

WESTERN CENTER ON LAW & POVERTY

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June 24, 2010

The Honorable Elaine Alquist, Chair
Senate Health Committee
State Capitol
Sacramento, CA 95814

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Re: AB 342 (Pérez) Oppose Unless Amended

Dear Senator Alquist,

At a time when our state's health care system and budget are under immense strain, the renewal of California's 1115 Medicaid waiver offers some hope of investment in and improvement of our Medi-Cal program as well as an opportunity to take early steps toward the promise of federal health reform. Despite these opportunities, AB 342 (Pérez) does not go far enough to protect our most vulnerable Californians during the transitions that this waiver will bring for seniors and people with disabilities into managed care and for coverage expansion at the county level. We must respectfully oppose AB 342 unless these protections, outlined below, are included.

Western Center has partnered with the state in every step of the waiver process. A year ago we formed a workgroup of other advocates for low-income consumers across the state, released with other advocates in September 2009 a paper with recommendations and in March 2010 our recommendations for consumer protections for mandatory enrollment of seniors and persons with disabilities (SPDs) into Medi-Cal managed care. We have, and continue to, participate in the Stakeholder Advisory Committee and two of the technical workgroups and gave suggested amendments to the Department's language to secure what we believe is needed for low-income consumers in the waiver. We highlight below the areas needed to remove our opposition and incorporate by reference our earlier specific language suggestions. We are in ongoing conversations with your staff and will continue to work productively to try to reach agreement.

I. Mandatory Enrollment of Seniors and Persons with Disabilities Into Managed Care

Until now Western Center has always opposed mandatory enrollment of SPDs into managed care as undermining beneficiary choice and because of concerns that the Medi-Cal managed care plans could not adequately meet the varied, often acute needs of the diverse SPD populations. While we would still prefer a voluntary approach, we have been willing to lay out what consumer protections and delivery systems improvements are needed to make managed care work for SPDs, and did so in our March 2010 paper. While your bill includes some of these elements, there are not enough protections for us to feel comfortable with this momentous transition of 380,000 poor seniors and persons with disabilities into managed care plans.

A. Readiness Standards Including Network Adequacy

As the state moves toward mandatorily enrolling SPDs, it is critical to ensure **prior** to enrollment that the plans have the capacity to meet the needs of SPDs. We suggested a particular readiness

tool with criteria focused on the needs of SPDs. Your bill incorporates the current readiness standards used to determine whether a plan can expand into a new geographic area rather than criteria tailored to SPDs. Further, many of these readiness standards are so vague that we do not think they can be assessed and enforced.

A key element to readiness is whether each plan has an adequate network of health care professionals to serve the tens of thousands of people the state proposes to enroll into each plan. We proposed the using Knox-Keene standard for primary care providers, using the Medicare standard for specialty providers, assessing which providers are taking new patients, and requiring a standard for providers, services and equipment relied upon by persons with disabilities. Instead of clear ratios, your bill uses the vague standard in 14087.48(b)(2) which incorporates geographic standards for primary care but no ratios for primary or specialty care and the requirement in 14183(c)(2) of the bill that plans to ensure and monitor an “appropriate” provider network. We do support the later portion of this subsection which requires plans to maintain information regarding providers’ ability to access new patients. This is critical since a long list of doctors is of no use to a consumer if none of them are accepting new patients.

B. Continuity of Care

We support your language in 14087.48(b)(12) requiring plans to allow newly enrolled SPD consumers to continue to see a provider with whom they have an ongoing relationship even if the provider is out of the plan’s network as long as the provider will accept the higher of the plan or FFS rate. Allowing beneficiaries transitioning into a plan the opportunity to continue to see a doctor who is already treating them is critical to maintaining appropriate treatment.

C. Transition and Enrollment

AB 342 would give the state authority to transition some 380,000 SPDs into a mandatory organized delivery system. Because of the complexity of this diverse population, many of whom have multiple serious medical and behavioral health conditions, SPDs cannot be enrolled into any closed system without careful outreach and education and then careful selection of the appropriate system and transition steps taken **prior** to enrollment. In addition, safeguards must be in place to correct the problems that will occur even with careful, individualized and collective preparation.

We strongly support the provisions of AB 342 which would require notification to consumers three months before enrollment packets are mailed, a larger education and outreach campaign, and possible contracting with local health consumer centers to assist consumers with the transition if non-General Funds can be secured for this purpose. Consumers need early information and assistance to understand the changes coming and make their choice of plan and doctors.

Several other components related to the transition and enrollment process we requested are not in AB 342 and we continue to think they are vital to avoiding serious harm to poor consumers who could be cut off from needed care through enrollment. We continue to think it necessary that SPDs be given 90 days to make a choice of plan. For consumers who do not choose a plan, rather than defaulting them into a plan without regard to their health conditions or providers, additional attempts be made to reach them and assistance offered to help them make a choice.

Then, if they still do not choose a plan, their claims data should be analyzed to assign them to a plan, medical group if applicable, and primary care provider which best meet their needs. The Department agreed for consumers who had not chosen a plan to at least make plan assignments based on their providers but that language was not included. We hope it will be and would like to work with you on this component.

D. Consumer Assessment

We appreciate the opportunity to work with your staff on the important issue of plans doing an initial assessment of a new enrollee's needs and support the approach of giving plans data about enrollees at enrollment, and developing an algorithm to determine, based on this data, the persons with the highest levels of risk and most complex health care needs to assess the needs of the higher-risk individuals. If a telephonic risk assessment tool will be used a particular tool should be required by the Department. In addition, it should be administered by a nurse. Further, we believe the timeframes of 45 and 105 days is too long and urge that these be shortened. Last, we want to make clear that this initial telephonic risk assessment not take the place of the requirement that plans do an assessment of new enrollees within 120 days. We suggested that all new SPD enrollees have an in-person assessment within 30 days and are troubled by the long times allowed for telephonic assessment and lack of an in-person assessment requirement for this population – the most vulnerable of whom don't even have a phone or home.

E. Delivery System

This waiver is premised on the notion, frequently asserted by the Department that, by enrolling SPDs into an organized delivery system, their care and health outcomes will be improved and concomitantly the costs for their care will decrease. To deliver on this promise AB 342 should specify standards for an effective delivery system and require that these standards be enforced by the Department. We appreciate the discussions with staff on standards for medical home, care coordination, and care coordination for beneficiaries with a high level of need and the development of definitions for the first two as well as the risk assessment and development of individual care plans. However, we would like to continue to work with you on these standards and on developing a standard of care for higher risk individuals where both the potential for increased outcomes and for cost savings is greatest.

F. Accessibility

We strongly support the language in 14183(b)(2) requiring that the Department ensure compliance with state and federal disability access laws and the language in 14183(b)(8) regarding development of an enhanced facility site review tool to assess the accessibility of providers including specialists and ancillary providers. We would suggest what we assume is a technical fix to subsection (b)(8) to require the Department not just to develop the tool and provide it to plans but also to require that plans use it. This should be added to 14138(c).

G. Exemption From Mandatory Enrollment

We support that AB 342 codifies the existing regulatory medical exemption request (MER) process for managed care but additional changes are needed. Consumers with other health

coverage (OHC) should not be mandatorily enrolled. If the condition exempting a consumer from mandatory enrollment is not subject to change she should not have to apply for the exemption annually. Last, consumers should not be barred from applying for an MER if they have been in a plan for more than 90 days.

H. Transportation

Subsection 14183(c)(8) requiring plans to inform beneficiaries of procedures for obtaining transportation must be strengthened to require that they arrange for and provide the transportation as well.

I. Enforcement and Oversight

Adequate monitoring and enforcement of plan delivery of care and compliance with standards will be key to the success of the waiver and we want to make sure the Department has the tools it needs, including intermediate-level tools, to enforce the requirements of the plans. We appreciate that subsection 14183(b)(12) includes a number of avenues to sanction plans that violate the rules and standards but urge that corrective action plans and transferring enrollees to other plans or to fee-for-service also be included in the Department's "toolbox" of sanctions.

J. Additional Amendments Sought

While the Department has always described this proposal as affecting only SPDs without Medicare, subsection 14183(a) grants broad authority to the Department to require "seniors and persons with disabilities" to be mandatorily enrolled. This needs to be modified to make clear that the authority does not extend to the more than one million poor Californians with both Medicare and Medi-Cal.

Subsection 14183(m) which provides that if there is a conflict between AB 342 and other portions of law, AB 342 controls. This exceedingly broad provision could undermine important portions of Medi-Cal law and should be deleted.

II. Mandatory Enrollment of Dual Eligible Persons Into Managed Care

AB 342 instructs the Department to develop pilot projects to integrate coverage for dual eligibles with both Medicare and Medi-Cal coverage. These projects could, if implemented carefully, could help coordinate and integrate the various health systems upon which dual eligibles rely, but we oppose mandatory enrollment of dual eligibles into the pilot as authorized by subsection 14132.275 (g). Dual eligibles would retain the right to opt-out of the pilot for their Medicare benefits, but would not have a similar opt-out option for their Medi-Cal. Requiring dual eligibles to mandatorily enroll in a managed care plan is a serious policy decision with potential disastrous effects for dual eligibles and allowing an opt-out on the Medicare side will not necessarily address the coordination problems. For example, a person in a Medi-Cal managed care plan with fee-for-service Medicare may not be able to continue to see her Medicare FFS doctor if that doctor does not also contract with her Medi-Cal plan.

A mandatory enrollment policy requires careful consideration based on a firm understanding of the types of plans or other pilot projects dual eligibles will be enrolled into. We still have several questions about the pilots including: whether Home and Community-Based Services (HCBS) will be fully integrated into the pilot, whether individuals in institutions will be part of the target population, whether all dual eligibles in a county will be targeted or only those who already have a connection to the pilot plan and other related concerns. Without more details about what the pilot projects will look like, what benefits they will provide and what beneficiary protections will be in place, the Department should not be granted broad mandatory enrollment authority. The Legislature should require the Department to return for more specific enrollment authority once more details about the pilots have been developed.

III. Coverage Expansion

While of course we would have hoped that California could enact a full Medi-Cal expansion prior to 2014 as allowed by federal health reform, we understand the state's current fiscal crisis makes that infeasible. Similarly, we recognize that the non-federal share of funding for the CEED projects will be county dollars. However, the state is proposing that those county dollars be matched by federal Medicaid dollars and the population to be served is the same as those who will soon enroll in Medi-Cal, therefore we think it important to set some minimal standards for the CEED projects and to prepare for maximum enrollment into expanded Medi-Cal. We seek amendments to the Department's proposed language on the CEED as previously submitted and as outlined below to best meet the twin goals of providing needed coverage to poor, uninsured Californians and preparing for full Medi-Cal expansion on January 1, 2014.

A. Coverage Initiatives.

The Coverage Initiatives (CIs) have provided important support for county coverage expansion, but we are concerned that 15908 (b) allows the Department to continue these projects indefinitely. The continuation of the CIs should be time-limited and we should move to the CEED projects and the goals of transitioning to health reform. The bill language should be clarified to do this.

B. Eligible Population.

We support 15910(b) allowing counties to conduct outreach and enrollment activities to individuals who are homeless, people who frequently use hospital inpatient or emergency department services for avoidable reasons and people with mental health conditions. Recognizing that there may not be sufficient funds from the counties to provide coverage for all low-income adults, irrespective of counties' mandatory obligations to serve all indigent residents, we support targeting these vulnerable populations.

C. Enrollment and Renewal Process.

We reiterate our suggested additions to the enrollment and renewal language to develop a simple, working enrollment process and screen for other health coverage programs. We also submitted language to provide retroactive coverage under CEED projects. For many, entrance into the CI program occurs when they have an emergency service and then apply for coverage after the fact.

The 90-day retroactive coverage helps many to get coverage and providers to be paid, as it always has in Medi-Cal. At a minimum, people should be permitted to apply in the month following the care so that, for example, if service is received on the 31st of the month, people still have an opportunity to apply. Currently, in many CIs, applicants can only get coverage for the month of application, so that if they get care on the 31st of the month, they do not have time to apply – an unjust luck of the calendar draw.

D. Health Care Homes and Care Coordination.

We suggest specific definitions and standards for “health care homes,” “enhanced health care homes” and “care coordination.” The current CIs tout their provision of health care homes but there are few requirements and standards in place for these models of care and, in our experience, not all CIs provide a meaningful health care home. The Obama Administration signals in numerous places in the PPACA a commitment to promoting and funding health care homes and the state can best ensure the health care needs of poor Californians are met and that the state is well-positioned in its negotiations with CMS if it has meaningful standards for these critical delivery system models. We applaud the Department for recognizing the need for “enhanced” health care for frequent users of inpatient hospital stays and suggest other high-need consumer populations will require this level of health care, as well as more robust standards for this level of care as we move to the CEED projects. As the standards we recommend are evidence-based and proven to result in decreased acute care costs, these standards will allow the state to reduce expenditures for these populations once they are enrolled in Medi-Cal in 2014.

Moreover, a definition that meets the requirements of the federal standard would enable the state to apply for 90% federal match under the provision of the PPACA allowing this high match rate for programs providing health care homes for people with chronic health conditions.

E. Benefit Package.

15910(e)(3) sets no minimum standards for what level of benefits the CEED projects must provide – leaving it entirely up to the negotiation process between the Department and CMS. We suggest that the PPACA benchmark/essential benefits be provided: ambulatory care, emergency services, hospitalization, mental health, substance abuse, prescription drugs, and rehabilitative/habilitative services, including chronic disease management though we understand the counties are requesting some time to develop the mental health and substance abuse services.¹ PPACA requires mental health and substance abuse treatment parity and the state should move toward this standard.

If this is to be real coverage and prevent huge medical debt for poor Californians, the CEED projects must cover out-of-county emergency care. This is consistent with Medi-Cal, Medicare and commercial coverage and, without this requirement, poor uninsured consumers will continue to be billed thousands of dollars for emergency care if they happened to be outside their county of residence or taken to the wrong hospital.

¹ Though maternity and newborn care and pediatric services are required essential benefits package elements, we did not include them here because the CEED projects will only serve adults and pregnant women are covered by Medi-Cal or AIM.

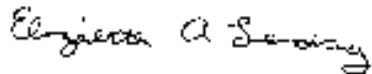
We also include language limiting premiums and cost sharing to those allowable under Medi-Cal to ensure affordability and welcome the opportunity to continue discussion on this.

F. Network Adequacy and Timely Access to Care.

15910(e)(4) allows counties to develop a provider network for their CEED projects without setting any standards they must follow. We suggest some minimal standards both on network adequacy and timely access to care. This is based on reports from consumers about significant problems accessing timely care, even primary care. For example, in one county, more than 5,000 persons who are enrolled in the CI are on a waiting list for primary care due, in part, to a very limited network for the CI.

We will continue to be available to help craft workable solutions to develop a waiver meets the needs of Medi-Cal consumers.

Sincerely,



Elizabeth A. Landsberg
Western Center on Law & Poverty

cc: The Honorable John A. Pérez
Members of the Senate Health Committee
David Maxwell-Jolly, Department of Health Care Services
Jennifer Kent, Governor's Office