

May 8, 2012

Director Toby Douglas
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95899-7413

**RE: Coordinated Care Initiative: California's Dual Eligibles Demonstration,
April 4, 2012 Draft for Public Comment**

Dear Director Douglas:

Thank you for the opportunity to comment on the California Department of Health Care Services April 4, 2012 draft proposal to integrate care for Medicare and Medicaid eligible individuals (draft proposal). The Disability Rights Education and Defense Fund (DREDF) is a leading national law and policy center that advances the civil and human rights of people with disabilities through legal advocacy, training, education, and public policy and legislative development. We have closely followed the national and state processes relating to care coordination and program integration for dual eligibles due to the profound impact that such integration will have on people with disabilities, including people with disabilities of all ages.

Much of the language of California's draft proposal is familiar from the stakeholder process, and laudable in its broad outlines. The state has consistently reiterated having the goals of coordinating state and federal public health care benefits for dual eligible, improving the availability and delivery of home- and community-based services (HCBS), preserving self-directed consumer care, and optimizing Medicare, Medi-Cal and state/county resources. One initial observation we have about the draft is how difficult it is to comment when the actual method and details for realizing these goals is often simply stated as "demonstration sites/health plans will be responsible." Even the draft admits at page 14 that only "some of California's health plans already provide a highly integrated approach to care planning." Many or most of the state's managed care organizations are primarily experienced in managing care for generally healthy adults, families, and children. The draft proposal's timeline projects a virtually complete transition of California counties to Medi-Cal managed care for seniors, people with disabilities, and dual eligibles by 2015, beginning imminently in January 2013. The plan places immense care coordination and delivery responsibility upon managed care organizations that do **not** have sufficient experience with, or understanding of, the medical, social, and behavioral support needs of a very non-homogenous population.

Our other overarching comment on the entire draft proposal is that all of its goals have implicit short, mid, and long-term dimensions to their achievement. While the two fundamental stated goals of improving the quality of beneficiary care and maximizing public resources are always presented as equally important, the enrollment plan, consumer protections, monitoring and enforcement provisions, and the actual implementation timeline undeniably favor short-term goals of resource savings above

both immediate and structural investments needed to preserve beneficiary well-being in the short term and sustain improved patient care in the mid- and long-term. These aspects of the proposal will be discussed in order in the following section.

Risks

Outreach and the enrollment process are the first crucial areas where resource concerns of the state and demonstration sites come into potential conflict with what is best for consumers. The draft proposal asserts that health plans “will need sufficient enrollment in the demonstration to sustain a capitated model” and “can only achieve the benefits of coordinated care if they have sufficient time to develop a case plan and implement care improvements.” On the other hand, respect for consumer choice and well-being argues for **first** having a plan credibly establish its capacity to serve the health care needs of people with multiple impairments and chronic conditions, and **then** offering those options to dual eligibles, who will stay with a plan that appropriately provides effective care assessment, coordination and services. As the PACE model has shown, managed care that can do the job and keep people at home safely in their homes is sustainable and will retain eligible consumers.

Unfortunately, almost every choice in these initial areas has been made in favor of the short term gain of the state and health plans over the short, mid- and long-term needs of consumers. Medi-Cal services can only be obtained through mandatory managed care. Dual eligibles will be passively enrolled in Medicare. Individuals who do not actively opt out of the demonstration will be locked in to a particular health plan for 6 months. Enrollees are left to rely upon a 6 month care continuity option, that does not appear to extend to such critical ancillary providers as Durable Medical Equipment (DME) suppliers and seating fitters, and a Medi-Cal Medical Exemptions Request (MER) process that has been fraught with interpretation and implementation difficulties during the mandatory enrollment of seniors and persons with disabilities under the 1115 waiver. Moreover, these decisions are made in the context of known outreach difficulties that have been captured in such sources as the California HealthCare Foundation’s study on the 1115 waiver process. Community and advocacy groups have reported on how limited English proficient (LEP) individuals received 1115 waiver enrollment notices and packages that they did not understand, and vision impaired individuals failed to receive enrollment packages in alternate formats when requested.

Passive enrollment for the draft project would be less troubling if we were confident that outreach would be highly effective, including for such difficult to reach beneficiaries as those who may lack a permanent home address or phone number, those who have cognitive, behavioral, and/or communication impairments, or whose primary language is not English. We are not confident about this. A lock-in period would be less problematic if it applied to a beneficiary’s active choice **to** enroll in a particular plan. It does not. Incomplete outreach, passive enrollment, and a lock-in together might conceivably be less dangerous if consumers had continuity of care mechanisms that applied broadly to all necessary primary, specialist and ancillary providers **and** well-established MER procedures with no backlog of requests. This is not the case. There is the additional fact that due process and appeal procedures, and the applicability of

Aid Paid Pending protections to Medicare benefits, are still very much works in progress. Finally, state and CMS monitoring, oversight, and evaluation of health plans – a vital element when plans will be assuming responsibility for entire service areas such as In-Home Supportive Services (IHSS) that they have little familiarity with – are also clearly in development. It must also be noted that the word “enforcement” is generally absent from the entire draft proposal.

The above factors establish a “perfect storm” that will catch those least likely to respond to outreach, those with complex health conditions that have the most to lose if care continuity is disturbed, and those least able to navigate the intricacies of MER requests and appeals in a unified system that has even been worked out yet. This is not a criticism of the administration’s initiation of a workgroup structure on such important issues as beneficiary protections and appeal procedures. DREDF supports the state’s commitment to gathering multiple stakeholder input for the development of performance measures and continues to hope that consumer needs will be well-reflected in the establishment of performance measures and targets. This is a strong criticism of the administration’s current timeline and enrollment decisions which leave all stakeholders – consumers, community and advocacy groups, providers, and plans - with virtually no margin of error for affecting a safe transition to managed care.

Other states have proposed later alternatives to a January 2013 start date in their dual eligible integration proposals. In general, these are states that have a much lower percentage of the nation’s dual eligibles than California, where a “demonstration” involving Los Angeles County implicates thousands and thousands of individuals. The immediacy of California’s proposal appears to be primarily budget-driven, from a state eager to achieve projected savings through a managed care transition of high-cost dual eligibles. The central question is who bears the risk of favoring short-term gain over a longer-term commitment to developing and testing the kinds of network readiness standards and tools, beneficiary protections, integrated appeal processes, and monitoring and enforcement mechanisms that should be put in place **before** enrollment takes place? Beneficiaries are on the front lines, and face care disruptions, delays in appropriate treatment, reduced functionality, and compromised health. Circling back to the topics of outreach and enrollment, at least two questions have to be raised:

- If effective outreach is one of the mechanisms relied upon for ensuring that passive enrollment actually reflects genuine choice, that same outreach should be recognized as an effective way to persuade potential enrollees of the benefits of *voluntary* membership in a plan;
- If, as we are reassured, the demonstration plans stand ready to provide effective case plans and care improvements for the dual eligible population, then isn’t the best way to avoid “enrollment churning and interruptions for an initial six month enrollment period” to lock-in only those that have actively chosen a plan and exhibited a commitment to realizing the benefits of switching to managed care?

The draft proposal already contemplates a rolling enrollment period that takes place over a year. DREDF supports this process given the numbers of dual eligibles involved. Instead of the arbitrary imposition of enrollment based upon birth date,

however, we suggest that it makes more sense to target enrollment based upon health and impairment levels. That is, active enrollment should be solicited first from eligible individuals with fewer complex health needs; any eligible individuals can actively enroll in a plan at any time. Outreach over the course of the enrollment period can culminate in active outreach to individuals with complex care needs, multiple provider teams and/or medication needs, and additional HCBS and long-term supports and services (LTSS) needs. This would enable plans to continue to gain experience meeting the needs of individuals with complex care conditions, learning the intricacies of HCBS and IHSS, and further solidify needed relations with community and advocacy groups. Word of mouth concerning plans that are effectively and appropriately meeting the care coordination and HCBS needs of the dual eligible population can spread, workgroups can continue to work out the details of vitally important beneficiary protections and unified appeal procedures, and California and CMS have more time to meet with, assist, and if necessary delay further enrollment among those plans that encounter difficulty meeting performance target measures for the first waves of enrollees. Passive enrollment should not be considered until dual eligible individuals are actually given the opportunity to see managed care done well for people with complex and multiple health conditions, and an extended period of time to freely voluntarily choose managed Medi-Cal and Medicare.

Opportunities

DREDF is not alone in our concern over the tremendous risks that accompany a transition to managed care for dual eligibles. Colleagues at Disability Rights California, National Senior Citizens Law Center, Western Center on Law and Poverty, and many other advocacy organizations have enumerated detailed concerns and excellent recommendations for the draft proposal. We support their work, and also want to take this opportunity to highlight what we see as two specific opportunities that a managed care transition will afford people with disabilities in the state, in addition to the general goal of improving health care quality and coordination for dual eligibles. These opportunities involve increasing the physical and programmatic accessibility of health care delivery to people with various disabilities, and rebalancing LTSS to ensure the ready availability of HCBS favored and needed by seniors and PWD in California.

Physical and Programmatic Accessibility

The physical and programmatic inaccessibility of smaller practices and clinics owned by a physician or physician group, where over 83% of outpatient facility visits take place, is becoming increasingly documented. One recent large-scale analysis of over 2300 primary care provider facilities in California serving Medicaid-eligible managed care enrollees found that 8.4% of provider sites have a height-adjustable exam table, and only 3.6% have an accessible weight scale.¹ Many people with mobility, balance, and

¹¹ These findings are published in N.R. Mudrick, M.L. Breslin, M. Liang and S. Yee, *Physical Accessibility in Primary Health Care Settings: Results from California On-Site Reviews*, 5 DISABILITY & HEALTH J. (2012) (forthcoming).

strength impairments cannot receive equally effective examinations without accessible equipment. The need for programmatic accessibility, which involves reasonable modifications of policies, practices and procedures such as providing written information in alternative formats or extended appointment times, is even less likely to be known among, and available from, providers.

DREDF supports the draft proposal's general declaration at p. 9 that "sites must comply with state and federal disability accessibility and civil rights laws, including communicating in alternate formats." However, ensuring actual adherence to accessibility laws by plans and among providers requires more than a declaration, or even contractual language. Legal accessibility obligations in healthcare have existed for decades in California. This fact in itself has not made health care delivery accessible.

Managed care presents another layer of resources and infrastructure that operates among and connects individual providers to one another and to state Medi-Cal funds. As an umbrella entity, a managed care organization can perform 3rd party trained physical and programmatic surveys of its provider network, provide linguistic translations and alternative formats of common health care and self-care information, efficiently undertake contracting and scheduling ASL services within the network, assist members to find accessible providers within a reasonable distance, and foster disability cultural awareness and training among providers. If the state can delegate practical administrative responsibilities for ensuring accessibility among thousands of California providers, then it can focus on committing resources to monitoring and enforcing compliance with accessibility laws and investigating and resolving disability civil rights healthcare complaints. However, the draft proposal must clearly establish these expectations and lay a common regulatory foundation among all demonstration plans, or nothing will change. Plans must be required to establish physical and programmatic accessibility targets for their provider networks – primary, specialist and ancillary – that are periodically updated. The state, including DHCS and DMHC, as well as CDSS, must hold plans accountable for meeting their targets, and must also review each department's own policies, practices, and procedures to ensure that all health care services and public interactions are accessible.

One ongoing example of inaccessibility are the bi-weekly provider timesheets that IHSS recipients must sign under penalty of perjury to initiate provider payments. The timesheets are a centralized state form that providers fill in by hand, and the state forbids any modification to the form. This form is wholly inaccessible to blind and many visually impaired IHSS beneficiaries, who nonetheless must "verify" hours that they cannot see for their providers to get paid. Currently county IHSS authorities receive signed timesheets and enter provider hours worked, but the state plans to centralize IHSS timesheet collection and entry functions across California. The timesheet procedure, as well as IHSS informational notices and Notices of Action that are sent to individual beneficiaries, are undeniably inaccessible and are barriers to the equal participation of visually impaired recipients in the IHSS program. This is currently the case, and will remain the case after IHSS benefits are folded into managed care in the demonstration sites. Who bears responsibility for developing and implementing accessible solutions to this issue? The forms come from CDSS. Managed care entities

will be responsible for administering IHSS services. County IHSS agencies will be subcontractors of managed care entities, and seem likely to remain the front line representatives for purposes of beneficiary interaction. California's Health and Human Services Agency is the overall coordinating agency for the dual eligibles project.

In the above situation, as in countless others, the complexity of overlapping public-private functions and local-centralized responsibilities make it all too easy for every responsible party to simply point fingers and take no action. The draft proposal claims that financial and service integration will simplify service delivery and make the system easier for eligible beneficiaries. This goal must include a guarantee of physically and programmatically accessible service delivery, which requires establishing clear and publicly transparent lines of responsibility and authority for enforcing federal and state disability rights laws. At the same time, plan or state administrative complaint and appeal procedures concerning inaccessibility must not infringe on existing rights to bring a complaint or legal action under current federal and state disability rights laws.

One of the fundamental tenets of the Supreme Court's *Olmstead* decision was that people with disabilities (PWD) could not be required to endure segregation in a nursing home or other institution in order to receive needed health care services. But the fundamental ongoing inaccessibility of outpatient provider offices makes it extremely difficult or impossible for people with various disabilities to actually receive equally effective healthcare services in their communities. High functional impairment levels among the dual eligible population makes accessibility a core prerequisite for achieving improved health care delivery and services through the coordinated care initiative. Furthermore, another advantage of ensuring that providers in Medi-Cal managed care networks become accessible is that doing so will benefit not only Medi-Cal enrollees and dual eligibles, but also many other PWD of all ages who are plan members or who visit those same providers through Medicare only or private insurance. Ultimately California's entire population benefits when providers, plans, and the state develop and systematize appropriate accommodations and reasonable modifications in response to the needs of the dual eligible population.

Rebalancing LTSS toward HCBS

The disability community and advocates, as well as the state and local counties, have invested time and effort over many decades into building IHSS into a system of HCBS that may not be perfect, but does recognize the critical importance of consumer direction and independence in such critical aspects as hiring, firing, and supervising personal care assistants. DREDF recognizes that the draft proposal establishes some safeguards for maintaining the best features of IHSS. For example, the proposal states that beneficiaries can choose to limit the role of their IHSS providers on care teams, county social service workers agencies and not medical providers will continue to assess and authorize IHSS hours, and existing grievance and appeals process will remain in place. We strongly advocate for additional necessary provisions that will set the stage for not only maintaining IHSS, but for optimizing HCBS within LTSS. These additional provisions include the state's commitment to:

- Develop managed care capitation rates that pay the same blended LTSS rate wherever a consumer lives so that plans will not be given fewer resources to provide HCBS relative to services in an institution, and full LTSS funding will follow beneficiaries to homes in the community rather than be conditional in any way on nursing facility placement.
- Establish a global budget in which managed care plans will draw out of the same fund for HCBS and institutional care, and accounting mechanisms will enable plans and the state to track and realize savings from providing HCBS to beneficiaries rather than institutional care.
- Prohibit any “carve out” of institutional costs from a managed care plan’s budget or costs after plan beneficiaries have passed some arbitrary time period of institutional stay.
- Set rate incentives that will reward plans that consistently and successfully provide HCBS to dual eligible beneficiaries in the community and assist those individuals to avoid hospitalizations and institutional stays. Incentivization should work hand-in-hand with the development of quality care measures that examine whether people with various disabilities receive common preventive tests and treatments in an accessible and equally effective manner, for example, a measure that examines whether dual eligible women who use wheelchairs receiving regular mammograms and pap smears. The development and use of quality measures for individuals with varying levels of functional impairment and medical complexity is important to ensure that no plan is penalized for, or discouraged from, taking on beneficiaries with more fragile or complex conditions, and a potentially higher propensity to require periods of institutional care.
- Ensure that managed care organizations receive all relevant information about beneficiaries receiving institutional care, including reporting requirements placed on nursing homes under Section Q of the Minimum Data Set 3.0, which mandate local agency referrals whenever a resident indicates that she or he wishes to talk to someone about living in the community. DREDF supports the administration’s decision to not exclude any beneficiary from the demonstration based on specific diagnostic categories or on institutional residence. This decision must be reinforced by establishing that managed care organizations are now key *Olmstead* players in California, and must reduce fragmentation among, and improve lines of accountability with, myriad subcontractors to ensure that HCBS fiscal incentives provided to managed care organizations translate into appropriate action at the level of the institutional provider, where fiscal incentives will run in the other direction.
- Maintain regulatory and policy support for full consumer choice of IHSS providers, including the hiring, training, and supervision of non-medical and non-licensed service providers to perform a wide variety of personal assistance and intimate care needs.
- Establish a robustly funded Ombudsman office to provide consumer education, independently investigate individual complaints as well as systemic LTSS issues, and provide information on, and assistance with, rights and appeal procedures, administrative hearings, and court filings. The Ombudsman is also an ideal centralized point for the public to obtain performance data, including physical and programmatic accessibility survey data and complaint data, on such LTSS

providers as including HCBS agencies, nursing facilities, and managed care plans. Given the centrality of rebalancing to all of the draft plan's goals, it is vital that the Ombudsman operate completely outside of the service delivery system and be free of conflicts of interest in both fact and appearance.

- Develop a unified LTSS database that includes the demographic data collection requirements established by the federal Department of Health and Human Services under the Affordable Care Act, utilization data according to type(s) of service used (e.g., waiver, IHSS, institutional stay), and assessment and service data (including discrepancies between a beneficiary's assessed needs and the services provided).
- Include the realignment of provider fiscal incentives toward appropriate HCBS for dual eligibles and beneficiaries with disabilities in the development of any managed Fee-for-Service model for less populated, rural areas or counties where there is no operating managed care plan.
- Maintain ultimate accountability for *Olmstead* implementation. California may choose to delegate aspects of HCBS service delivery and LTSS coordination to managed care organizations, but it cannot abdicate its legal responsibility for ensuring that people with disabilities do not endure unnecessary and unwanted segregation outside of their chosen communities because of a medical condition or diagnosis.

Specific Concerns and Recommendations

DREDF's primary recommendations for this draft proposal are to slow down the process and to do it right. Within the parameters of the draft proposal as written, however, we do also have some specific recommendations and questions as follow:

- Page 7- enhanced quality monitoring and enforcement.

The language here should clarify that performance outcomes relate to more than just medical goals, and should encompass outcomes that are important to the individual consumer such as remaining in the community, maintaining maximum independence, and retaining sufficient functionality to pursue employment, educational opportunities, and family/social relationships.

- Page 7 – exclusion of some beneficiaries in long-term care facilities that actually have to establish meeting their monthly Medi-Cal share of cost.

We are unsure why any long-term facility resident should lose the opportunity to benefit from the demonstration projects' anticipated benefits of care coordination and re-emphasis on HCBS and a return to the community just because of administrative or accounting difficulties.

- Page 11 – provider network requirements.

Provider network requirements must include geomapping standards that address the need for physical and programmatic accessibility from a wide range of providers, including primary, acute, specialist, and key ancillary providers such as DME and wheelchair seating specialists. Consequently, the state should suspend new enrollment of dual eligible beneficiaries into managed care plans that lack sufficient

accessible providers. On an individual beneficiary level, if an appropriately experienced, accessible network provider who is actually accepting patients cannot be found in a reasonably proximate location, these should be automatic grounds for the managed care plan's authorization of grant out-of-network provider payments.

- Page 13 – care coordination standards.

Without diminishing the importance public input to developing care coordination standards, we still strongly recommend the state's adoption of some uniform, "bottom line" standards for immediate implementation by managed care plans. Mandatory managed care for dual eligible persons and people with disabilities may be relatively recent, but there have always been people with various disabilities voluntarily enrolled in managed care. The use of an immediate baseline performance standard, with a clear timeline for the development and refinement of additional specific standards with stakeholder input, will greatly assist the state, consumers, and advocates to detect care assessment and coordination issues and support remedial steps sooner rather than later.

- Page 14 – comprehensive health risk assessments and care planning.

Individual care plans must include the member's actual or anticipated physical and programmatic accessibility needs, such as "height adjustable exam table," "fillable forms and information in electronic format," or "extended appointment time for examination." These accommodation or modification needs must be regularly updated. Even if a younger person with a disability is capable of transferring independently for a number of years, that ability can diminish fairly rapidly during periods of illness, after acquiring a secondary condition, or even simply due to aging and repeated stress on joints over years of transfers.

- Page 15 – use of technology.

Electronic health records (EHR) is mentioned here, but not with regard to patient access, which the draft plan should at least address. EHR must be made accessible for patients with various disabilities and/or Limited written English Proficiency to review, to provide corrections where appropriate, and to obtain copies in alternative formats and in threshold languages without any additional surcharge.

- Page 17 – LTSS only available through Medi-Cal managed care in demonstration counties.

We are concerned for those individuals who strongly wish to opt out of the demonstration in order to maintain long-held relationships with key fee-for-service Medicare providers, but who also require IHSS services and therefore must enroll in Medi-Cal managed care. Will their services and billing/payment procedures in fact be even more fragmented than the current status quo, as there are now additional differential layers of dual eligibles fully enrolled in the demonstration, mandatory Medi-Cal and Medicare opt-out dual eligibles (either initially or at the 6 month mark), and those who will apply for a MER from managed care Medi-Cal and opt-out of Medicare. If enrollment is truly to be optional, at least on the Medicare side, then potential enrollees must be given some clear idea of what happens after opt-out, and the impact of that decision on needed LTSS services which are now imbedded in Medi-Cal managed care.

- Page 18 – evidence based practices.
DREDF favors the use of evidence-based medicine, but also cautions that many people with disabilities, and especially those with low-incidence conditions/impairments or who have multiple conditions, are simply excluded from the parameters of evidence-based practices. When health plans are educating network providers and staff, they must also indicate that the opinions of established treating physicians and clinical experts concerning best practices and medical necessity can be applied as well or in lieu of general guidelines that were developed without the participation or input of any person with any kind of disability whatsoever. Any state administrative staff involved with medical decision review or appeal should also be provided with this information.
- Page 18 – telephone survey.
We strongly suggest that any telephone survey options in future find simultaneous ways to capture the opinions of beneficiaries who does not have a phone, or cannot use a typical voice line because of voice or speech impairments. We also would like to clarify whether the last key finding is that four percent of *all* beneficiaries scheduled to transition to Medi-Cal managed care under the 1115 Waiver made a MER, or whether it is four percent of the 463 individuals called who actually responded to the phone survey who indicated that they had applied for a MER?
- Page 19 – health plan adjustment to needs of 1115 waiver population.
The best practices described, such as partnering with member advocacy and community groups, budgeting more time for welcome calls, and developing new ways to disseminate information, should be compiled and disseminated among all plans who wish to be a demonstration site, to be incorporated as standard practice for the dual eligible project.
- Page 21 – Other home and community-based waiver programs.
Before community-based waiver program services are integrated or taken over by health plans, the plans need to engage in a thorough analysis of where plan services and waiver services are duplicative and where different services are provided, taking into account the availability, frequency, duration, and quality of the service (e.g., experience levels of the service providers, opportunities for beneficiary input, etc.). The plan analysis and any proposed eliminations of duplicative services should be made available to the public, who will have the chance to offer further insight to the services provided under waiver programs.
- Page 25 – notification about enrollment process.
Plans must include in their information concerning benefits and grievance and appeal procedures the name and position of a specific individual who is at least partially dedicated to solving accessibility issues for members.
- Page 28 – performance based reimbursement for providers.
Health plans should be strongly encouraged to provide incentives that motivate network providers to establish practices that combat known health disparities, such

as providing reimbursements for physicians and other providers who acquire accessible equipment and offer physically and programmatically accessible services.

- Page 29 - potential improvement targets for performance measurement. Is there any specific reason why the development of plan performance measures cannot remain an open process beyond January 2013? That is, given the many innovative and duals integration projects happening across the country, and a common need for performance measurement, the state or other stakeholders could learn of good validated performance measurements after January 2013. Including additional or new performance measures may make it more difficult to compare overall performance within one plan over time, but should have minimal impact across plans, and all stakeholders benefit from using the best available performance measures.
- Page 29 – potential improvement targets for performance measurement. “An increase in the number of beneficiaries with mobility impairments receiving preventive screenings” or “an increase in the number of beneficiaries with communication impairments participating in health risk and behavioral health screening” are some additional potential improvement targets that would also address documented disparities experienced in the disability community.
- Page 31 – state infrastructure/capacity. The relationships among multiple state departments and agencies remains unclear, especially with regard to projected lines of authority and responsibility for the demonstration project in such important areas as consumer protections, complaint investigation, regulatory authority, data gathering, appeals procedures, and so forth. These basic structural issues must be worked out and clearly documented before the demonstration is initiated, and include any additional relationships with private entities that play a critical role, such as the enrollment agent. DREDF supports the expansion of HICAP counselors for the open enrollment period in the demonstration counties.

Two final specific concerns are not addressed in the draft proposal. The first concerns the myriad of primarily non-profit service providers that have served beneficiaries through the home and community-based waiver programs. For the most part these are local providers with a wealth of experience who also respect the dignity and autonomy of waiver recipients. DREDF believes managed care plans should be strongly encouraged to enter subcontracts with these providers and preserve existing waiver provider relations wherever possible, thereby minimizing beneficiary disruption and retaining the valuable experience amassed by these providers. One way to encourage these subcontracts would be to require plans to properly weight familiarity and levels of existing contact with the incoming beneficiary population, and not merely seek “the lowest bidder” when seeking subcontractors.

Finally, we do commend California’s demonstration and stakeholder process as being among the more open adopted by states interested in duals integration across the country. We would ask that a commitment to transparency, data publication, and stakeholder engagement be retained as the process moves forward and as the state

continues to discuss options and details with CMS. If the state, as one public entity, approaches CMS as another public entity, to advance a particular interpretation of either CMS guidance or a consumer protection stated in the state's own draft proposal, affected consumers and stakeholders should be given the opportunity to give feedback on the implications of that particular interpretation. For example, after the 1115 Waiver was granted and CMS terms and conditions were published, California sought CMS approval to 'clarify' its position that only medical doctors were considered "providers" for continuity of care purposes. This clarification has had a negative impact on wheelchair users who rely heavily on the specialized expertise of ancillary providers such as seating experts to avoid dangerous pressure sores and to preserve musculoskeletal functioning. The entire approval process was done behind closed doors and without the input of informed beneficiaries or providers. DREDF would like to avoid a repetition of this process.

Thank you again for the opportunity to comment on this critically important health care transition for dual eligible persons and all Californians with disabilities.

Yours truly,

A handwritten signature in blue ink that reads "Susan R. Henderson" followed by a horizontal line.

Susan Henderson,
Executive Director