Melanie Bella, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
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Via email: Melanie.Bella@cms.hhs.gov

Toby Douglas, Director
California Department of Health Care Services
Sacramento, California 95812
Via email: Toby.Douglas@dhcs.ca.gov

May 2, 2013

Dear Directors Bella and Douglas,

The recent finalization of a Memorandum of Understanding (MOU) between California's Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) represents an important benchmark in the implementation of the Cal MediConnect program and the other elements of the Coordinated Care Initiative.

The undersigned organizations all represent individuals and communities that will be impacted by the tremendous changes brought by Cal MediConnect and the other elements of the Coordinated Care Initiative. Many of our groups have been actively engaged in the CCI stakeholder process and we all will be tasked with assisting beneficiaries with what promises to be a significant and challenging transition to this new delivery system. We have supported and continue to support the demonstration's goals of person-centered care, increased access to services, quality improvement and shifting the delivery of long term services and supports to home and community based settings. We have consistently, over the last year and a half, raised issues about the CCI, which threaten its ability to meet those goals. Many of our concerns remain.

The MOU contains several positive elements that we hope and expect will move California's delivery system closer to those goals. It also, however, has several provisions which leave beneficiaries exposed to risk of loss of services and disruptions in care. We are mindful of the numerous problems that have been well-documented in the transition of Seniors and Persons with Disabilities (SPDs) and recipients of Community-Based Adult Services (CBAS) into Medi-Cal managed care, many of which seem likely to be repeated in the pilot.[1]

[1] See, California HealthCare Foundation "Briefing,— Transitioning the SPD Population to Medi-Cal Managed Care, (March 28, 2013)" at www.chcf.org/events/2013/briefing-spd-transition-managed-care; and "A First Look Mandatory Enrollment of Medi-Cal's Seniors and People with Disabilities into Managed Care (August 2012)," at /www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/F/PDF%20FirstLookMandatoryEnrollmentSPD.pdf.

The attached document provides detailed information about our organizations' top concerns and recommendations for moving forward. Our primary recommendations are summarized below.

1. Find additional ways to limit the size of the demonstration;
2. Set a realistic timeframe for implementation of Cal MediConnect and the other elements of the CCI;
3. Start the enrollment process with a voluntary enrollment period in all counties and take steps to simplify the enrollment process;
4. Require that home and community based waiver services be part of the plan benefit package;
5. Strengthen and broaden the continuity of care requirements in the MOU;
6. Develop and execute, before notices are delivered to beneficiaries, a plan for delivering ombuds or consumer assistance services to beneficiaries that will be independent, community-based, and capable of providing individual assistance to CCI enrollees; and
7. Provide data on the assumptions that were made in the development of spending reduction amounts so that stakeholders can evaluate whether these reductions will threaten access and/or quality.

We request from DHCS and CMS a joint response, in a meeting and in writing, to these issues. We appreciate your work on this project and your attention to our concerns. Please contact Kevin Prindiville at the National Senior Citizens Law Center, kprindiville@nsclc.org, to confirm that a response will be forthcoming.

Sincerely,

AARP California
Alternative Home Care as Lead Organization for the California Community Transitions Project
Alzheimer's Association, California Council
California Advocates for Nursing Home Reform
California Alliance for Retired Americans
California Consumers for Quality Care, No Matter Where; an initiative of the National Consumer Voice for Quality Long-Term Care
California Council for the Blind
California Foundation for Independent Living Centers
California Health Advocates
California In-Home Supportive Services Consumer Alliance
California Senior Leaders Alliance
Center for Health Care rights, Los Angeles County HICAP
Council on Aging, Orange County HICAP
Dayle McIntosh Disability Resource Centers
Disability Rights California
Disability Rights Education and Defense Fund
Disability Rights Legal Center

Easter Seals, California
Gray Panthers of San Francisco
Health Consumer Alliance
Health Consumer Center of the Legal Aid Society of San Mateo
IHSS Consumers Union
Independent Living Resource Center, Inc.
Jewish Family Service
Law Foundation of Silicon Valley
Legal Assistance for Seniors, Alameda County HICAP
Maternal and Child Health Access
Multipurpose Senior Services Program Site Association
National Health Law Program
National Senior Citizens Law Center
Neighborhood Legal Services of Los Angeles County
Personal Assistance Services Council
San Diego IHSS Coalition
Self Help for the Elderly, San Mateo County HICAP
Senior Services Coalition of Alameda County
Southeast Asia Resource Action Center
Southern California Rehabilitation Services, Inc.
The Arc California
Through the Looking Glass
Western Center for Law and Poverty
World Institute on Disability

TOP CONCERNS AND RECOMMENDATIONS

1. *Find additional ways to limit the size of the demonstration.*

Our overarching concern is that this demonstration remains much too large. We appreciate that the size of the demonstration has gotten smaller as DHCS has learned more about the true size of the eligible population. We also appreciate that effort was made to limit the size of the demonstration in Los Angeles. However, even with those reductions, the MOU approves a demonstration bigger than all other approved MOUs combined. The demonstration population in Los Angeles alone, even with the 200,000 person cap, is larger than any other state's demonstration.

State	Enrollment Size
Massachusetts	109,000
Washington	22,000
Ohio	115,000
Illinois	135,000
California	**456,000**
Los Angeles	**200,000**

Throughout this process we have expressed our concern about the size of this demonstration. We note that original proposals by California were for a 'pilot' of just 120,000 beneficiaries in up to four counties. As the size of the proposal grew we have become more concerned that this is not a demonstration, but a permanent programmatic change to Medicare and Medi-Cal that is being pursued with no real data to support it. We are concerned about the large numbers of people that will go through this transition and the capacity of health plans to effectively provide all of these services.

In our recent experience with the enrollment of approximately 20,000 dually-eligible recipients of Community-Based Adult Services (CBAS) into Medi-Cal managed care, there were significant problems involving real or perceived access to Medicare doctors, hospitals, and needed services such as non-emergency medical transportation. To the extent these problems were rectified at all, it required intensive individualized attention by CBAS providers, family members, and DHCS staff. The current size of this pilot is prohibitively large to resolve the problems that will undoubtedly arise, which will result in affected beneficiaries losing access to critical medical care and services.

We understand that DHCS and CMS have reached an agreement on these numbers and that the prospect for further reduction is limited. If the size of the demonstration cannot be limited any further, the recommendations below become that much more important.

2. *Set a realistic timeframe for implementation of Cal MediConnect and the other elements of the CCI*

We do not feel that the State or the managed care organizations (MCOs) will be ready to initiate Cal MediConnect and other elements of California's Coordinated Care Initiative (CCI) on October 1, 2013. The CCI places enormous responsibility on MCOs to deliver and coordinate care. California's MCOs have had little to no experience providing the full array of services , including medical, social, behavioral, and long-term supports and services (LTSS), upon which this high need, high cost population relies.

Planning to meet these needs is a large undertaking requiring ample time to develop and prepare. While the Department of Health Care Services, plans, providers, advocates and other stakeholders have been working diligently on this effort, the unavoidable fact is that much work remains to be done – too much work to be ready for notices to be sent to affected individuals in just 83 days (as of 4/8/13) as planned. Important steps in the process remain to be completed including, but not limited to, the approval by CMS of a modification of the State's 1115a waiver, the setting of rates, the development of plan contracts, the readiness review process, the creation of an enrollment process for Los Angeles County, the development of beneficiary notices and other materials, securing funding for enrollment counseling and consumer assistance and the development of rules for operationalizing appeal rights, assessment processes and care continuity.

In past transitions to managed care, DHCS set implementation dates and then repeatedly delayed them. While we appreciate that DHCS has been willing to delay transitions when they knew they were not ready, the delays have increased the level of confusion among beneficiaries, providers and others. Furthermore, the current timeline coincides with Medicare open enrollment for Part D and Medicare Advantage, implementation of Covered California, expansion of Medicaid Managed Care in rural zip codes and the final phase of transitioning the Healthy Families Program to Medi-Cal. The volume of messaging regarding health care changes during this period will lead to increased confusion and any CCI outreach and education campaigns will be overshadowed by these competing changes. We encourage DHCS and CMS to set a realistic timeline for implementation to lessen the likelihood that delay will be necessary. We believe that no enrollments should occur before January 1, 2014, at the earliest, and conditioned upon DHCS and the plans meeting readiness requirements.

3. *Start the enrollment process with a voluntary enrollment period in all counties and take steps to simplify the enrollment process*

The MOU sets out a very complicated enrollment process that varies from one county to the next and is full of exceptions to the already complicated general rules. We are concerned that this process will be nearly impossible to explain to beneficiaries and will advance enrollment in the demonstration more quickly than plans and DHCS and its contractors have the capacity to handle. We also note that this exception filled, county-by-county enrollment process was not

the product of discussions with consumers and their advocates. None of our groups were consulted about the final details of the enrollment process.

Under the MOU, the demonstration will start with passive enrollment in seven of eight counties. Only in Los Angeles will there be any voluntary enrollment period to allow plans and providers to adjust before taking on larger numbers of enrollees.
In seven counties, enrollment will be phased in over 12 months. In six of those counties, beneficiaries will be passively enrolled by birth month, unless they fall into one of at least five exceptions. In Los Angeles, the state has promised to work with stakeholders to develop a process for phasing enrollment. Whatever the enrollment process is for Los Angeles, the MOU requires that all 47,000 Medicare Advantage enrollees in that county be passively enrolled on January 1, 2014 – the first month of passive enrollment in that county. This massive enrollment will strain plans' capacity to perform required assessments and effectively deliver new LTSS benefits. San Mateo County will use a different process than all other counties, enrolling all eligible dual eligibles on two dates: October 1, 2013 or January 1, 2014.

In order to both simplify the process and ensure that enrollment proceeds slowly enough to allow plans and providers adjust to these major changes, we request that the state begin the demonstration with a three month voluntary enrollment period in all counties before moving to a passive enrollment process. Once the passive process begins, monthly enrollment should be capped at a level that matches the demonstrated capacity of the participating plans. In no case should tens of thousands of individuals be enrolled in a single month.

Three other states (Illinois, Massachusetts and Ohio) have signed MOUs with CMS to conduct passive enrollment of dual eligibles into capitated, risk-based managed care plans. Even though these states all signed MOUs before California and are planning to enroll much smaller numbers of duals, they are all using a voluntary enrollment period to launch their demonstrations (see table below). No state is starting passive enrollment any earlier than 10 months after they signed their MOU and no state is starting before California's start date. In addition, once passive enrollment begins, Illinois is capping enrollments at 5,000 per month (in urban areas) to ensure that plans have the capacity to meet the needs of new enrollees.

State	Date of Signed MOU	Voluntary Enrollment Begins*	Passive Enrollment Begins*	Passive enrollment phased
Massachusetts	8/22/12	7/13	10/13	Three dates
Ohio	12/11/12	9/13	10/13	Four dates, by region
Illinois	2/22/13	9/13	1/14	6 months; with monthly caps
California	3/27/13	10/13 in LA; No voluntary in 7 counties	10/13 1/14 in LA	Varies by county; generally 12 months

*(*Current projections. The dates in Massachusetts have already moved back once and advocates there and in other states are calling for further delays.)*

4. *Require that home and community based waiver services be part of the plan benefit package.*

The MOU would allow, but not require, plans to provide some home and community based services (including respite, nutritional assessment, counseling, supplements, home or environmental adaptations, habilitation, transition assistance, supplemental home health and personal care, and other services), in addition to the list of required services, as elements of the covered benefit package. Likewise, the MOU requires plans to contract with MSSP providers, but only for a limited time, and it fails to require plans to provide benefits proven successful by programs like the California Community Transition Project. Overall, the MOU does not go far enough to promote the goal of home and community based services

The MOU does not include the full range of services contained in the Nursing Facility/Acute Hospital HCBS Waiver, which is currently California's primary alternative to nursing facility, Subacute facility, and long-term acute hospital placement, nor does it include Assisted Living. While the state will continue to operate those waivers, the NF/AH waiver has fewer than 2,000 slots statewide, and the Assisted Living waiver is available in only a handful of counties. The MOU should include, as required elements of the plan benefit package, the full menu of NF/AH Waiver services and Assisted Living Waiver services: Case Management/Coordination; Habilitation Services; Home Respite; Waiver Personal Care Services (WPCS); Community Transition Services; Continuous Nursing and Supportive Services [Congregate Living Health Facilities]; Developmentally Disabled/Continuous Nursing Care (DD/CNC); Non-Ventilator Dependent Services [existing DD-CN facilities]; Developmentally Disabled/Continuous Nursing Care, Ventilator Dependent Services [existing DD-CN facilities]; Environmental Accessibility

Adaptations; Facility Respite; Family/Caregiver Training; Medical Equipment Operating Expense; Personal Emergency Response (PERS) Installation and Testing; Personal Emergency Response Systems (PERS); Private Duty Nursing - Including Home Health Aide and Shared Services; Transitional Case Management; Assisted Living services.

Failure to include these types of additional HCBS services as part of the covered benefit package sends a signal to plans that additional or supplemental HCBS are optional rather than mandatory, even for those who need them to avoid nursing home or other less integrated living arrangements. At best, giving complete discretion to plans to decide whether to offer waiver-level HCBS turns these important services into a 'hidden' benefit. Members of a dual demonstration plan may not know that these benefits exist. These beneficiaries will be denied access to the appeals and other due process protections currently available to waiver participants. And without strong reporting requirements, neither DHCS, nor the legislature, nor stakeholders will know whether plans are in fact providing these HCBS benefits.

We understand that the policy in the MOU is based on the assumption that because managed care plans will have the financial incentive to avoid more costly institutional care, they will provide all waiver-level care to those who need it. If this financial incentive is truly sufficient, however, there is no reason *not* to formally include these services in the agreed-upon benefits package. Inclusion in the benefit package will ensure that plan rates are sufficient to provide the services; that plans establish a network of providers to deliver the services; and that plans actually offer these services to beneficiaries that need them to live in the community.

The current policy runs counter to a national trend among states to include HCBS waiver services in the required benefit package. Our review of other states' contracts with managed care organizations shows that a significant number of states with existing managed LTSS programs (including Arizona, Minnesota, Tennessee, Texas and Wisconsin) explicitly identify HCBS waiver services as part of the benefit package in their contracts with managed care organizations. California must do the same.

5. *Strengthen and broaden continuity of care requirements established in the MOU.*

California's recent transition of nearly 240,000 Medi-Cal only seniors and persons with disabilities (SPDs) into mandatory Medi-Cal managed care revealed that the continuity of care provisions in the MOU are not sufficient to protect beneficiary access to current providers and treatments. While the timeframes for care continuity in the MOU are relatively long (6 months for Medicare providers and 12 months for Medi-Cal providers), the restrictions upon which providers qualify for care continuity are too restrictive. The standards must be broadened and DHCS and CMS must take steps to operationalize continuity of care protections so that they are easily accessible for the beneficiary.

The special terms and conditions that accompanied the 1115 waiver authorizing the SPD transition included essentially the same continuity of care protections that appear in the MOU (12 months for existing Medi-Cal providers). A recent California HealthCare Foundation study

of SPDs who transitioned to Medi-Cal managed care indicated that there were significant problems with care continuity in the transition. [2]

- More than 80% of SPDs did not know that they had a right to continuing seeing their current providers.
- Among the 89% of those surveyed who had previously been seeing a primary care provider (PCP) and tried to see a PCP since the managed care transition, 40% indicated that they were not able to keep their primary care doctor;
- Among the 70% of those surveyed who had previously been seeing specialists and tried to see a specialist since the managed care transition, 40% reported having to change at least one specialist;
- Among the 37% who reported using medical equipment or supplies, 28% reported having to change medical equipment suppliers because of the transition;
- Among the 88% who reported using prescription medication, 33% reported having to change some prescriptions and 6% reported having to change all prescriptions.

To ensure that these same problems do not arise in the demonstration, the continuity of care provisions in the MOU must be extended to all providers, including DME, medical supplies and transportation. Care continuity provisions for current nursing facility residents must be extended. In addition, CMS and DHCS must operationalize the care continuity protections in a way that does not require the beneficiary to know about and trigger the rights themselves. Instead, care continuity rights should trigger as automatically as possible based on existing data. Finally, plans must be required to collect and report data on continuity of care.

6. *Provide data on the assumptions that were made in the development of spending reduction amounts so that stakeholders can evaluate whether these reductions will threaten access and/or quality.*

The California MOU reduces spending on the dually eligible population. The reduction will be at least 1%, 2% and 4% in the first, second and third years respectively (before accounting for additional reductions for plans that do not meet quality withholds) and could be as large as 1.5%, 3.5% and 5.5% in each year in some counties. The total reduction in spending could be hundreds of millions of dollars over the three year life of the demonstration. Despite repeated requests, neither CMS nor DHCS has provided information to consumer advocates about how it was determined that these reductions would not threaten access or quality.

The spending reductions in California are significantly higher than in any of the other three states that have signed capitated MOUs. California already outperforms each of these states in reduced hospitalization and percentage of LTSS spending at home and in the community. Without data from CMS and DHCS proving otherwise, it appears unrealistic to expect that California can achieve more savings than these other states. It is also important to note that

[2] See, California HealthCare Foundation "Briefing, Transitioning the SPD Population to Medi-Cal Managed Care, (March 28, 2013)" at www.chcf.org/events/2013/briefing-spd-transition-managed-care.

these reductions are in addition to several other reductions in Medi-Cal spending that are taking effect this year.

State	Demonstrations Savings Yr 1, Yr 2, Yr 3	Percentage of LTSS Spending for HCBS (Rank)[3]	Duals Potentially Avoidable Hospital Admissions (Rank)[4]
Massachusetts	1%, 2%, 4%	44.8% (20th)	114 (12th)
Ohio	1%, 2%, 4%	32.5% (43rd)	205 (45th)
Illinois	1%, 3%, 5%	27.8% (49th)	204 (44th)
California	1%, 2%, 4% (min) 1.5%, 3.5%, 5.5% (max)	55.2% (9th)	96 (7th)

We request that CMS and DHCS release information about the assumptions that were used to determine that the spending reductions authorized in the MOU were reasonable, accurate and attainable.

7. *An Independent, Funded Ombuds or Consumer Assistance Program is Needed Prior to Implementation*

Given the enormity of the change Cal MediConnect and the rest of the CCI represents, it is essential that enrollees have assistance addressing problems they encounter once enrolled. Consumer assistance will be crucial to assure that individuals affected by the CCI understand their options and maintain continuity of care. An effective program will be independent from plans, DHCS or CMS and provide direct assistance to enrollees with filing complaints and appeals, exercising care continuity rights, accessing specialty and out-of-network care, disenrolling from plans that are not working well and more. In addition, an effective program will serve as on the ground eyes and ears for DHCS and CMS, helping to identify systemic problems and recommend solutions.

This function is different from the equally important enrollment counseling services that must also be available to prospective Cal MediConnect and CCI enrollees. Both roles require funding, independence and time to get set up – including time to be trained on the intricacies of Cal Medi-Connect and the CCI. These programs must be identified, funded and trained prior to notices being sent out to beneficiaries.

This is not a comprehensive list of our concerns and questions. We expect to raise additional questions and concerns with you as we further analyze and absorb the MOU. These are, however, our top, high level concerns and we would appreciate the opportunity to meet with you to discuss them. Thank you for your consideration of that request.

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[3] http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/Final-BIPP-Application.pdf
[4] http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/Segal_Policy_Insight_Report_Duals_PAH_June_2011.pdf