Disability Rights California

California's protection and advocacy system

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Re: Comments on Dual-Eligible Integration Proposal from California

Dear Director Bella,

Thank you for providing this opportunity to comment on California's demonstration proposal to integrate care for dual eligible individuals.

Disability Rights California has supported the concept of integration of long term services and supports for years, for its potential to shift resources away from institutional care and towards the preferred and generally less expensive home and community based services, and for its promise of a coherent system of long term services and supports understandable to and useable by the people who need the services. We believe that if done right, coordinating and integrating services and their funding has potential to do great good, and also the potential, not coincidentally, to move California ahead on its very slow and bumpy path toward compliance with the US Supreme Court's 1999 Olmstead decision.

We would have welcomed a thoughtful and measured process to achieve coordination and integration – one which tried different approaches involving small numbers of consumers, who would voluntarily enroll into pilot projects which were fully prepared to meet their needs, with careful evaluation of a variety of outcomes preceding any expansion.

Instead we are responding to the state's proposal which would force around 700,000 dual eligible people into only one model – mandatory managed care – delivered by plans who are almost completely inexperienced in both serving this population and in delivering ANY long term services and supports – and whose track record in delivering only medical services is mostly below average, and in some cases, far below average.

Despite the state's insistence that the demonstration will be person-centered and preserve consumer choice, it is requesting passive enrollment, a six-month lock-in, and opt-out only for Medicare services with no opt-out or exception process for Medicaid services.

Despite the state's assurance that plans will deliver the long term services and supports people need to remain in their homes, the benefit package will **not** include services currently available to the duals population, meaning that people in the demonstration counties may well be worse off than they would be absent the demonstration, and disadvantaged compared to dual eligibles with identical needs who reside in counties not included in the demonstration.

The state has held and is holding a stakeholder process, which we appreciate. However, that does not mean that the proposal reflects the desires of stakeholders or that the concerns of stakeholders have led to significant changes in the state's intentions. While the state's proposal to CMS is better than its draft proposal in some respects, it falls short in several key interconnected areas.

SCOPE

In 2008, the California legislature authorized the state to start up to four pilot projects in four counties to integrate Medicare and Medicaid benefits. Instead of undertaking four pilots, the administration proposed to drop the "pilot" designation and expand the demonstration to 8 counties, including Los Angeles, which has about 350,000 dual eligibles, 40% of the statewide total. The 8 counties will include about 80% of the state's duals.

The common understanding of a demonstration is a small-scale trial of a concept or concepts, subject to evaluation before expansion, and that is not what California proposes to do.

Even if Los Angeles were ready to be a duals pioneer, the sheer scale would be daunting – larger than the demonstrations in most of the other states and equal to the total of many state combined with each other.

Los Angeles is not ready to be a pioneer; the managed care plans involved are among the worst in the state, as documented by the National Senior Citizens Law Center from public data. One of the plans was suspended by Medicare from new enrollment because of concerns about its quality. Given that the Los Angeles plans have not served this population, have never delivered long term services and supports, will be responsible for an incredibly ethnically and language-diverse community, it is easy to predict that this experiment will, at best, fail to achieve its goals.

Recommendation:
This demonstration should start with the number of counties and plans which are demonstrably ready, according to stringent readiness standards – which are yet to be developed. Further, Los Angeles is too big and too diverse to be included in this demonstration.

SPEED

The state has moved from a January 2013 start date to March 2013 for some services and June 1, 2013 for others. This schedule is both too fast and too confusing. The state is running stakeholder groups which are raising more and more questions while debating the possible answers to earlier questions. The legislature just approved this demonstration this week, with significant new readiness requirements which must be digested and realized.

Recommendation
Considering the enormous amount of work necessary by the state and the plans to effectively enroll people in plans which are ready to adequately serve them, January 2014 is the earliest feasible target date.

ENROLLMENT

Disability Rights California has always advocated for voluntary enrollment in managed care; if the service is good and people are informed about it, they will want it and enroll. However, the Department proposes mandatorily enrolling almost all dual eligibles into Medi-Cal managed care, passively enrolling them into the demonstration and then locking them into plans even if a plan is not meeting their needs, with no exemption process. No consumer group supports this. Quality plans do not need a lock-in to succeed.

Recommendation: Preserve consumer choice and adopt voluntary enrollment.

Recommendation: There should not be any mandatory or lock-in enrollment

for either Medicare or Medi-Cal benefits. Having a different set of enrollment rights for each program introduces new levels of confusion and misaligned incentives.

QUALITY

DHCS has selected several plans that have below average Medicare and Medi-Cal quality ratings. Every plan with the exception of the Health Plan of San Mateo County received a plan rating of one out of five stars for their Adult Medi-Cal program in the California Assessment of Healthcare Providers and Systems Health Plan Survey (CAHPS), a survey DHCS uses to assess performance. In addition, two of the plans selected have below average ratings in the Medicare program, and one plan has a recent history of significant Medicare enrollment and marketing sanctions, according to a report recently released by the National Senior Citizens Law Center.

We are also concerned that several of the plans do not currently Dual Eligible Special Needs Plans, including one that currently offers no Medicare plans. Even those plans that do currently offer D-SNPs are serving too small a number of dual eligibles to take on the increased enrollment targeted by this proposal.

Recommendation: Select only plans with strong performance records in both Medicare and Medi-Cal. Do not allow plans with below average Medicare quality ratings or plans with a recent history of sanctions in the Medicare program to participate. If these plans are allowed to participate, they should not be eligible for any passive enrollments.

CAPACITY AND READINESS

We are gravely concerned both about the capacity of the state to manage the transition and the capacity of the managed care plans to deliver the services needed by the dual eligible consumers. The state is in the final weeks of enrolling seniors and persons with disabilities (who are not dual eligible) into managed care. That process has been fraught with serious and systemic problems, many of which were dismissed by the state as anecdotal for the first several months. Physicians, beneficiaries and advocates have repeatedly testified before the legislature about interrupted cancer treatments, cancelled surgeries, missed dialysis appointments and separation from long-time medical providers, all due to problems with the notification and enrollment process. While the state says it has learned from that process, its own evaluation of the enrollment will not be final until December. This proposed duals enrollment involves at least twice as many beneficiary lives.

The state is currently moving around 37,000 people into managed care as a

condition of receiving Community Based Adult Services (CBAS), formerly known as Adult Day Health Center services. Some CBAS providers are facing closure or financial disaster because of late payments from the state, which the state attributes at least in part to a "resource issue."[1]

Several other simultaneous developments will further tax the capacity of the California Department of Health Care Services; among them:

- Seniors and persons with disabilities (non-duals) in the duals demonstration counties will receive long term services and supports only through managed care. Although they are already in managed care, managed care has never provided those services. A substantial provider readiness and consumer notification must be undertaken.
- A new California law abolishes the Health Family Program and moves the 880,000 families into beneficiaries into Medicaid.
- The Department will be taking over most of the programs of the former Department of Mental Health.

As previously stated, none of the designated managed care plans have ever been completely responsible for and at financial risk for long term services and supports. Most have little or no experience providing any services to people with the sometimes complicated combination of health and services needs of the typical person who is dually eligible.

There is no evidence that the plans and their facilities comply with federal and state disability rights laws' requirements for physical and programmatic access for people with disabilities. The state does not have data about whether the already-selected plans are even familiar with the requirements, much less an inventory of whether the plans' providers have have accessible doorways and paths of travel, adjustable examining tables, or information in alternate formats such as Braille.

BENEFIT PACKAGE

The proposal does not include many new protections nor guarantee any new benefits or services for dual eligibles.

Assessment and care management: Health plans would be required to administer an assessment of the health care and long-term care needs of beneficiaries, but the minimum elements of the tool are not yet defined, many health plans do not have

[1] "*Cash Flow Glut Pushes Health Centers Into the Weeds*", Ventura County Star, June 21, 2012, quoting California Department of Health Care Services spokesman Norman Williams.

experience in using such tools, and training will be necessary to ensure these tools are administered appropriately. These issues cannot be adequately addressed under the current time frame. The plan is silent on what entity will perform this function, and the required qualifications of the assessors and managers. Most recently state officials have said that the assessments for long term services and supports will be the ones currently in use by existing services, rather than a tool used by plans which takes into account non-medical functional and social needs. The state has committed to develop, test and evaluate a universal assessment tool, but the target date is two years after the first duals are enrolled in the demonstration.

It appears that beneficiaries would still be on their own to navigate through the eligibility processes for the fragmented existing services, despite that fragmentation being a major justification for this demonstration. Integrated appeals process, integrated enrollment notices and centralized enrollment assistance processes have not yet been developed.

Current benefits not guaranteed

The state is relying wholly on assumptions of behavior of the managed care plans – that they will, regardless of the rate paid or the characteristics of the plans – offer services outside the mandated benefits, because they will believe that those services will save them money in the long run. The state offers no proof to support this assumption.

For instance, the state proposes to exclude certain currently available home and community based waiver services from the mandatory benefit plan, including habilitation, extended personal care services, assisted living and home modifications. The people who are on the waivers will be excluded from managed care; those hundreds on the waiting list for the waivers will lose their place in line and will be mandatorily enrolled in managed care in the demonstration counties. If their "number" comes up, they will not be allowed to get on the waiver. People who are in non-demonstration counties will continue to have access to the waivers. Disability Rights California believes this violates Medicaid statewideness requirements, and that it completely undermines the state's assertion that the duals project will "maximize the ability of dual eligible beneficiaries to remain in their homes and communities with appropriate services and supports in lieu of institutional care", a promise made in SB 208, the authorizing legislation for the duals pilots.

In addition, the proposal says that specific medical necessity criteria must be met in order to qualify for those benefits, but does not say what the criteria are. DHCS should state in its proposal that managed care plans are specifically authorized to

provide that package of services. In addition, specific medical necessity criteria should not be more restrictive than the generally applicable medical necessity standard, except that the state can require, in addition to the regular criteria, that individuals meet nursing facility (NF) level of care in order to qualify for those particular services.

> *Recommendation:* Require that the state demonstrate that the experience for dual eligibles in the demonstration will, in fact, be integrated and significantly better than what it is now. Require the inclusion of additional protections and benefits including hcbs waiver services, dental and vision in the plan benefit packages.

Integration of Medical, LTSS, and Behavioral Health Services

There are two problems with integration of Medicare and the Medi-Cal specialty mental health benefit provided through county mental health departments. Both arise in counties that do not contract with Medicare providers to provide outpatient services. The first problem is that the dual eligible beneficiary has to receive psychiatrist services through Medicare and other mental health services through the county mental health department. County mental health departments are reluctant to work with psychiatrists that they do not have a relationship with, let alone take orders from them. The second problem is that a dual eligible beneficiary must get psychologist or therapy services from a Medicare provider until the Medicare benefit is exhausted, then switch to a county or county-contracted provider if more services are needed. This prevents continuity of care and is extremely disruptive for beneficiaries.

The solution to both of these problems is to have the counties employ or contract with Medicare outpatient mental health providers. The Medicare managed care plans can then contract with the counties to provide the specialty mental health outpatient services that are covered under both Medicare and Medi-Cal. This arrangement would insure seamless coverage. Another way to do this would be to have the Medicare managed care plans contract with the same Medicare outpatient mental health providers that the county contracts with. That way, the counties could begin Medi-Cal reimbursement when Medicare is exhausted. Both of these arrangements would also allow for seamless payment of Medicare deductibles and copayments by Medi-Cal.

We are certain that all of the Medicare managed care plans, as well as DHCS, recognize these problems. Some of the Medicare plans are willing to contract with the county mental health programs, as described above. DHCS encourages this,

which is positive. However, at least one Medicare plan in San Diego County is not willing to do this. That plan has a contract with a behavioral managed care plan other than the county. Under this arrangement, a beneficiary has to receive some services, such as psychiatrist services from the non-county behavioral health plan, and other services from the county. Likewise, a beneficiary who receives psychologist or therapy services must receive those services first from the non-county behavioral health plan and then transfer to a county provider when Medicare is exhausted.

The San Diego plan in question plans to solve the problem by paying for beneficiaries who need coordinated services to see a county psychiatrist on a fee-for-service basis. We are not aware of any solution to the psychologist or therapist problem. In any event, this approach on the part of the San Diego plan does not provide for adequate continuity of care. It's a Rube Goldberg process that beneficiaries and their providers are not going to be able to navigate. In addition, the managed care plan has every incentive to steer beneficiaries away from county mental health services because it would be in its financial interest to pay a capitation rate to a non-county behavioral health plan rather than a fee-for-service rate to the county.

When CalOPTIMA of Orange County first set up its D-SNP a number of years ago, it also contracted with a non-county behavioral health plan. Medi-Cal beneficiaries were passively enrolled into the D-SNP. CalOPTIMA then had to disenroll all of the beneficiaries who received specialty mental health services from the county in order to avoid depriving those beneficiaries of care that they were then receiving from the county.

> *Recommendation*: We request that CMS require that the D-SNP plans contract with county mental health departments to provide specialty mental health services, or, at a minimum, that they contract with the same Medicare providers that the county contracts with.

SAVINGS EXPECTATION

Federal/state sharing: DHSC continues to assume that the federal government will share in 50 percent of any Medicare savings achieved under this pilot program, projections which remain unverified.

The state also projects savings from reduced Medicaid expenditures. Absent information about the adequacy of the capitated rates, and the shortcomings of the benefits package, we are concerned that savings will come at the expense of the beneficiaries.

Recommendation: The state must ensure that plans provide the services needed by beneficiaries, must construct a rate and which does not reward plans for doing otherwise, must monitor the use of home and community-based services versus institutional care, and must not define success by savings to the state.

EVALUATION

The proposal does not clarify how an evaluation will be done, when it will start, what will be evaluated, what if anything will change during or after the demonstration as the result of an evaluation, and to what the results will be compared. One example: the state has not mandated any assessment process or tool for assessing the need for long term services and supports, nor has it defined the relationship between an assessment and the services offered to the beneficiary. How will an evaluation assess whether the assessments were valid, and whether they led to an offer of services, and whether the services met the needs of the beneficiary?

The evaluation has not yet been designed, and will likely not be in place before the current pilots start date. Evaluation measures should be developed and made clear before the pilots commence, so that the pilots can be designed with the desired outcomes as a guide, and are successful in reaching intended goals.

CONTINUITY OF CARE PROVISIONS

While we appreciate the state's effort to address the problem of beneficiaries losing access to their current Medicare providers, we are concerned that these provisions are not sufficient. Continuity of care protections have not worked well during the transition of Medicaid only seniors and persons with disabilities into Medi-Cal managed care.[2] Problems are also developing with the transition of CBAS recipients into managed care.[3]

Recommendation: CMS must develop with the state a process for monitoring continuous access to existing providers, services and prescriptions. Emergency mechanisms must be in place to prevent disruptions.

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[2] ***Hearing Examines Patient Care Under Medi-Cal Overhaul*, California Healthline, March 9, 2012. www.californiahealthline.org/articles/2012/3/9/hearing-examines-patient-care-under-medical-overhaul.aspx**

[3] *State under Fire for Adult Service Denials, Appeals*, California Healthline, June 14, 2012. www.californiahealthline.org/capitol-desk/2012/6/adult-service-denials-appeals-spark-criticism.aspx

Recommendation: An individual must be able to get continued services pending an appeal when the managed care plan terminates or reduces an existing service. The provision of services pending appeal must not be limited to an existing authorization period.

Recommendation: Develop a mechanism for continued access to Medicare providers who will not accept payments during a transition period from the demonstration plan.

INDEPENDENT CONSUMER ASSISTANCE PROGRAMS

The proposal does not designate or provide funding for an independent group or groups that assist dual eligibles making enrollment choices and navigating plans (filing appeals and grievances for example) once enrolled. It is essential that dual eligibles have trusted sources they can turn to for unbiased advice about whether or not to join a demonstration plan and for assistance when they have problems accessing services from that plan. Many existing community based organizations can play this role (HICAPs, ILCs, legal services programs), but they need authority and funding to do so.

Recommendation: Designate and fund non-profit organizations that can provide unbiased enrollment advice and navigation assistance to beneficiaries.

Disability Rights California is gravely concerned about the impact of California's proposal on the lives of the hundreds of thousands of potentially affected beneficiaries. The proposal goes far beyond the scope of a demonstration. It has serious defects which undermine consumer choice, threaten access to medical and long term services and supports and undermine the stated goals of the demonstration. We continue to be willing to work with our state officials to shape a demonstration which fulfills the promise of integration.

Thank you for your consideration of our comments.

Sincerely,

Deborah Doctor
Legislative Advocate

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Disability Rights California