Health Net Community Solutions, Inc.
Health Net of California, Inc.
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April 22, 2016

Ms. Sarah Brooks, Deputy Director
Health Care Delivery Systems
Department of Health Care Services
1500 Capitol Ave.
Sacramento, CA 95814

VIA ELECTRONIC MAIL
Sarah.Brooks@dhcs.ca.gov

Dear Ms. Brooks:

Health Net appreciates the Department of Health Care Service's (DHCS) continued willingness to refine the Coordinated Care Initiative, including Cal MediConnect, to improve its success and long term viability. We believe that the Cal MediConnect program provides high quality care for individuals with complex care needs but has been disadvantaged in the Medicare market due to programmatic decisions made at the outset. Further collaboration with the Medicare-Medicaid Plans (MMPs) and stakeholders will help develop the right approach to improve enrollment and increase program sustainability.

Overall, Health Net supports the CCI program enhancements released during the April 7th stakeholder call. Below are our specific comments on the proposed program changes.

1. **Annual Passive Enrollment into Cal MediConnect:**

Health Net supports DHCS's proposal to perform annual passive enrollment into Cal MediConnect for individuals newly eligible for the program coupled with enhanced outreach prior to enrollment. As is well documented, the opt-out rate for CMC was higher than anticipated due confusion during the passive enrollment process and generalized anxiety over the change. Dually eligible beneficiaries did not understand what CMC could mean for them and decided to remain in fee-for-service Medicare for fear of the unknown. Use of mailers and limited group information sessions was not sufficient to reach the member level. If this same approach is continued, the new passive enrollment period will not have different results.

To be successful, DHCS and the MMPs must modify their outreach strategy becoming individualized and targeted to make sure people understand the change. Health Net recommends DHCS provide member level data to MMPs for those duals that are currently enrolled in the Medi-Cal managed care plan for LTSS services 120 days prior to the passive enrollment period. This additional outreach time will allow MMPs to reach out directly to individuals to explain the CMC program and answer any questions or concerns about the change.

Health Net is committed to providing resources to discuss the program changes to future members. We expect to develop new outreach scripts for outbound call and increase staffing to provide individuals with assistance. Connecting to the individuals directly will help us to alleviate anxiety regarding provider choice and develop continuity of care agreements or new contracts to facilitate continued access to care. Additional, if necessary transitional medication fills can be provided during the initial move into managed care to ensure needed medications are available. During the prior passive enrollment period, DME equipment issues were identified as a major concern. We have worked closely with our CMC provider groups to make sure that continuity of services was provided and, as necessary, continuity of DME providers.

Health Net also identified providers with high opt out rates for additional outreach. We identified geographical and cultural pockets that accounted for significant opt outs. This information has helped us to better identify those areas where additional educational outreach will be needed for another passive enrollment period. In particular, informing providers of the value associated with the integrated care model in CMC can help providers engage more effectively in the CMC program.

For individuals that are not enrolled in Medi-Cal Managed Care, DHCS should consider taking a similar hands-on approach to the passive enrollment process. Mailings do not adequately inform individuals of change. Implementing outbound calls to explain the program and discuss their enrollment options will help minimize confusion and increase the likelihood the beneficiary will be enrolled into the program ready to engage in their care.

In terms of how to divide the enrollment, Health Net recommends equal distribution of the passive enrollments across the two months. MMPs can staff up for the outreach and enrollment process and ensure resources are appropriately allocated to meet the volume.

Health Net also recommends that, to the extent that individuals decided to opt out of CMC, those individuals be re-enrolled into their prior Medi-Cal managed care plan.

2. Operationalizing Mandatory MLTSS

Health Net supports mandatory MLTSS for duals in the CCI counties as required by law. Implementing this requirement will ensure alignment of requirements across the CCI counties and ensure equal treatment of dual eligible regardless of when they enrolled into Medi-Cal.

3. Exploring Potential Extension of Deeming

Health Net supports the extension of deeming to 60 days if MMPs do not maintain the liability for the second month of IHSS services. The current 30 day deeming period has not been sufficient to ensure contact and reenrollment of pended members into Medi-Cal. Due to the lack of sufficient contact information, MMPs cannot always reach members in enough time to

prevent a break in CMC enrollment. The additional time will assist in the outreach efforts and ensure the appropriate documentation can be submitted to the counties prior to the lapse in coverage.

However, Health Net recommends DHCS/DSS maintain liability for the cost of IHSS as MMPs do not have control over or the appropriate mechanism to account for the IHSS hours. MMPs do not authorize or approve IHSS hours and do not have a mechanism to track if the cost of IHSS hours incurred during a month aligns with those dollars taken from our capitation by the state. If DHCS were to reduce the MMPs capitation payment for IHSS, the reduction would negatively impact our ability to serve current member and present an undue financial hardship.

4. MMP Enrollment Process

Health Net fully supports the use of MMP in all CCI counties to enroll individuals into the CMC program. Currently, the COHS plans have the ability to perform direct enrollment. Expanding the process to all counties will create consistency across regions. Moreover, enrollment in CMC is voluntary, giving beneficiaries the ability to leave at any time. Consistency across the counties will ensure oversight is aligned across the models and prevent confusion for beneficiaries moving between counties.

In addition, when a beneficiary approaches a MMP regarding the program, MMPs are better suited to provide enrollment assistance to individuals interested in CMC. Currently, if a beneficiary is interested in CMC, the MMP first provides a great deal of information regarding the choices and value of program. When an individual decides CMC is right for them, the MMP must transfer the person to HCO to complete the enrollment process. In our experience, only 30% of individuals end up enrolled in the program. We believe the complexity of the transfer to HCO and a lack of programmatic understanding at HCO is the reason for the drop off. HCO staff is not trained to provide choice information on Medicare plans and results in a reliance on 1-800-Medicare if the beneficiary has questions about Medicare choices. The reliance on and transfer to yet another call center is not a consumer friendly process, adds to the time and increasing confusion in the enrollment experience.

The streamlined CMC enrollment process will mirror the highly regulated D-SNP process. Health Net, like the other MMPs with D-SNP products, have been doing direct enrollment for over several years now. The Medicare Marketing Guidelines include strong beneficiary protections including rules that strictly regulate marketing and enrollment activities for Medicare beneficiaries, closely monitored by CMS. We believe applying these same stringent rules to CMC enrollment will ensure only those individuals that want to join CMC will be enrolled.

5. Continuity of Care

Health Net also supports the proposal to extend the continuity of care period for Medicare services from 6 to 12 months to match the Medi-Cal continuity of care requirements. However, we request that the 2017 Medicare payment rates continue to reflect Medicare adjustment coding for CMC based on the anticipated percentage of new fee-for-service enrollments.

The Cal MediConnect Medicare payment rate in 2017 is currently set to reflect the full Medicare Advantage coding intensity adjustments of -5.66%. The new enrollments in the Cal MediConnect program, as a result of the proposed changes, will generally come from the fee-for-service Medicare and will not have the higher RA coding that is found in the Medicare Advantage population.

Health Net also supports the DHCS proposal to modify the continuity of care requirements from two visits with a specialist within the past 12 months, to one visit per year with specialists and primary care providers. The alignment of the policy will help to prevent confusion for members and providers.

To reflect the policy changes, Health Net recommends DHCS and CMS review the current rate setting methodology to ensure it accurately reflects the risk of the new individuals enrolled into the CMC program. Currently, Medi-Cal rates are set to reflect a projected mix of members in a blended rate. To continue to support the recommendations, Health Net also recommends, all new enrollments be paid by the actual category of aid (LTC, HCBS High, HCBS Low, and Healthy) for at least 12 months after initial enrollment.

Health Net also recommends DHCS develop a separate payment rate for residential care facilities (RCFs) in addition to the use of the payment buckets listed above. Currently, funding is not sufficient to provide the needed level of care to move individuals from institutional, custodial care back into the community. The most significant constraint to repatriating individuals is a lack of sufficient housing options. The move from a SNF to an apartment or home is often not possible due to a lack of appropriate infrastructure around the individual's level of need. Creating a RCF category would provide funding to help move people through the transition back to the community with the right level of support.

6. Standardize Health Risk Assessment LTSS Referral Questions

During the implementation of the Cal MediConnect program, the MMPs developed the Health Risk Assessments (HRA) based on industry best practices and the MMP's model of care. As experienced has been gained, the HRAs have been refined to narrow the overall volume of questions and target those areas that most effectively assess individual need. These HRAs have also already been approved by DHCS and are in use across the market. As a result, standardizing these tools is not a simple process. Changes to the HRAs have systems and technology implications that may be costly.

We recommend DHCS work with the MMPs to develop a best practice guide to the HRA and allow the plans to adopt changes as feasible.

7. Enhanced Data Collection

Health Net appreciates DHCS desire to have a more accurate and data driven approach to evaluating the CCI. Refining the data we collect and streamlining to those areas which most accurately reflect the quality of care provided to members is necessary to prevent data collection for the sake of having data. The use of objective measure such as HEDIS and consumer based feedback through surveys are preferable as they have long standing base in practice. Health Net recommends that DHCS limit unnecessary data collection and focus on those measures that objectively reflect the quality of care in the program.

8. Comprehensive Dental for CMC

Health Net has long advocated for the inclusion of a comprehensive dental benefit for Cal MediConnect members inclusive of the current Denti-Cal benefits and supplemental benefits currently offered under Cal MediConnect. This offering would require integration of the FFS Denti-Cal dental benefits and dollars for Duals beneficiaries under Cal MediConnect to align with the comprehensive dental benefits offered by the market's Dual Eligible Special Needs Plans (D-SNPs). Currently, funding is not sufficient in Cal MediConnect to provide a comprehensive dental benefit package, leaving the Medicare Medicaid Plans (MMPs) at a disadvantage in the Medicare market place. We believe this benefit enhancement should be included in the DHCS CCI improvements package.

Health Net appreciates DHCS's continued commitment to the Cal MediConnect program. We look forward to working with you to develop these policies further. Please feel free to contact me at any time if additional clarification on our comments is needed.

Sincerely,

Abbie A. Totten
Director, Government Programs Policy and Strategic Initiatives

cc: Tim Engelhardt, Director, Medicare Medicaid Coordination Office, CMS