



July 27, 2010

Ms. Cindy Mann
Director, Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: California's 1115 Medicaid Waiver Renewal: Advocates' Remaining Concerns Regarding SPDs

Dear Ms. Mann,

Our California organizations have been engaged through multiple avenues to ensure that the needs of seniors and persons with disabilities are protected as the state moves to mandatorily enroll them into managed care. We are members of the Waiver Stakeholder Advisory Committee and the technical workgroups on SPDs and dual eligibles, we have

met with Department and legislative staff, and we have submitted comments in writing. While significant progress has been made on a number of issues and we appreciate staff's willingness to meet with us, there are still some issues that remain unresolved of which we felt it important to apprise you.

We support the goals of the waiver to begin implementation of health reform, strengthen our safety net, and improve health outcomes and delivery systems for seniors and persons with disabilities. Our comments are designed to ensure that these latter goals are realized.

Our comments are based on the state's waiver proposal to CMS and the California legislation (SB 208 and AB 342). If there is a relevant section in the legislation which we seek to be amended it is noted below.

Many of our organizations have spoken with you regarding ensuring that the needs of SPDs are adequately addressed in the waiver. As some of our stated concerns may be appropriate to address through the waiver Terms and Conditions, we hope to have the opportunity to review and offer our input on those as well before they are finalized.

Plan Readiness Including Network Adequacy and Disability Access Standards

As the state moves toward mandatorily enrolling SPDs, it is critical to ensure **prior** to enrollment that the plans have the capacity to meet the needs of SPDs. The proposed California legislation incorporates the current readiness standards used to determine whether a plan can expand into a new geographic area rather than criteria tailored to SPDs. Further, many of these readiness standards are so vague that we do not think they can be assessed and enforced. We think the following changes must be made:

- Meet explicit network standards for primary, specialty, and other critical professional, allied, and supportive service and equipment providers (e.g. wheelchair fitting clinics) that are analogous to the California Health & Safety Code (Knox-Keene) standards for primary care providers and the Medicare standards or other specific standard for specialty providers. While the plans would have to meet the California standard for primary care and the Department expressed a willingness to explore standards for key specialists, no specialist standard has been adopted to date.
- Clarify a plan's obligation to inform beneficiaries who is responsible to arrange or pay for non-medical transportation to and from service sites. §14183(c)(8).
- Include in the requirement for communication access that plans have policies and procedures in place to provide and inform the public and providers of effective communication access. For example, plans may say they provide or reimburse for ASL interpreters but patients who are hearing impaired often find that plan staff and providers are not informed of how to arrange for those services. §14183(b)(11).
- Include in the enhanced facility site review tool developed by the Department an assessment of programmatic accessibility (e.g., availability of diagnostic equipment,

policies and procedures) and require that the reviews be conducted before enrollment begins. § 14183 (b)(8).

- Meet explicit network standards for the physical and programmatic accessibility of providers and provider facilities, including primary, specialty, and other critical professional, allied and supportive services and equipment providers, with a right to an out-of-network authorization if the standard is unmet.

Enrollment and Exemptions

- Enrollment for beneficiaries who do not make a plan choice will be based on an analysis of the managed care plan/medical group/PCP that best matches that beneficiary's historical provider utilization data. We agree with this approach. We discussed this with the department but it is not reflected in the California legislation. Moreover, the state's waiver proposal is conflicting on this point, both stating that "enrollment will take into account where possible the enrollees' recent use of providers" but also stating that "enrollment would also be distributed among participating plans in proportion to the shares of the population that each participating plan currently serves." *California Section 1115 Comprehensive Project Waiver Proposal, 6/3/2010, p. 44 (hereinafter Waiver Proposal)*.
- The legislation allows the Department to "contract with community-based nonprofit consumer or health insurance assistance organizations with expertise and experience in assisting seniors and persons with disabilities." §14183(b)(3). While this language is permissive in the legislation, we urge that it be required. Health consumer assistance programs are critical both in assisting SPDs with navigating the significant delivery system changes being proposed through the waiver and in providing advocacy through an independent consumer assistance program to address systemic problems. This will be an important tool to monitor problems that arise with enrollment. California has a network of nonprofit health consumer centers that currently assist consumers with navigating health care options and resolving problems with accessing care.
- The legislation puts into statute the current regulatory design of medical exemption request (MER) for beneficiaries. We support this, but think some additional changes must be made. Currently, beneficiaries can only file for a MER if they have been in a plan for 90 days or less. We think this arbitrary timeline should be deleted. Further, beneficiaries whose MERs have been granted on the basis of conditions that are recurring or not subject to change should not have to reapply for an exemption annually. Last, we should expand the grounds for getting a medical exemption in order to receive coordinated and team services through hospital outpatient and specialty care clinics not available in the plan's network. Because of the narrow definition of safety net and traditional providers, plans are under no obligation to include in their networks outpatient or specialty care clinics needed and relied upon by Medi-Cal recipients with complex medical conditions. §14183(b)(14).

Assessment

The legislation calls for plans to get claims data from the Department and apply a Department-approved algorithm to determine which beneficiaries are higher and lower risk. Plans would then be required to conduct a preliminary telephonic risk analysis/triage tool within 45 days of plan enrollment for higher risk beneficiaries and within 105 days for lower risk beneficiaries. §14183(b)(12). We believe these timelines should be shortened to 30 and 60 days respectively. The Department's timeline calls for continuous, rolling enrollment each month so it is critical that plans continuously triage and assess new enrollees to more timely meet their needs. Further, in-person assessments should be scheduled promptly thereafter, based on needs determined by the phone triage but in all cases not later than 120 days after enrollment. The current contract standard is 120 days for an in-person assessment, but this should be included in the statute and Terms & Conditions.

Medical Home and Care Coordination

- While the legislation includes a definition of medical home, it should be augmented to make it consistent with broadly accepted descriptions such as the Joint Principles of Patient-Centered Medical Homes developed by several professional physician associations.¹ §14183(c)(13), (14). Additionally, health care plans should be required to provide “health care homes” to beneficiaries with complex conditions, including beneficiaries experiencing multiple chronic conditions or a combination of medical and behavioral health conditions. We define a “health care home” as a team that fosters a partnership between the patient and the patient’s health care professionals, that uses the partnership to access medical and non-medical health-related services the patient needs to improve health outcomes, and that maintains a comprehensive record of health-related services to promote continuity of care.
- The legislation calls for an assessment of beneficiaries, as mentioned in the previous section, but does not identify which beneficiaries would be considered “high risk”

¹ Missing components include:

- The personal physician (who can be a specialist) leads a team of individuals who collectively take responsibility for ongoing care of patients;
- A whole-person orientation that requires the personal physician to take responsibility for all of the patient’s health needs;
- Care that is integrated across all elements of the complex health system and the patient’s community (including family members, and public- and private-based services);
- Care is facilitated by registries, IT, health information exchange to assure the patients get the care when and wherever they need it in a culturally and linguistically competent manner;
- Engagement in performance measurement & improvement;
- Patients actively participate in decision-making;
- Enhanced access to care through measures like open scheduling, expanded hours, and new methods of communication between physician and patient; and
- Payment that recognizes services necessary to coordinate entire health needs of individual patients.

and does not require the health plans to provide more intensive services to beneficiaries considered “high risk.” The state and the health plans should work together to stratify the intensity of non-medical services based on beneficiary need.

- Consistent with a health care home, the health care plans should be required to offer community-based care coordination that is not reliant solely on telephone contact, and that connects beneficiaries to county behavioral health providers when the beneficiary suffers from a behavioral health condition, even if diagnosed conditions in claims data do not include a serious mental illness. Though the Department has indicated a desire to integrate medical and behavioral health care, nothing in the Waiver Proposal or the legislation now pending includes effective means of integrating care. Care coordination, at a minimum, can act to ensure beneficiaries with behavioral health needs are receiving the care they need, while facilitating communication between health care providers.
- Plans and county alternative models of care should be required to contract with community-based organizations to provide high-need beneficiaries with intensive care coordination services, offer assistance with non-covered items and services needed to maintain health and functioning within the community, and link beneficiaries to such community resources as housing providers, behavioral health treatment providers, veterans services organizations, independent living organizations, and relevant county social service agencies.

Enforcement and Oversight

- The current bills allow, rather than require, the Department’s reporting on the transition to managed care, health outcomes of enrollees, and the care management and coordination process. §14183(r). This monitoring and reporting is critical and should be mandatory.
- The Department should be required to adopt clear standards for suspension of enrollment into managed care based on monitoring of all standards. For example, §14183(u) of the legislation currently states that the Department will suspend enrollment if the plan does not have sufficient primary and specialty providers to meet enrollees’ needs but there is no standard for specialty providers against which they will be measured and the legislation does not make clear how the Department will determine whether enrollees’ needs are being met. In addition to adopting a standard for specialists and assessing network adequacy, the Department should be required to conduct “real time” monitoring to ensure assessments are being done timely and that services are physically and programmatically accessible, and suspend enrollment if they are not.

County Alternative Models of Care

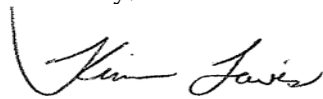
County alternative models of care should be required to meet applicable Knox-Keene standards. §14183(f).

Dual Eligibles

Even at this late date, the state's proposal remains unclear for dual eligibles in this waiver. The proposal appears to include two elements: a limited number of pilot projects and an expanded integration strategy to begin in year three of the waiver. It contains only limited detail regarding each of these elements and their relationship to each other. We are particularly concerned about the lack of specificity provided to support the stated goals of long term care integration and enrolling all one million dual eligibles into medical homes provided by organized systems of care. We are willing to support and participate in California's development of a comprehensive, detailed plan complete with methods of oversight, enforcement and evaluation. We cannot support, however, the current vague proposal that would limit choice by requiring membership in undefined "organized systems of care", and that includes aggressive timetables without providing any details that would demonstrate how systems would be ready to meet the needs of this most vulnerable population. Until the Department develops a complete proposal with stakeholder involvement, CMS should not consider endorsing any plan to enroll all one million of California's dual eligibles into organized systems of care within the waiver period. Other than agreeing to continue conversations about potential plans, CMS should not make any commitments to California relating to dual eligibles in this waiver or grant the state new authority to waive existing protections afforded to dual eligibles. Specifically, CMS should deny any request to mandatorily enroll dual eligibles into Medi-Cal managed care or passively enroll dual eligibles into Medicare plans.

We would welcome the opportunity to talk further with you about any of these issues.

Sincerely,



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Western Center on Law & Poverty

Casey Young, AARP

Jackie McGrath, Alzheimer's Association, California Council

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