



**CALIFORNIA  
HOSPITAL  
ASSOCIATION**

*Providing Leadership in  
Health Policy and Advocacy*

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Richard Figueroa  
Acting Director  
California Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, CA 95814

**SUBJECT: California Department of Health Care Services' Expanding Access to Integrated Care for Dual Eligible Californians Proposal**

Via e-mail: [Richard.Figueroa@dhcs.ca.gov](mailto:Richard.Figueroa@dhcs.ca.gov)

Dear Acting Director Figueroa:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) appreciates the opportunity to provide recommendations to the California Department of Health Care Services (DHCS) on its proposal to discontinue Cal MediConnect and the Coordinated Care Initiative and transition to a statewide managed long-term services and supports (MLTSS) and dual eligible special needs plan (D-SNP) structure.

Titled *Expanding Access to Integrated Care for Dual Eligible Californians*, the proposal was released as part of the California Medi-Cal Healthier California for All initiative, the state's multi-year initiative to redesign the Medi-Cal delivery system. It aims to promote integrated care through D-SNPs and MLTSS plans across California. This includes mandatory enrollment for dual eligibles into MLTSS plans and increasing the availability of D-SNPs, which would allow duals to voluntarily enroll into the D-SNP that is aligned with their MLTSS plan. CHA supports the move to standardize policies and procedures addressing long-term services and supports, long-term care, and D-SNPs throughout the state and agrees that these changes could support streamlined plan oversight, as well as greater consistency in care services.

CHA appreciates the opportunity to provide the feedback below, informed by the experience of California's hospitals and post-acute care providers under the current system. Our experience to date has shown us that there are many opportunities to improve care coordination for this vulnerable population. Specifically, we offer recommendations in the following areas:

- D-SNP integration requirements
- Selective contracting with D-SNPs
- D-SNP grievance and appeal requirements
- Medi-Cal managed long-term services and supports
- Mandatory enrollment into Medi-Cal managed care plans
- Enrollment considerations and consumer protections

- Reporting requirements, oversight, and quality
- Alignment of D-SNP and companion Medicaid plan service area
- Transition and enrollment policies
- Interaction with other parts of the health care system, including health-related initiatives

### **D-SNP Integration Requirements**

DHCS indicates it will require all D-SNPs to use a model of care addressing both Medicare and Medi-Cal services in order to support coordinated care, high-quality care transitions, and information sharing. CHA urges DHCS to provide oversight to ensure that Medi-Cal managed care plans that develop new D-SNP products adhere to Medicare Advantage policies regarding beneficiary access to all levels of care, including inpatient rehabilitation facility and long-term care hospital care. CHA is very concerned that these Medi-Cal managed care plans may not clearly understand Medicare eligibility and benefit criteria, thereby limiting access to covered services. Conversely, long-established D-SNPs with expertise in Medicare eligibility and benefits may be driven out of the market if they do not have a companion Medicaid plan. CHA has concerns about such an impact on patient access to high-quality, coordinated care.

For example, under Cal MediConnect, hospitals reported that enrollees were frequently denied access to long-term care hospitals and inpatient rehabilitation facilities even when their clinical condition and functional status clearly met Medicare criteria for these benefits and when these medically necessary services would result in improved medical and functional outcomes. In some instances, case managers in some regions reported that plan case managers communicate they do not have the ability to offer care in a long-term care hospitals, so they direct the hospital to seek skilled-nursing facility placement instead. In other cases, hospital clinicians have been informed that patients who are eligible for IRF care can receive adequate care in a skilled-nursing facility with physical therapy. This is a clear violation of Centers for Medicare & Medicaid Services (CMS) policy governing Medicare Advantage services. More importantly, patients are being denied access to the critical medical services they need, which negatively impacts patient outcome and level of independence.

### *D-SNP Categories*

DHCS indicates it will not require D-SNPs to operate as fully integrated or highly integrated SNPs; however, a plan may pursue this designation. Instead, DHCS' contracts with D-SNPs will require all D-SNPs to notify, or arrange for another entity to notify, the state or its designee of hospital and SNF admission for at least one state-identified population of high-risk enrollees to improve coordination of care during transitions of care.

CHA urges DHCS to consider the benefits of FIDE and HIDE SNP designation in light of the larger Medi-Cal Healthier California for All vision. In developing its final D-SNP regulations, CMS created a definition for a new D-SNP category, the Highly Integrated Dual Eligible Special Needs Plan (HIDE-SNP). To be considered a HIDE-SNP, a plan must provide, either directly or through a companion Medicaid managed care plan, either long-term services and supports or behavioral health services, as well as other Medicaid services to its dual eligible members. This contrasts with a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), which provides virtually all Medicaid services — including both long-term services and supports and behavioral health. It would seem that FIDE-SNPs focus on a more whole-

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person care approach, providing dual eligible individuals with even greater care coordination, and are more aligned, in concept, with the aim of the Medi-Cal Healthier California for All initiative.

#### *Notification of Hospital Admissions*

Because coordination of benefits during discharge planning is particularly critical for a successful transition, all D-SNPs should have systems in place to ensure both care and benefit coordination for all members leaving institutional settings. CHA requests that D-SNPs be contractually required to have such systems. In addition, CHA requests that plans demonstrate to DHCS that they have their own systems in place to receive notifications of admission and discharge and to coordinate with D-SNPs and discharge planners.

#### **Selective Contracting with D-SNPs**

##### *Partial Duals and D-SNPs*

DHCS indicates that it will require managed care plans to pursue D-SNPs that limit coverage of full-benefit dual eligibles. If the plan sponsor wants to offer coverage to partial-benefit dual eligible individuals, DHCS will require separate plan benefit packages. In issuing its final D-SNP regulations, CMS questioned the value of partial duals enrollment in D-SNPs because they are not eligible to receive any Medicaid-covered services, raising a question about whether D-SNP enrollment provides any added value. CMS indicated that it may consider future rulemaking in this area. As some states have chosen to restrict D-SNP enrollment for partial duals but many have not, CHA requests that DHCS share with stakeholders its rationale for not restricting D-SNP enrollment for partial duals.

##### *D-SNP “Look-Alikes”*

DHCS indicates it will pursue several avenues with CMS to limit enrollment into Medicare Advantage plans that are D-SNP “look-alikes,” but which do not offer integration and coordination with Medi-Cal. CHA appreciates that DHCS will limit enrollment into D-SNP “look-alikes.” These plans threaten to undermine DHCS’ proposal as they 1) aggressively market to dual eligible individuals, 2) are not subject to the regulations governing D-SNPs and, therefore, have no responsibility to coordinate Medicare and Medicaid benefits, 3) draw dual eligible individuals away from coordinated options, and 4) place responsibility on the consumer to navigate two separate delivery systems, potentially exacerbating disruptions and gaps in care.

#### **D-SNP Grievance and Appeal Requirements**

DHCS acknowledges that, as part of the updated D-SNP requirements, HIDE and FIDE D-SNPs with exclusively aligned enrollment — meaning their enrollees are all enrolled in the same health plan organization’s managed care plan — will need to comply with CMS’ rules to unify Medicare and Medicaid grievances and appeals processes for D-SNPs and affiliated managed care plans beginning in 2021. Although CMS limited the requirements for integrated appeals to HIDE and FIDE D-SNPs, the agency also encouraged states to explore other, more limited, steps that will make appeals for overlapping services easier for beneficiaries enrolled in other D-SNPs.

CHA urges DHCS to explore ways to make the grievances and appeals process as streamlined as possible for dual eligible individuals. For example, D-SNPs with matching Medicaid plans, even if not exclusively

aligned, could provide integrated appeals for the portion of their membership enrolled in the matching plan. All D-SNPs could provide appeal notices that clearly explain to members the path for pursuing the Medicaid side of an appeal. Alternatively, DHCS could modify Medicaid managed care contract terms so that, where the Medicaid rules are more restrictive, they are replaced by those applying to D-SNP appeals.

### **Medi-Cal Managed Long-Term Services and Supports**

DHCS will begin requiring statewide integration of long-term care (LTC) into managed care for Medi-Cal populations by 2021, starting with **non-dual** eligible populations in 2021 and including all **dual eligible** populations in counties or plans that do not already include long-term care by 2023. CHA supports this approach, as it seeks to reduce the complexity of the varying models of care delivery in California, which has been a challenge for patients and providers. However, with the increased responsibilities of managed care plans, DHCS must increase oversight of the plans and their delegated entities to ensure that not only are current requirements being met, but that the additional layers of benefits and requirements in the Medi-Cal Healthier California for All initiative are being achieved.

As DHCS notes in the proposal, the Coordinated Care Initiative provided valuable lessons about the challenges of coordinating between Medicare-covered services and Medi-Cal services for dual eligible individuals. With the transition to Medi-Cal Healthier California for All, it will be important for DHCS to proactively address the issues identified in the Coordinated Care Initiative, including but not limited to enrollment, access to services, prior authorization and appeals, and care coordination between medical care and long-term services and support services. It will be important to clarify plan responsibilities for all dual eligible members, including those enrolled in traditional Medicare fee-for-service, as well as those enrolled in Medicare Advantage or D-SNP plans.

CHA urges DHCS to develop and implement timely, accessible, and clear appeal procedures, especially regarding access to Medicare benefits and the coordination with delegated entities. This is particularly important in the context of prior authorizations and timely access to medically necessary care after acute hospitalization. This process must include the ability for providers to pursue appeals on behalf of Medi-Cal members, ensure that decisions are made on a real-time basis to allow for care planning, and ensure managed care plans remain responsible for reimbursement of care during the appeal time frame.

A major concern in the Coordinated Care Initiative was the ability to access post-acute hospital services, in particular skilled-nursing care and medically necessary post-acute care services such as inpatient rehabilitation and long-term hospital services. Plan networks were often inadequate and even inaccurate, in that contracted facilities declined to admit plan members based on clinical or financial concerns. CHA strongly recommends that DHCS consider require that managed care plans:

- Demonstrate network adequacy based on actual care transitions, rather than a list of “available” beds or facilities.
- Provide reimbursement to hospitals for care that extends beyond the patient’s need for acute medical care while awaiting an appropriate post-hospital in-network care setting.

### *Skilled-Nursing Facility Coordination*

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DHCS indicates it will also consider new requirements for managed care plans working with long-term care facilities, align quality metrics, and potentially require skilled-nursing facilities to coordinate with D-SNPs to align with D-SNP requirements and coordinate around hospital and other facility discharge planning.

With regard to skilled-nursing facility coordination, there must be clarity for the respective responsibilities around care coordination so that it is not interpreted to mean that the skilled-nursing facility would be responsible for the care coordination, when it should be ultimately the plan's role. At a minimum, the skilled-nursing facility should be in communication with the plan, provide requested medical information, and provide clinical services consistent with the treatment needs and goals of care, as determined by the overall plan of care.

### **Mandatory Enrollment into Medi-Cal Managed Care Plans**

DHCS indicates it is committed to providing beneficiary and provider education, as well as technical assistance around managed care plan requirements for mandatory enrollment of dual eligible individuals into Medi-Cal managed care. As part of this work, DHCS will engage in various outreach and educational efforts including but not limited to: 1) updating education and enrollment materials used to assist dual eligible individuals, 2) educating providers about necessary billing practices as well as the processes that will not change, and 3) providing technical assistance around new managed care plan requirements for dual eligible individuals. CHA looks forward to partnering with DHCS on provider education as this initiative is implemented.

### **Enrollment Considerations and Consumer Protections**

CHA appreciates that DHCS has addressed additional enrollment considerations such as the Medi-Cal procurement, prescription drug benefit carve-out, enrollment dates for dual eligible individuals, and beneficiaries that would crosswalk from Cal MediConnect plans to D-SNPs. In addition, DHCS outlines how it will limit churn, ensure consumer protections are standardized across the state, and provide notices to MLTSS dual-eligible members, informing them of their new option to enroll in a matching D-SNP.

#### *D-SNP Crosswalk Transition*

DHCS indicates that, given the large volume of beneficiaries that would crosswalk from CMC plans to D-SNPs, DHCS could request from CMS continued demonstration authority during the transition to allow Cal MediConnect member health risk assessments and care plans to qualify under the D-SNP, rather than requiring plans to conduct health risk assessments and develop care plans for members who do not have them. DHCS indicates it may request this authority to also apply to members crosswalked from Medicare Advantage plans to D-SNPs. CHA understands that, to the extent that the established health risk assessments and plan of care can be transitioned to the new plan, this may help with continuity of care. CHA believes there should, however, be some review and updating of that health risk assessments and plan within a set period of time post-enrollment. In addition, CHA requests that DHCS clarify that all services indicated by the original plan continue in the meantime.

### **Reporting Requirements, Oversight, and Quality**

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DHCS indicates it will align D-SNP quality improvement and oversight requirements with new requirements under the Medi-Cal Healthier California for All initiative and managed care plan contract requirements, to the extent possible. DHCS indicates it will work with stakeholders, plans, and CMS to identify the range of quality and reporting results that D-SNPs will report to DHCS on an annual basis. CHA requests to be included in this stakeholder process. CHA believes that required quality and resource use measures that focus on timely access to medically necessary service, beneficiary experience of care, and achievement and maintenance of optimal medical and functional outcomes should be included.

In addition, DHCS indicates it will provide education and training to the long-term care ombudsman to support this population following the transition from Cal MediConnect. As we've previously shared, to enhance the real-time assistance for consumers and providers when managed care plans are not meeting their contractual obligations or not providing the necessary case and care management, CHA recommends that DHCS revisit its ombudsman program and create a single point of entry for patients and providers who have concerns with their health plan so that DHCS can track trends in patient and provider complaints to inform systemic improvements.

Currently, DHCS maintains a Medi-Cal Managed Care and Mental Health Office of the Ombudsman to answer consumer questions and resolve complaints. In addition, there is an independent ombudsman, a program funded by a federal grant, that offers services to Cal MediConnect members for individuals enrolled in Medicare and Medi-Cal. There is also an independent long-term care ombudsman program to help patients in nursing and other health facilities, and in residential care facilities. Patients and providers need a single point of contact — a “no wrong door” approach — to receive real-time assistance with their health care coverage and to effectively hold plans accountable.

#### **Alignment of D-SNP and Companion Medicaid Plan Service Area**

CHA requests clarification on required alignment of D-SNP and companion Medicaid plan service areas. To enhance integration for full-benefit dual eligible individuals in D-SNPs, CMS has encouraged Medicare Advantage organizations offering D-SNPs to consider ways in which alignment of D-SNP service areas relative to those of affiliated entities offering capitated Medicaid benefits would be beneficial. CMS notes that such alignment of service areas allows for better integration of Medicare and Medicaid benefits for enrollees. It also provides opportunities for HIDE and FIDE SNPs to take advantage of administrative flexibilities to better coordinate member communications materials, models of care, and – beginning 2021, or earlier if required by the state in its contract with the D-SNP, and when enrollment is exclusively aligned – to unify Medicare and Medicaid appeals and grievance procedures. It is unclear whether DHCS would require such alignment, so clarification would be appreciated.

#### **Transition and Enrollment Policies**

##### *Default Enrollment*

DHCS indicates it is exploring pathways to encourage aligned enrollment of dual eligible individuals into matching managed care plans and D-SNPs to promote more integrated care. DHCS indicates it could allow D-SNPs to pursue approval from CMS and DHCS to enroll — unless the member chooses otherwise — existing managed care plan enrollees into the D-SNP when the enrollee becomes newly eligible for Medicare. If DHCS proceeds in this direction, CHA requests that individuals enrolled through this process

are provided timely information about their alternative health care coverage options. CHA requests that DHCS clarify if the default enrollment process also applies to individuals who are newly eligible for Medicare by virtue of a disability.

*Aligned Enrollment – Medicare Fee-for-Service (FFS) Dual Eligible Individuals*

DHCS indicates that dual eligible beneficiaries who are in Medicare FFS would remain in Medicare FFS, unless they voluntarily choose to enroll in a Medicare product. CHA requests additional clarification on care coordination responsibilities of D-SNPs, both when they are **aligned** and are **not aligned** with a member's managed care plan. What is the care coordination responsibility of the managed care plan if the member is in a D-SNP that is not aligned with the managed care plan? How will information about roles and responsibilities be communicated to patients and providers?

**Additional Considerations**

*Interaction of Delegated Entities*

In the Medi-Cal Healthier California for All initiative, DHCS acknowledges that plans are responsible for ensuring their delegates comply with state and federal regulations, as well as DHCS policies. As this proposal proceeds, it will be important to include a mechanism for Medi-Cal members and providers to identify and address concerns on a timely basis about the behavior of delegated entities. CHA encourages DHCS to develop processes and oversight mechanisms that address the unique opportunities and challenges of the delegated model to ensure consistency in application of policies across the plans and their delegated entities. Plans must be responsible for delegated entity failures to comply with payment practices and California law.

As managed care plan networks grow increasingly complex with more delegation of risk, CHA urges DHCS to take a greater role in overseeing the plans' entire networks, including ensuring delegated entities comply with each plan's contractual requirements. In some California markets where the delegated model is more dominant, there are additional challenges. Specifically, it is a challenge for DHCS to receive accurate and timely encounter data to ensure plan contract compliance. There is also a lack of care coordination for members, creating greater risk of duplication and inefficiencies. CHA urges DHCS to evaluate the economy and efficiency of care networks and apply greater accountability to the primary plans that have chosen to enter into such arrangements. Far too often, hospitals hear from delegated entities that they are not aware of contractual or significant policy changes (e.g., effectuating contractual changes to meet the network provider definition).

*Interaction of Proposal with Broader Medi-Cal Healthier California for All Initiative and Master Plan for Aging*

The broader Medi-Cal Healthier California for All goals are to (1) promote whole person care approaches and address social determinants of health, (2) move Medi-Cal to a consistent and seamless system, reducing complexity and increasing flexibility, and (3) improve quality and transform delivery systems through value-based initiatives, modernization of systems, and payment reform. The D-SNP proposal developed as part of the larger Medi-Cal Healthier California for All proposal fails to identify how any of its contents would advance these goals. CHA urges DHCS to align the proposal with the Medi-Cal Healthier California for All goals and outline how this proposal interacts with other proposals within the

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Medi-Cal Healthier California for All initiative, such as the requirement that managed care plans develop and maintain a beneficiary-centered population health management program, and the interaction of the proposal with Medi-Cal managed care plans' enhanced care management and in lieu of services programs.

A complete proposal further requires DHCS to examine creative ways outside of the traditional benefit package that can support dual eligibles. We applaud the department's efforts to implement in lieu of services and appreciate its clarification on a recent webinar call that in lieu of service will be mandatory for plans beginning in 2026. Data from Cal MediConnect illustrates that when care plan options services were optional and financial incentives were not in place, beneficiaries largely did not benefit from these services. CHA urges DHCS to take those learnings into account and ensure that the provision of in lieu of services is encouraged, and that the financial incentives are in place, both with respect to dual eligibles in aligned D-SNP and Medi-Cal plans as well as those in original Medicare. Successful implementation of in lieu of services helps the department achieve its commitment to deliver care in the most appropriate, least restrictive setting.

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

*Interaction of Proposal on PACE, IHSS, Palliative Care, and Behavioral Health*

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

The proposal also fails to mention palliative care, a benefit Medi-Cal managed care plans started delivering as of January 1, 2018. To date, DHCS has not required Medi-Cal managed care plans to deliver the benefit to duals despite duals representing a population that would both be eligible for and greatly benefit from palliative care. CHA urges DHCS to address palliative care in its proposal, since an integrated delivery model is one in which palliative care for duals can most easily be implemented. Similarly, we are concerned that there is no clear discussion about how access to behavioral health services will be coordinated. This is a key area of discussion for this population that requires careful consideration.



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CHA appreciates the opportunity to provide initial recommendations on this proposal. We look forward to participating in the stakeholder engagement effort and in discussions over the next several months to inform the final approach, prior to submission for CMS approval.

If you have any questions, please contact me at (916) 552-7543 or [akemp@calhospital.org](mailto:akemp@calhospital.org), or my colleague, Pat Blaisdell at (916) 552-7553 or [pblaisdell@calhospital.org](mailto:pblaisdell@calhospital.org).

Sincerely,



Amber Kemp  
Vice President, Health Care Coverage



Pat Blaisdell  
Vice President, Continuum of Care

cc:

Dr. Mark Ghaly, Secretary, California Health and Human Services Agency  
Ms. Jacey Cooper, Chief Deputy Director, Health Care Programs  
Ms. Sarah Brooks, Deputy Director, Health Care Delivery Systems