



May 28, 2010

David Maxwell-Jolly, Director
Department of Health Care Services
1501 Capitol Mall, Room 6001
Sacramento, CA 95899-7413

Re: California Section 1115 Waiver Implementation Plan:
Consumer Protections for SPDs in Managed Care

Dear Mr. Maxwell-Jolly:

Our organizations have reviewed the implementation plan proposed by the California Department of Health Care Services in May 2010 for the 1115 Waiver.

On behalf of our organizations which represent a broad range of consumers, including seniors and persons with disabilities, we find that the implementation plan is inadequate to protect consumers who are proposed to be mandatorily enrolled into managed care. We offer recommendations to provide necessary, minimum consumer protections.

Our organizations have participated actively in the stakeholder and workgroup process: almost all of our organizations are represented on either the stakeholder group or a specific workgroup. We have very much appreciated this process and the opportunity to hear both other perspectives and the Administration.

We recognize that the stakeholder/workgroup process is only part of a larger conversation that involves the California Legislature as well as the Centers for Medicare and Medicaid Services and other branches of the federal government. We are sending this letter to the California Department of Health Care Services and seeking the opportunity to meet to discuss it as the next step in that larger conversation.

Most of our organizations will also be submitting separate written comments on the plan that reflect the particular perspective of our various organizations and constituencies. This letter reflects our shared concern about minimum consumer protections.

Our comments are most pertinent to the plan to move seniors and persons with disabilities into mandatory managed care. We note those comments that also apply to children with special health care needs.

1. Transition to Managed Care: Timeline and Plan Readiness

We are gravely concerned about the ability of the state to safely transition 380,000 seniors and persons with disabilities into managed care plans in less than twelve months. Determining plan readiness to accept SPDs is a major undertaking. Prior experience with expansions of Medi-Cal managed care also suggests that a short timeline is unlikely to be met.

Since 2005, the Department has had authority to expand into counties adjacent to counties with pre-existing Medi-Cal managed care plans. That transition has not yet been completed more than five years after its approval. Similarly, when Medi-Cal managed care was first implemented in the early 1990s, implementation stretched out over a number of years.

Given prior experience and the greater demands of network adequacy, disability-related access (including physical, communication and programmatic), care coordination, and transition of providers for the SPD population, we question whether enrollment of the entire population can be done safely within twelve months. While it may be a simple matter to amend existing contracts, it is not a simple matter to assure that existing plans are ready to provide care for this population.

Recommendation:

- Planned implementation of enrollment of SPDs into managed care, staged either based on acuity of the enrollee with the least complex first or by county depending on plan readiness or a combination of the two starting with the least complex populations in the counties with the greatest plan readiness for SPDs as measured by objective criteria (see below).
- No enrollment into a specific plan until the Department has certified that the plan has met all readiness standards in advance of enrollment, including network adequacy, disability-related access, a care coordination system, continuing access to existing providers over a limited period as specified below, and demonstration of compliance with all existing Knox-Keene requirements (language access, timely access, financial solvency).

2. Access to Existing Providers:

The Department proposes only sixty days of continuing access to existing providers for a population where 97% report an existing source of care. (Cite to UCLA/CHIS) Seniors and persons with disabilities tend to have multiple providers, sometimes a large number of providers.

While there may be some overlap between the providers on which an enrollee relies and the provider panel for a particular managed care plan, whether that overlap is sufficient to assure continuity of care is a complicated clinical and practical question not readily resolved from review of claims data. Also, the clinical importance of a particular provider to a senior or person with disabilities may not be evident from the claims data. Given the complexities of transitioning care for a SPD, more than sixty days is required.

The Knox-Keene Act, which applies to commercially insured populations that are generally healthier, generally requires twelve months of access to existing providers when plan contracts with a provider group or general acute care hospital are terminated.

Generally, Knox-Keene allows access to existing providers until completion of a course of treatment or twelve months, with specific exceptions for certain circumstances. These protections apply only to those already enrolled in a Knox-Keene plan, not to those who are moving from fee-for-service to managed care: we propose to revise and extend these protections to those SPDs covered by fee-for-service Medi-Cal who will be mandatorily enrolled in managed care because they have existing provider relationships.

Because Medi-Cal-only SPDs have greater health needs than those covered by commercial managed care regulated under Knox-Keene and given that some SPDs rely on multiple providers, we propose both an extended period of access to existing providers and assistance in transition of providers for those SPDs with more than five providers.

Recommendations:

- For SPDs without complex medical needs use the Knox-Keene standards specified in S. 1373.96 of the Health and Safety Code for access to existing providers that generally allows up to 12 months for completion of covered services or a lesser period consistent with that section (such as for completion of services for an acute episode).
- For SPDs with complex medical needs allow transition of up to 24 months and provide case management services at a level sufficient to assist with the transition.
- A SPD with complex medical needs is defined as:
 - A SPD that has seen five or more providers in the prior twenty-four months, including any hospitalization, to be determined from claims data shall automatically be considered a SPD with complex medical needs.
 - A SPD may request and shall be considered to be a SPD with complex medical needs if the SPD has two or more of the following, using the definitions in S.1373.96 of the Health and Safety Code for completion of covered services:
 - An acute condition
 - A serious chronic condition or more than one serious chronic condition
 - A pregnancy
 - A terminal illness
 - A surgery previously approved
 - SPDs shall be informed of the obligation to transition care and the right to receive care for a limited time consistent with these standards.

3. Assessment of Needs

a. Prior to enrollment or auto-assignment

Choosing a new health plan is confusing, as demonstrated by prior experience with the initial implementation of Medi-Cal managed care as well as Medicare Part D.

Reliance on consumer choice alone is not sufficient: consumers are not clinicians. Even with the finest outreach and enrollment effort, consumers may not have sufficient information about their needs to make an informed choice. Informed choice may often require more expertise than a consumer or the responsible party can reasonably be

expected to have. We note that in other programs serving particularly persons with disabilities, such as CCS, the regional centers or the school system, assessment prior to enrollment or assignment in services is commonplace.

The existing Health Care Options process was not designed to assist seniors and persons with disabilities: this is a very different population than the existing mandatory population of parents and children. Virtually all SPDs on Medi-Cal have multiple providers and multiple conditions: in contrast, moms and kids are usually healthy and have often lacked a usual source of care prior to enrollment.

Further, if the premise of the expansion is that fee-for-service is inadequate, there is no reason to believe that fee-for-service data provides a complete picture of the needs of the SPDs: this is particularly problematic for those with cognitive impairments and behavioral health needs but it is also characteristic of undiagnosed physical health needs, such as hypertension and pre-diabetes.

We note that in the Department's implementation plan, they propose identifying those enrollees with needs: we offer our recommendations as a specific means of accomplishing that objective.

b. After enrollment

The implementation plans says that consumers *may* be assessed for care management and that the assessment will be done within 90 days of enrollment.

If the fee-for-service system has failed to provide adequate care, then assessment of *every* SPD on initial enrollment is appropriate. It is essential that the initial assessment include not only physical health but also cognitive impairment and behavioral health needs, precisely those needs most likely to have gone undetected or not to be identified through claims data.

If managed care is going to deliver better care, it needs to start with a comprehensive assessment conducted by the appropriate professionals.

c. Ongoing

We commend the Department for recognizing that some enrollees will need annual assessment. However, given that a senior or person with disabilities, even those that seem relatively stable, may face changes in need, we recommend annual review. We note that both CCS and the regional centers currently engage in annual review of needs. We also recommend that all of the relevant providers engage in such review, similar to what is done in a CCS clinic or IEP for a special needs child.

Recommendations:

- Initial assessment, including cognitive, behavioral and substance abuse, needs to be done of each individual *prior* to enrollment to facilitate a transition plan and providers who can meet consumers' needs. This assessment should include identification of higher risk consumers who need a transition plan to assure that care is not interrupted. The initial assessment is reimbursable under Medicaid rules.

- For each SPD enrollees, the Department shall provide to the health plan or county alternative comprehensive data on fee-for-service claims, including diagnosis codes, provider information, prescription data and a list of Medi-Cal services received from other systems.
- Assessment for care management needs must be done for *all* enrollees within 30 days of enrollment, or sooner if urgent needs are identified in the initial assessment or through the fee-for-service data. Assessment should include not only physical health needs but cognitive impairment, behavioral health and substance abuse needs and it should be conducted by professionals competent to assess these needs.
- Re-assessment should be conducted no less than annually for all SPD enrollees and more often if the needs of consumer as identified by the consumer, a treating health professional, or family member change.
- Re-assessment must be done on the occasion of admission to a hospital or skilled nursing facility as well as emergency room visits that indicate a need for a change in services or care management plan.

4. Exemption from Mandatory Managed Care and Switching Plans

Under existing Medi-Cal managed care, if there is a choice of more than one plan in a county, a consumer can switch at any time. We support this.

We are deeply concerned that some consumers will face disability-related barriers that the plan is unable to correct or a lack of network adequacy, including lack of access to highly specialized providers. For these consumers, the existing medical exemption process should be revised and improved. It is not sufficient to tell someone that their provider should contract with a managed care plan when the provider has refused and the consumer's life depends on continuing care by a specific provider.

Recommendations:

- In a county in which there is a choice of managed health care plans, the consumer should be able to switch plans at any time.
- If the Department fails to conduct an assessment of an enrollee prior to enrollment, the consumer should be allowed to opt out of managed care entirely at any time in the first year. If the consumer fails to participate in a pre-enrollment assessment, this provision would not apply.
- Consumers who face disability-related barriers to access in available managed care plans or who are unable to access highly specialized providers should be able to obtain an exemption from managed care.
- Certain categories of beneficiaries should not be mandatorily enrolled but should be offered a voluntary option, including:
 - Organ transplant patients, particularly those awaiting transplants who might lose their place in line if coverage is disrupted and those with transplants at any time.
 - Those also receiving care under veterans' benefits.
 - Those covered under medical home and community based services Section 1915(c) waivers (Nursing Facility-Acute Hospital Waiver, AIDS waiver, MSSP waiver).

- Any form of disenrollment or plan changes should be tracked and the reasons for the disenrollment or changes monitored for problems with plan readiness and capacity.

5. Network Adequacy

The Administration proposal includes initial assessment and quarterly monitoring of network adequacy. Unfortunately, the proposal does not specify how network adequacy will be monitored. Currently DMHC assesses network adequacy when a plan is initially licensed or when it enters a new area of business. The standards used by DMHC are intended for use with a commercially insured population that is generally healthier than the low-income SPD population covered by this proposal.

Existing DMHC regulations impose timeliness of access standards in part as an indicator of adequacy of network. These regulations specify that monitoring of timely access should be done through a combination of annual and quarterly monitoring. For the initial implementation of mandatory managed care, we propose more frequent monitoring to detect problems with timely access and network adequacy. If care is not being provided timely or if emergency room use is excessive, then the adequacy of the network should be reviewed promptly.

Recommendations:

- The network adequacy standards used by DMHC should be reviewed and adjusted to reflect the needs of seniors and persons with disabilities
- The network adequacy standards must include primary care as well as behavioral health and substance abuse. (Please note that for the commercial population effective today mental health parity should require this and effective 2014 substance abuse parity will be in place.)
- Network adequacy must include disability-related access (see below).
- In addition to the quarterly monitoring of network adequacy proposed by the Department, we recommend quarterly monitoring of compliance with timely access standards for the first three years of implementation, using the procedures described in Title 28, S.1300.67.2.2 (d) (2) but conducted quarterly. If compliance is demonstrated for five years after initial enrollment and if the rates remain actuarially sound to deliver timely access to an adequate network, then monitoring of timely access consistent with the regulations for commercial managed care plans should be sufficient.

6. Disability-Related Access

Lack of physical, communication and programmatic access is a well documented barrier to effective health care for persons with disabilities. Health plans and health providers must comply with existing law by assuring disability-related access.

Recommendations:

- All contracting plans must comply with the disability access standards in a health plan readiness and provider tool developed and/or approved by consumers with disabilities and disability advocates, including initial minimum requirements that a health plan and its network of medical groups, IPAs and individual providers each must meet before enrolling SPDs.

- All contracting plans must have provider directories that list which providers are physically accessible and which are not.
- All SPDs must have access to information about physical accessibility *prior* to enrollment in a plan.

7. Transition and Enrollment

Education and outreach for SPDs prior to enrollment is critical to educate SPD communities about the coming changes. Consumers need to be informed that the way they get care will be changing and how, when the changes will occur, what will happen before their system is changed and what they can do to participate in the transition and to resolve problems.

Beneficiaries must be given adequate time, assistance and information to make an informed choice.

Recommendations:

- The Department shall develop an education and outreach campaign to educate SPDs about enrollment into managed care, consulting with consumer advocates.
- After the period of education and outreach, beneficiaries shall be sent an enrollment packet and should be given at least 90 days to enroll in a health plan or other choice of system.
- Revise the existing Health Care Options process to reflect the needs of seniors and persons with disabilities.
- For beneficiaries who do not affirmatively choose a plan, they should not be enrolled into a plan or medical group without determining a network that best meets their particular needs.

8. Consumer Assistance

Moving hundreds of thousands of low-income seniors and persons with disabilities into a new system of care will cause confusion. We appreciate the elements of the plan that suggest some degree of education and stakeholder input into the development of that education. What is proposed is not sufficient. Having watched the early implementation of Medicare Part D as well as the initial implementation of Medi-Cal managed care in the early 1990s, we recommend several forms of consumer assistance.

Recommendations:

- The Department of Health Care Services needs to staff a 24/7 hotline capable of answering questions, resolving basic concerns, and referring consumers to a grievance and appeals process regarding their Medi-Cal coverage as well as the Medi-Cal processes regarding enrollment in or assignment to a managed care plan and access to pre-existing providers under the Welfare and Institutions Code. This hotline should be available in alternative formats for those with physical barriers and in multiple languages for those who speak languages other than English.
- The Department of Health Care Services needs to enter into an inter-agency agreement with the Department of Managed Health Care to clarify what types of calls will be handled by which entity and when a referral is appropriate. We recommend this because of the increased volume faced by DMHC of consumers with significant medical needs newly enrolled in HMOs.

- DHCS should contract with outside, non-profit entities with a track record of serving low income consumers, particularly those with Medi-Cal coverage, to provide assistance to these consumers in navigating the transition. These non-profits should also be competent to assist consumers with disabilities. This is critical to have an outside mechanism for analyzing the transition and helping consumer with the transition.

9. Delivery System

The Department is premising its proposal for mandatory enrollment of SPDs into managed care on plan's effectively coordinating care, avoiding unnecessary hospitalization, and managing chronic health diseases. While the Department asserts that plans can achieve better care management and improved health outcomes through health care homes, the current managed care contracts do not include definitions or requirements for care management or the health care home. This must be remedied to ensure effective and comprehensive care management of SPDs.

Further, though asserting the need for organized delivery systems to improve care, the implementation plan is silent on improving care for beneficiaries in counties without Medi-Cal managed care plans. This should be remedied by establishing a health care home network in these counties.

Recommendations

- The Department must develop standards, including policies and procedures that require the plan to provide a medical or health care home for every SPD beneficiary with clear definitions and requirements.
- For high-risk beneficiaries, there must be a higher level of care management with routine face-to-face care coordination that includes linkage to community services, community-based behavioral health, PCP, and specialty providers, depending on need.
- In counties without managed care plans, the Department shall pay an administrative fee for providers meeting the requirements of a medical home, utilizing the 90% match rate under the PPACA.

10. Financial Solvency

California has a long, sad history of financial insolvency of entities that accepted risk for medical care. Indeed it was the failure of the predecessor of DHCS to assure financial solvency of early Medicaid managed care plans that led to the enactment of the Knox-Keene Act with its strong emphasis on financial solvency of health plans. Similarly in the 1990s, the delegated medical model which involved organized physician groups accepting capitation resulted in the financial failure and collapse of numerous physician groups and along the way resulted in denials and delays in care for consumers.

The Knox-Keene Act provides two levels of financial solvency standards for commercial managed care: first, for those entities that accept full capitation and function as full service health plans and second, for those risk bearing organizations (RBOs) that accept limited capitation, generally for physician services only.

These concerns apply to any entity that accepts financial risk, including those proposed for Children with Special Health Care Needs as well as managed care for SPDs.

Recommendations for SPDs and Children with Special Health Care Needs

- If an entity accepts full capitation, then it should be licensed as health care service plan and meet the requirements of Knox-Keene for fiscal solvency and other consumer protections.
- If an entity accepts partial capitation, it should meet the same standards as other risk bearing organizations and be subject to the financial solvency standards for risk-bearing organizations under the Knox-Keene Act.
- For the county alternative plan and for the coverage initiatives, the counties in effect self-insure for costs not met. As these projects transition to full coverage, compliance with the appropriate financial solvency standards should be part of that transition.

11. Adequacy of Rates, Updating of Medical Loss Ratio

It is our understanding that the Administration intends to contract with managed care plans at 90% of fee for service rates with a medical loss ratio of no less than 85%, the statutory minimum for Knox-Keene plans.

Under existing California law, health care service plans regulated by the Department of Managed Health Care cannot spend more than 15% of the premium dollar on administrative costs for their entire book of business regulated by DMHC, including all coverage sold to employers and individuals as well as any public programs, such as Medi-Cal or Healthy Families/CHIP. The precise medical loss ratio for each Medi-Cal managed care plan is a matter of contract between an individual plan and the Department: we are not aware of the specifics of those contracts and the medical loss ratio for specific Medi-Cal managed care plans may be more or less than 85%.

We also note that federal law now requires a medical loss ratio of 85% for insurers in the small group market. Generally large employers and large purchasers are able to obtain much better medical loss ratios: for example, CalPERS has a medical loss ratio of 95% and other large employers are in that range as well.

Among insurers and health plans, the medical loss ratio varies. Kaiser Permanente has a medical loss ratio of 95% while Anthem Blue Cross has a medical loss ratio of 82%. Products offered by insurers through the California Department of Insurance had loss ratios of 50% or even less prior to regulatory changes requiring a minimum lifetime ratio of 70%.

To the extent that DHCS contracts to provide care for SPDs at 90% of fee for service rates with a medical loss ratio of 85%, that translates into funding at 76.5% of Californian's completely inadequate current Medi-Cal provider rates.

Here is an illustration of what that 76.5% on care translates into:

For illustration purposes only, if California currently spends \$1000 per SPD per month, in the future California will spend

- \$765 for care---and
- \$135 for insurance company profit and overhead

- While the state reduces overall reimbursement to \$900 per SPD per month, by paying 90% of fee-for-service
- A cut of \$235 out of \$1000 in spending on care

Is it possible that coordination of care will so dramatically reduce unnecessary and inappropriate care? Will care literally be cheaper by almost 25%?

However if the medical loss ratio was 95%, even at 90% of fee-for-service spending, the amount spent on care would be considerably more: again, for illustration purposes: If the amount spent per SPD is \$1000 per SPD per month, the rate is paid at 90% of that and the MLR is 95%, California will spend

- \$810 for care
- \$90 for insurance company profit and overhead
- While the state reduces overall reimbursement to \$900 per SPD per month, by paying 90% of fee-for-service
- A cut of \$190 in spending on care or 14.5%---instead of almost 25%

Our recommendations in this area are based on earlier advocacy in this area. We do not have the precise medical loss ratios for the existing Medi-Cal managed care contracts: that information would help to further inform our thinking.

Recommendations:

- Rate Methodology: Statutory provisions to:
 - Base rates on actuarially sound measures, not arbitrary state budget savings
 - Update rates annually based on actual experience
 - Include measures to reduce reimbursement for health-acquired infections and adverse events
- Medical Loss Ratio:
 - Specify by statute that administrative expenses and profits for Medi-Cal managed care plans cannot exceed 5%
 - Define administrative expenses and profits to include those activities traditionally included as administrative expenses, including utilization review, quality assurance, credentialing, case management, fraud prevention, medical policy-making, referral authorization programs, health plan accreditation, and provider contracting and network management. These activities are administrative in nature and while they may track or report on health care quality, they do not in and of themselves improve quality.

12. Oversight and Evaluation of Outcomes

a. Oversight and Enforcement

While existing state law provides authority to sanction Knox-Keene licensed plans, it is not clear that any enforcement action by the Department of Managed Health Care with respect to Medi-Cal managed care plans. We are also not aware of a single instance in which a Medi-Cal managed care contractor has faced contract sanctions or other enforcement action by the Department of Health Care Services for failure to comply with the provisions of the Medi-Cal regulations and contracts. We find both of these troubling.

Recommendations:

- By statute require Medi-Cal managed care plans to comply with *all* provisions of the Knox-Keene Act and expressly disallow enforcement tools that fail to provide full consumer protections as provided for commercial managed care plans, including surveys, fines and other penalties.
- By statute require monetary penalties and other contract sanctions, including ceasing new enrollment and denial of new contracts, to any Medi-Cal managed care plan that fails to comply with the contract requirements.

b. Evaluation of Outcomes

If the objective is to control costs and improve care as well as supporting the efforts of the safety net and providing care for the uninsured, there should be measurable outcomes.

Recommendations:

- Develop HEDIS standards to monitor and measure improvements in quality of care and outcomes for SPDs. These standards must be specifically designed to meet the needs of the SPD population and include the following: physical and programmatic accessibility, care management and coordination, treatment planning, carve-out services, member services, network capacity, client satisfaction surveys, access to specialty care, including hospital outpatient specialty care and specialty care clinics, and complaint, grievance and appeals procedures
- Measure reductions in morbidity, mortality, avoidable hospitalizations, adverse events and health-acquired infections compared to a comparable risk-adjusted population receiving care in the same geographic region.
- Measure cost effectiveness of annual increases in managed care rates compared to fee-for-service system with no increase in provider rates over the prior decade.
- Measure progress of safety net system in creating better organized and more accountable delivery models, as has been done for coverage initiatives
- Sunset review of expansion five years after initial implementation to assure full legislative review of the impact to assure that the goals of the Medi-Cal managed care expansion are being met and to allow for adjustments as needed.

Our organizations support these recommendations and ask that they be included in both the implementation plan and enabling legislation.

Most of our organizations will be submitting separate comments on the proposal, reflecting specific concerns. This letter represents a shared commitment to consumer protections, particularly for the SPD population.

Sincerely,

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