
5	Provider Network and	2. Policies and procedures to ensure	This needs to be accompanied by standards to

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	Contracting-NF/SCF	members have opportunities to transition from nursing facility to community settings, as specified in the Care Coordination Standards.	ensure that the member is maintained at the least restrictive level of care including repatriation expectations and what comes along with that. Assisted Living Waiver and CCT are not benefits included in the CCI and there needs to be stated expectations / standards in their absence. These are the two primary programs that provide this service currently. Additionally, these transitions are successful because of the NF-A/H Waiver, which is also excluded from the CCI. With these actions, it appears that the infrastructure to successfully transition people out of institutional settings is being eliminated. Language should either protect the provision of these services, otherwise making it the Plan's responsibility without sufficient assurance of adequate rates to voluntarily include a replacement of these benefits will set them up for failure.
5	Provider Network and Contracting-NF/SCF	3. Evidence of orientation and training programs for registered nurses, other clinical personnel, and appropriate Health Plan staff, directly employed or contracted, to conduct utilization management and community care transition for plan members. This training shall include, but not be limited to incorporating the core concepts of the Olmstead Decision, i.e. serving members in the least restrictive	As stated above, this is already accomplished through CCT. Either the Plans need to contract with CCT and continue with the ALW and NF-A/H Waivers, or place this burden elsewhere. This is not something that can be learned and taught in the time frame before CCI implementation. Managed care plans do not specialize in transition services and do not have the expertise it takes to oversee health and welfare for a medically-fragile population served

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		settings as appropriate, as well as criteria for safe transitions, transition planning, and care plans after transitioning.	in assisted living settings, nor to provide housing research and advocacy, furniture location and moving, housing adaptations, vehicle adaptations, applications to services to provide services such as paratransit, home-delivered meals, and so much more. This is an unreasonable expectation of plans and puts the lives of the frailest population at jeopardy if transitioned without everything in place.
6	Financial Information/Claims Processing	Provide assurance that, through December 31, 2014, they shall allocate to their contracted MSSP organization(s) the same level of funding as those organizations otherwise would have been allocated under their MSSP contract with the California Department of Aging (CDA).	How will this work? The structure of Waiver Services does not allow for the application of a viable capitation calculation as it varies from person to person. Other than a pass through formula, the structure could not remain as it is, yet it is guaranteed in the statute. Since the plans will be dependent on the state to be successful in assuring this requirement, the state must declare its role in this process in this document as well. In Los Angeles County, for example, no one of the 7 health plans could possibly know if it is providing the same level of funding to an MSSP site, without the state overseeing the process.
8	Management Information System	Entire Section	It is not enough to have an MOU. Prior to implementation, evidence of data communication and transfer, including successful test billing, need to occur.

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Organization: MSSP Site Association
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9	Quality Improvement System	Entire Section	MSSP sites are already monitored for compliance with state and federal regulations, including QA. Either the Plan replaces the work of CDA, which is counterintuitive given the level of expertise with MSSP at CDA, or it should be sufficient for the Plan to receive reporting from CDA and DHCS on their compliance monitoring.
9	Member Services	1. Policies and procedures for the training of Health Plan staff to answer any service related questions or direct members to appropriate agency. 2. Policies and procedures ensuring that all Health Plan members and/or authorized representatives are fully aware and informed of their rights, and that those rights are not violated.	1. How is the knowledge level tested? Suggest creating a frequently asked questions fact sheet in concert with providers to help arm Plans' staff with how to respond to questions. 2. How will this be measured?

Comment Template for LTSS Network Adequacy Standards
Due Dec 10, 2012

Organization: SEIU California
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1	"Provider Network and Contracting"	"1. Effective February 1, 2013, an executed Memorandum of Understanding (MOU) with county agencies that reflects an agreement between the Health Plans and county agency regarding roles and responsibilities for the ***first year*** of the demonstration and Medi-Cal LTSS."	During the December 5, 2012 stakeholder call to discuss this document, Margaret Tatar (DHCS) stated that the intent of the MOU is to last the duration of the three year demonstration. It is unclear why it is defined in this section that the Plan must execute an MOU with the county that outlines roles and responsibilities for only year one of the demonstration if, in fact, the MOU is meant for the entire three year duration of the demonstration. SEIU California does not disagree that the MOU may need to be adjusted, with robust stakeholder input, after year one for a variety of potential reasons (i.e. changes in how collective bargaining is handled for the IHSS program or necessary changes to address any issues in the delivery of care for dually-eligible beneficiaries that have arisen in year one, etc.). However, the actual intended duration of the MOU between the Plan and the county must be specified.
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).

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			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."
2	"Provider Network and Contracting"	"5. Policies and procedures for an ***expedited referral***, when appropriate, to county social services agencies for a member who is at risk for out-of-home placement, and may qualify for IHSS services."	It is unclear what is meant by "expedited referral." SEIU California suggests that a definition of "expedited referral" be inserted into this section.
5	"For NF/SCF, Health Plans shall meet the following:"	"5. In contracting with NF/SCFs pursuant to these standards, Health Plans shall contract with licensed and certified nursing facilities that provide all levels of care. Health Plans must contract with a sufficient number of	Considering the dual-eligible population, currently or soon to be residing in nursing facilities, is among our state's most vulnerable populations, we must ensure that these facilities are of the highest quality. Furthermore, for

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		facilities located in the Health Plans' covered zip code areas and, to the extent necessary, in adjacent zip code areas accessible to Health Plans members. 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. (WIC 14186.3(c))"	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.
5	" For NF/SCF, Health Plans shall meet the following:"	"7. When contracting with NF/SCFs, the	**Suggested textual additions:** 7. When contracting with NF/SCFs, the

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		executed contract must include evidence of the following: • A comprehensive policy on occurrence reporting, including, but not limited to sentinel events and quality issues. • Provisions on how the Health Plan will address change of ownership, loss of licensure, or any expected or unexpected closure of a contracted NF/SCF. • Policies and procedures that address the management of the nursing facility benefit. • Provider training curriculum for newly contracted NF/SCF providers. • Staff curriculum for training on how to manage the benefit including: ▪ Sign in sheets for the staff training on how to manage the benefit. ▪ Care coordination for members in nursing facilities. ▪ Required notices for members in nursing facilities. ▪ How to provide notices to members in nursing	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***

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		facilities. ▪ Relevant state and federal standards on the benefit. ▪ Relevant state and federal standards on consumer rights and protections. ▪ Sentinel events-quality reporting ▪ How to pay claims ▪ Encounter data submissions	
8	"Quality Improvement System, For NF/SCF, Health Plans shall meet the following:"	"1. Evidence of quality standards for NF/SCF services provided to members, and policies and procedures for health plans to monitor quality and the process to address any deficiencies identified by Health Plans."	**Suggested textual additions:** 1. Evidence of quality standards for NF/SCF services provided to members, and policies and 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,***

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			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 for Care Coordination Standards Organization: Silicon Valley Independent Living Center

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1	**California Duals Demonstration**	In addition, the State is developing policy guidance on Home- and Community-Based Services (HCBS) "In-Lieu of" Benefits,	The notion of "in lieu of" benefits encourages plans to cut corners to save money.
9	Member Grievance System	Policies and procedures describing 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.	This procedure is relatively toothless. Also, the ombudsman should be independent, not a state employee; this poses conflict of interest.

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Organization: The SCAN Foundation
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General Comment		Document title: "Long-Term Services and Supports Network Adequacy Standards"	The proposed standards do not define LTSS *network adequacy* but rather lay out requirements for contracts between Health Plans and LTSS programs (IHSS, CBAS, MSSP, NF). We recommend the document be retitled to "Long-Term Services and Supports Readiness Standards" to reflect this distinction. Furthermore, this document lays out procedural requirements for the above-named programs and Health Plans, but does not recognize the range of services individuals may need to live safely in their homes and communities and how plans would be ready to meet these needs. We recommend that this issue is specified clearly in the supplemental guidance described on page 1 and listed in the comment below.
1	Introduction	In addition, the State is developing policy guidance on Home-and Community-Based Services (HCBS) "In-Lieu of" Benefits…; that guidance will supplement the standards.	LTSS Network Adequacy Standards cannot be developed without clear HCBS policy guidance. Therefore, we recommend that these standards be revisited and posted for public comment once the HCBS policy guidance is in place.
2	Provider Network and Contracting - CBAS	For CBAS, Health Plans shall meet the following: 1. Policies and procedures to evaluate and document, on an annual basis, the amount of time that elapses when a member is referred for CBAS services, and when those services are received.	The timeliness in which services are put in place following referral is a critical issue. However, this provision appears to only apply to CBAS and not to the other programs/services that may be included. Furthermore, the state is asking only that Plans monitor and document the time between referral and service commencement

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			and does not provide guidance on the target interval toward which Plans should be striving. We recommend that Plans be required to monitor the length of time between referral and commencement of services for all HCBS programs and that the state be more prescriptive about the time interval that it deems acceptable.
3-4	Provider Network and Contracting - MSSP	Health Plans will provide evidence of having executed contracts with all MSSP organizations in the Health Plan's covered zip code areas for providing MSSP waiver services to eligible members…	It is unclear what will happen if Members are referred to MSSP but the available slots are filled. Should MSSP-like services be permitted under the Demonstration when traditional waiver slots are filled, we recommend that Plans adhere to the same services and standards provided under the MSSP waiver program and that this is reflected in the executed contracts between the Plans and MSSP organizations.

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5	Provider Network and Contracting - Nursing Facility/Sub-acute Care Facilities	2. Policies and procedures to ensure members have opportunities to transition from nursing facility to community settings, as specified in the Care Coordination Standards.	We applaud the state's efforts to ensure that nursing home residents have the opportunity to transition to the community, in accordance with individual needs and preferences. We recommend that this standard be strengthened to ensure that Plans identify individuals in institutions who wish to transition to the community and consult with the proper entities to facilitate this transfer. Plans should work in consultation with the California Community Transition/Money Follows the Person program's local lead entities, and should also 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. In addition, 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.
6	For all LTSS	Health Plans shall have a process to train care coordination staff on LTSS, eligibility for LTSS, and the benefits to members of these services.	We recommend that this standard be further specific and strengthened. The Massachusetts Dual Eligibles Integration Demonstration MOU provides useful guidance, as follows: *The Health Plan shall train care coordination staff o the person-centered planning processes, cultural competence, accessibility and accommodations, independent living, and*

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			wellness principles, along with other required training, as specified by the Plan, initially and on a annual basis; *b. The Plan shall document completion of training by all care coordinators, including both employed and contracted personnel and has specific policies to address non-completion; and* *c. The Plan shall documents that all care coordinators have agreed to participate in approved training.*
7	Management Information System	2. Evidence of having executed data sharing agreements (to include sharing of clinical data, utilization of plan benefits and MSSP waiver services) with their contracted MSSP organization(s).	We are unclear what constitutes "clinical data" in this context. We recommend that health and functional assessment data be included in this list of items shared between the Plan and MSSP sites.