



**Board Chair**

Bradley Gilbert, M.D.

**Members**

**Alameda Alliance for Health**  
Ingrid Lamirault  
Chief Executive Officer

**Community Health Group**  
Norma Diaz  
Chief Executive Officer

**Contra Costa Health Plan**  
Patricia Tanquary, PhD  
Chief Executive Officer

**Health Plan of San Joaquin**  
John R. Hackworth, PhD  
Chief Executive Officer

**Inland Empire Health Plan**  
Bradley Gilbert, M.D.  
Chief Executive Officer

**Kern Health Systems**  
Carol Sorrell  
Chief Executive Officer

**L.A. Care Health Plan**  
Howard A. Kahn  
Chief Executive Officer

**San Francisco Health Plan**  
John Grgurina  
Chief Executive Officer

**Santa Clara Family Health Plan**  
Elizabeth Darrow  
Chief Executive Officer

**LHPC**

John Ramey  
Executive Director

Corky Oakes  
Association Coordinator

**Lobbyist**

James C. Gross  
Nielsen-Merksamer et al

May 19, 2010

David Maxwell-Jolly  
Director  
Department of Health Care Services

Toby Douglas  
Chief Deputy Director  
Department of Health Care Services

VIA EMAIL

RE: 1115 WAIVER IMPLEMENTATION PLAN

Dear David and Toby,

We are committed to work with the Department to move the Waiver Implementation Plan forward. We appreciate the work that has gone into the waiver renewal process on the part of DHCS staff as well as the stakeholder committee and technical workgroup members. We would like to take this opportunity to provide our comments and concerns.

- **We support the movement of Seniors and Persons with Disabilities into managed care.** Managed care plans have the infrastructure necessary to provide the level of care required by SPDs and desired by the State. Managed care represents great opportunities to improve health outcomes through care coordination and integration for this population. More specifically, Local Initiative plans (LIs), where enrollment of SPDs is voluntary, have a strong track record of serving SPDs. LIs serve more than twice as many SPDs than commercial plans.<sup>1</sup> We have the experience and know-how to build upon existing programs and strategies to provide the services this population needs.
- **Data is critically necessary to prepare for an expansion of this magnitude.** De-identified, aggregate data will allow the plans to determine patterns of care, providers, and diagnoses – all of which will enable plans to make any necessary programmatic and operational enhancements. The sooner plans receive this data, the sooner we can be ready. We acknowledge that the data process for DHCS to produce and for plans to assimilate is demanding. However, it is essential that as we approach the initiation of enrollment that the State provide

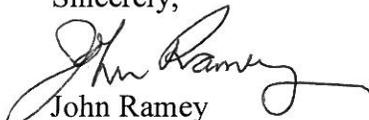
<sup>1</sup> Tim Reilly, Bobbie Wunsch and Steven Krivit, Pacific Health Consulting Group, "California's Local Community Health Plans: A Story of Cost Savings, Quality Improvement, and Community Leadership," January 2010. p. 11.

plans with member-specific data, preferably before, if not at the time of enrollment.

- **The timeline is aggressive but there are high value cost and quality opportunities available.** Both the State and the plans need time to prepare for the transition of SPDs into managed care. If you are seeking a fast-paced transition we need a high degree of collaboration among the State and plans. Obtaining more specific guidelines regarding performance standards, readiness criteria, and de-identified beneficiary and provider data as soon as possible will help. In addition, the more we can work collaboratively upfront to develop contractual provisions that address consumer/advocate concerns increases the likelihood that you have auditable standards meet your intent to enhance quality care and coordination.
- **Rates for the new mandatory population must be carefully done to ensure the viability of the plans and the Medi-Cal program.** We know from published reports and publicly available plan rate data that COHS rates and Fee-for-Service payments reflect costs that are twice our current rates. It is reasonable for you to start an analysis of projected costs with the fee-for-service experience and then apply assumptions related to carve-out aid codes, carve-out benefits, and general utilization trends that will make SPD enrollment in two-plan counties differ from COHS and Fee-for-Service. However, we would like to review these assumptions and provide you feedback informed by our on-the-ground experience with voluntary enrollees.
- **We support the default assignment of beneficiaries based on current plan membership ratio.** Members vote with their feet and public plans for the most part have consistently held a clear majority, up to almost 75% for all LIs combined, of member enrollment.<sup>2</sup> When members have a choice, they choose the public plans.

Thank you for considering our comments. We look forward to working together to implement the new waiver.

Sincerely,

  
John Ramey  
Executive Director

---

<sup>2</sup> Ibid, p. 7.