NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

March 18, 2014

Center for Medicare and Medicaid Services
Medicare - Medicaid Coordination Office

Delivered via email to : mmcocapsmodel@cms.hhs.gov

Re: California State-Specific Reporting Requirements Appendix

The National Senior Citizens Law Center submits the following comments on the proposed Contract Year 2014 California State-Specific Reporting Requirements Appendix. While we believe the requirements include many important measures, the requirements do not adequately measure several of the primary goals of Cal MediConnect, including:

- Plan progress on rebalancing the provision of long-term services and supports from institutional placement to home and community based settings
- The delivery of health care that is person-centered and member-driven
- Access to health care at the right time and right place for all populations
- The effectiveness of providing additional benefits, including vision and medical transportation

Rebalancing Measures

One of the major goals of the Cal MediConnect program is to provide care to beneficiaries in the least restrictive setting. Yet, the reporting requirements do not include any way for CMS to measure progress on rebalancing of services from institutional care to home and community based services. In fact, there are very few reporting measures that address long-term services and supports (LTSS), generally. Pursuant to the draft, plans are not required to report on the provision of Community-Based Adult Services (CBAS) or services provided by the Multi-Purpose Senior Services Program (MSSP); measures for nursing facility placement only act to capture hospital readmissions. Measures must be included that demonstrate how well plans are integrating long-term services and supports in the community.

We request that CMS require plans to report on the following:

National Senior Citizens Law Center
www.nsclc.org
nsclc@nsclc.org
1444 Eye St., NW, Suite 1100
Washington, DC 20005-2210
202-289-6976 • Fax: 202-289-7224
3701 Wilshire Blvd., Suite 750
Los Angeles, CA 90010
213-639-0930 • Fax: 213-368-0774
1330 Broadway, Suite 525
Oakland, CA 94612-2522
510-663-1055 • Fax: 510-663-1051

- Number of beneficiaries receiving LTSS in the community; number of beneficiaries receiving LTSS in an institution;
- Number of members discharged from a nursing facility to the community; of those discharged, number who did not return to a nursing facility during the current measurement year;
- Number of members discharged from a nursing facility to the community who received LTSS services, including IHSS, CBAS, MSSP, and care plan option (CPO) services;
- Number of members who have CBAS in their care plan; number of members who received CBAS; number of members who requested CBAS and did not receive it; total number of members utilizing CBAS and admitted to a hospital and/or nursing facility;
- Number of members who have IHSS in their care plan; number of members who received IHSS; number of members who requested IHSS and did not receive it; total number of members utilizing IHSS and admitted to a hospital and/or nursing facility;
- Number of members who have MSSP in their care plan; number of members who received MSSP; number of members who requested MSSP and did not receive it; total number of members utilizing MSSP and admitted to a hospital or nursing facility;
- Number of members who have CPO services in their care plan; number of members who received CPO services; number of members who requested CPO services and did not receive them; total number of members utilizing CPO services and admitted to a hospital or nursing facility;
- Number of members who received services through California Community Transitions (CCT) (Money Follows the Person);
- Total expenditures on LTSS; total expenditures of LTSS provided in institutional settings; total expenditures of LTSS provided in the community.

Person-Centered and Member-Driven Measures

A member's experience in a Cal MediConnect plan is supposed to be person-centered and member-driven. To ensure that health plans are accomplishing these objectives, requirements for measuring a member's experience with the Interdisciplinary Care Team (ICT) and involvement in the individualized care plan (ICP) process must added. Similarly, reporting on the number of members who selected or changed their providers will help to evaluate whether the members are driving their own care decisions.

We request that CMS require plans to report on the following:

- Number of members who requested changes to their ICP;
- Number of members who requested more contact with the ICT;
- Number of members who appealed the ICP;

- Number of members who requested that someone be added to the ICT; number of members who requested that someone be removed from the ICT;
- Number of members who selected their own provider(s); number of members who changed their provider(s).

Health Care at the Right Time at the Right Place Measures

It is important to track the experience of particular populations within the larger demonstration population to ensure that the right care is provided at the right time and right place. For example, requiring specific reporting on members with sensory impairments, members with primary mental health diagnoses, members with hearing impairments, and other specific populations will help to measure whether health plans are accomplishing parity of delivery of services among populations. The provision of durable medical equipment (DME) is one example of delivery of the right services to a specific population. The Cal MediConnect program does not extend continuity of care protections to DME providers. Many beneficiaries have long-standing relationships with these providers and we have serious concerns regarding continued and adequate access to DME providers. Furthermore, plans should have to report on whether members are receiving accessible care in compliance with the Americans with Disabilities Act.

We request that CMS require plans to report on the following:

- Number of members who have DME needs in their ICP;
- Number of members who receive DME from a provider of their choosing;
- Number of members who request a change in their DME provider;
- Number of members who file a complaint or grievance regarding access to DME;
- Number of members who are denied a request for DME;
- Number of reasonable accommodations, both physical and non-physical (e.g. extended appointment times), requested by members and number of accommodations provided;
- Number of members inquiring into whether a provider is accessible.

Vision and Transportation Measures

A primary incentive for dual eligibles to elect to enroll in Cal MediConnect is the availability of vision and additional medical transportation services. Collecting data on these benefits will allow plans, CMS, and DHCS to better understand the needs of this population.

We request that CMS require plans to report on the following:

- Number of members who have vision and or transportation included in their ICP;
- Number of members requesting these benefits who receive them;
- Number of vision and transportation providers available to members;
- Number of members who receive these benefits from a provider of their choosing.

Thank you for the opportunity to comment on these reporting requirements. Please feel free to contact us to discuss our suggestions further.

Sincerely,

Amber Cutler, Staff Attorney
National Senior Citizens Law Center

Cc:
Melanie Bella, Medicare Medicaid Coordination Office
Kerry Branick, Medicare Medicaid Coordination Office
Toby Douglas, California Department of Health Care Services
Margaret Tatar, California Department of Health Care Services
Sarah Brooks, California Department of Health Care Services
Nathan Nau, California Department of Health Care Services