



May 15, 2012



Honorable Members
California State Legislature



**Re: Duals Demonstration/Coordinated Care Initiative (CCI)
As Amended by May Revision — Concerns**



The undersigned organizations have been active participants in the planning process for the Duals Demonstration Project, which was authorized by SB 208 (Statutes of 2010) as pilot programs in up to four counties. We have also written to oppose the Governor's State Budget Proposal which proposed to expand the demonstration from four to ten counties as part of the Coordinated Care Initiative (CCI). In early May, several of our organizations individually gave input to the Department of Health Care Services (DHCS) and Department of Social Services (DSS) on our outstanding concerns regarding the State's draft plan to the Centers for Medicare and Medicaid Services (CMS).



We continue to work collaboratively with the Administration and hope to see a demonstration which delivers on the potential for integrated funding and services for people who are dually eligible for Medi-Cal and Medicare. While we appreciate the proposed changes in the May Revision to delay implementation from January 1, 2013 to March 1, 2013 and to reduce the proposed expansion of pilots to eight counties, we must continue to oppose the CCI as it is proposed. We believe that the timeline and scope of the CCI as proposed in the draft plan has the potential to harm rather than help the participants.



Disability Rights Education & Defense Fund



CWDA



Below we outline the major themes of our organizations' comments submitted on the State's draft plan, many of which were identified in our previous letters to the Legislature and Administration. The Administration is currently vetting these and other issues raised by numerous stakeholders for inclusion into its final plan to CMS. **However, given the number and scope of the issues raised, we urge the Legislature to articulate minimum readiness standards for the health plans in the four pilot counties and State departments to meet, which would address the issues noted below and improve the chances of meeting the goals in SB 208. These standards should be developed with input from stakeholders.**



- Timing: The bulk of the assumed General Fund savings resulting from the implementation of the CCI initiative could be realized without needing to meet the March 2013 start date.



- 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 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.
- Oversight: The plan would give DHCS all authority for health plan oversight, providing no Legislative oversight on the performance of the health plans and the department's attentiveness to resolving issues.
- Capacity: The plan does not articulate assurances for DHCS's capacity to manage this transition. This is concerning given the experience of seniors and persons with disabilities in the Section 1115 Waiver, particularly around enrollment and seamless access to health services. There is also no opportunity to learn from that experience, as the formal Section 1115 Waiver evaluation will not be ready until December, 2012. The draft plan does not describe how DHCS will verify that plans and providers have the capacity to deliver the services
- Consumer protections: None of the consumer protections, including due process, are defined.
- Outreach and enrollment: Enrollment and outreach materials are not yet developed and cannot possibly be rolled-out effectively, on time, on the current schedule.
- Interaction between health plans and current programs: The pilots are intended to bring together health care services with programs providing long-term care services and supports, the latter of which are administered by counties and other local agencies. The plan does not define the expectations for health plans and LTSS programs nor lay out an effective plan for how health plans and LTSS will work together.
- In-Home Supportive Services (IHSS): The draft plan is not clear how IHSS will work with health plans after the first three years, upon implementation of the universal assessment that is proposed by the pilot and trailer bill. For individuals who are exempted from the pilot, or who opt out, the plan does not effectively describe how they will access their IHSS benefits. The proposed purchase of additional IHSS hours by health plans is also not yet defined.
- Mental Health: The draft plan underestimates the complexity of expanded mental health coverage for Medi-Cal beneficiaries and the counties' current role in local risk management and financing, and does not adequately describe how a shared accountability and savings framework will be developed.

- Duals in nursing homes: The plan does not make clear how persons in nursing homes will be served, whether plans will be at financial risk for all Medi-Cal nursing home residents, and whether the plans will be required to conduct outreach.
- Waivers: The draft plan isn't clear on what happens to the people on HCBS waivers. For beneficiaries who opt out or are exempted, the plan does not make clear that they still will have access to the waiver program services.
- Benefit package: The draft plan indicates these are not yet determined, yet this question is a fundamental and critical one to establish at the outset.
- Rates and Funding: DHCS indicates these rates will be determined in the Fall but the basis for determining the rates is not defined in the draft plan. The draft plan also omits reference to the County contribution in the IHSS program, although this is addressed in the proposed trailer bill. It is unrealistic for some counties to establish contracts with health plans or agree to yet-to-be-defined financial commitments until the financing issues are determined.
- 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.
- Evaluation: The evaluation has not yet been designed, and will likely not be in place before the current pilots start date. These 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.

Timeline is unrealistic considering the amount of unanswered policy and implementation questions: While we appreciate the opportunity to comment on the draft plan, we are concerned that the current timeline for vetting the many outstanding policy issues and making decisions on critical elements of the proposal is unrealistic. The Administration plans to submit a proposal to the federal government in a few short days, for approval this June. Under the recently revised timeline, the demonstrations would be enrolling dual eligibles in ten months.

The Administration has established several work groups that are tasked with developing policy recommendations and pilot deliverables to guide implementation, but these workgroups have just begun and have numerous issues to address during this spring and summer. Some of the groups have not yet met for the first time. Others have met, but specific outcomes from the groups remain unclear. We do not know how the views of stakeholders will be considered by the decision-makers, or when and how the crucial policies and procedures will be finalized and made public. There is not adequate time to

make these difficult and important decisions and to explain them to beneficiaries, providers and community based organizations.

In addition, we have concerns with the capacity for DHCS to prepare, launch and oversee the four pilot counties. There have been numerous concerns raised before the Legislature concerning the conversion of seniors and persons with disabilities into managed care. For example, many seniors and persons with disabilities experienced disruptions to their critical medical treatments, and policies allowing enrollees to remain with their fee-for-service provider because of medical instability for 12 months were misunderstood and inconsistently applied. DHCS also does not have sufficient capacity to address all of the current initiatives they are responsible for undertaking. DHCS has to focus efforts to implement the court-ordered ADHC settlement agreement and new CBAS program, is also assuming oversight of mental health and substance use disorder programs from the Department of Mental Health and the Department of Alcohol and Drug Programs due to State restructuring and in 2014, will be responsible for implementing major expansions in Medi-Cal under the Affordable Care Act, among other legislative and court-ordered initiatives that are either in process or pending.

CMS has indicated that states pursuing integration demonstrations may request a later date to begin enrollment, and, as of April 27, 2012, 10 states have requested an implementation date of January 1, 2014. We strongly encourage a stronger focus in California on “readiness” to allow for proper planning. We believe additional time is critical to develop – and then educate the community about - an innovative, person-centered system of care that will simplify the existing system and improve care for dual eligible beneficiaries.

Expansion to additional counties is not appropriate. The proposal to CMS requests federal approval of the CCI, which the Legislature has not approved. The four counties selected to be pilots account for approximately 535,000 of the 1.1 million dual eligibles in California. Despite the lack of a final design of the pilots, and absent any evidence that the pilots will achieve anticipated savings or better care, the Administration continues to propose a rapid expansion of the demonstration from four to eight counties in the first year, to another 22 counties in 2014 and then to all counties in 2015. We continue to oppose this proposed expansion and have urged the Administration to carefully plan for the successful implementation of the first pilots, and allow an opportunity to test assumptions and make adjustments to the pilots prior to expanding statewide.

Mandatory enrollment and lock-in benefits managed care, not consumers: The Administration has been unwavering in its intention to utilize a passive enrollment process (whereby a beneficiary who does not select a plan or decides not to participate in the demonstration has one selected for him/her), and to lock-in members (thus preventing a plan change or a disenrollment) for six months. While this may be beneficial to health plans, it does not protect consumers who wish to change plans due to issues around access to services, providers and high quality care. Again, adequate planning for the coordinated care needs of beneficiaries will enable the health plans to attract and maintain enrollees while also protecting consumers. The experience with the mandatory enrollment of seniors and persons with disabilities into managed care provides an important lesson in this regard, as the initial data indicates that many enrollees changed plans after their first month, demonstrating the fact that their needs were not met by the plan that they were first enrolled in, whether by choice or by default.

Many of the selected health plans struggle with providing quality care: 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.

Given the volume of policy development that still needs to occur just to launch pilots in 4 counties and the uncertain benefits to the state or consumers of integrating dual eligibles and IHSS into managed care, we urge the Legislature to articulate minimum readiness standards, based on input from stakeholders, for the health plans in the four pilot counties and for the State departments to manage these pilots. Every effort should be made to ensure that the Duals Demonstration as currently authorized by SB 208 is implemented successfully and that lessons learned can be applied to future expansion, with any expansion to be considered by the Legislature.

Thank you for your consideration of our concerns, and our organizations' specific comments in response to the Duals/CCI draft plan can be provided upon request.

Sincerely,



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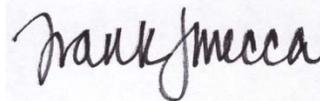
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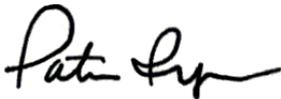
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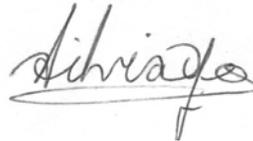
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