April 20, 2016

California Department of Health Care Services
Delivered via email to: info@calduals.org

Re: 2016 Proposals to improve and sustain the Coordinated Care Initiative

The SCAN Foundation appreciates the opportunity to comment on the proposals from the Department of Health Care Services (DHCS) to improve the Coordinated Care Initiative (CCI). We commend the department's efforts to improve and strengthen the CCI program based on information gathered from evaluations and stakeholder feedback, and offer the following suggestions regarding program improvements, sustainable enrollment and streamlined voluntary enrollment.

Coordinated Care Initiative Program Improvements

Strengthening Care Coordination and Access to Long-term Services and Supports

Review Cal MediConnect Health Plan Policies and Procedures Regarding Referrals to LTSS: We agree that strong oversight of health plan referrals to LTSS is important to ensuring access to LTSS and believe it to be critical to the success of the CCI. While we support efforts to review plans' policies and procedures, we recommend addressing how the Contract Management Team will oversee compliance with these policies and procedures. Specifically, we recommend that DHCS:

- Address oversight of policies and procedures relative to plan-provider-delegated entity communications, as raised in the UC evaluation; and
- Define the timeline for plans to implement identified changes to address gaps and deficiencies in policies and procedures for LTSS referrals.

Standardize Health Risk Assessment LTSS Referral Questions: The Foundation supports DHCS' effort to develop standard HRA LTSS referral questions. We recommend identifying questions that best elicit functional need for LTSS. Further, we recommend leveraging the state's universal assessment efforts to identify indicators capturing functional need for LTSS. Finally, we recommend that DHCS clarify how the proposed standardized HRA process will be implemented in a coordinated fashion for the counties piloting the Universal Assessment for LTSS in accordance with W&I Code section 14186.36(b)-(i).

Collect Quarterly Care Coordination and LTSS Referral Data: The Foundation commends DHCS' efforts to respond to stakeholder feedback by proposing to collect and report care coordination and LTSS referral data. The proposal identifies areas for strengthening reporting around Interdisciplinary Care Teams, Individualized Care Plans, and LTSS referrals, but does not specify the types of measures that will be reported. We recommend that DHCS clarify the type of measures to be reported such as timeliness number and percent of completions, and beneficiary experience. We recommend that DHCS gather data reflecting individuals' receipt of LTSS services in relation to referrals. A 2015 report from Center for Health Care Strategies, Inc. (CHCS), Assessing Success in Medicare-

Medicaid Integration: A Review of Measurement Strategies, may be useful in identifying key quality measures for care coordination and LTSS referral.

Sharing Best Practices and Lessons Learned

The proposal to convene the CMC plans to discuss best practices and highlight lessons learned is critical to the continued development of quality services. We recommend that DHCS consider the following sources in identifying topic areas to address:

- CCI Evaluation and Polling results;
- Plan performance data;
- A report by Avalere Health describing the value of targeting services based on a comprehensive assessment and implementing person-centered care coordination. The research demonstrates that an enhanced health risk assessment used by Medicare Advantage plans assessing medical, social, and functional needs can identify individuals who would benefit from care coordination;
- Recent articles published in the *Journal of the American Geriatrics Society* that define person-centered care and describe ways in which organizations use person-centered care for high-need/high-risk older populations; and
- NCQA materials addressing quality measurement for adults with complex care needs: *Setting Goals with People with Complex Needs: A Collaborative Approach* and Policy Approaches to Advancing Person-Centered Outcomes Measurement.

Finally, while the proposed meetings will be open only to the participating health plans, we recommend periodically inviting stakeholders (i.e. community-based organizations, consumer advocates) to present information regarding successes and barriers to participation to help identify areas of improvement. Eliciting stakeholder experiences and perspectives provides a broad view of the system dynamic to better inform practice improvements.

Strengthening Continuity of Care

The Foundation supports DHCS' proposal to align continuity of care provisions within CMC (i.e. extending the Medicare timeframe from six to 12 months, and requiring just one instead of two specialty visits within 12 months), in an effort to reduce confusion and allow for a smoother transition. Additionally, in CCI evaluation focus groups, participants described challenges with accessing medication and medical equipment when transitioning to CMC. Therefore, we recommend that DHCS also develop:

- Standards to address access to off-formulary prescriptions and medical equipment while plans work with providers and beneficiaries to arrange alternatives; and
- A plan to proactively identify and address barriers to provider participation through education and incentives.

Using Opt-Out Data Analysis to Target Provider Education

Understanding and addressing provider concerns is an important step to improving enrollment and reducing the number of people who opt-out of CMC. Using opt-out data to target providers for outreach may be an effective approach to communicating with the appropriate audience. In forums conducted by the Network of Ethnic Physician Organizations (NEPO) to educate providers about CCI, the Foundation heard that fee-for-service medical

providers are 1) largely unaware of the CCI and its goals, 2) reluctant to enter into an agreement with health plans that may result in broad participation commitments, 3) not comfortable with authorization requirements and processes of managed care, and 4) displeased with Medi-Cal rate structures in general. Responses to these concerns will need to come both from the state and the relevant health plan(s). We recommend DHCS clearly articulate the responsible parties, and delineate specific roles and timelines.

Ensuring Sustainable Coordinated Care Initiative Enrollment

Annual Passive Enrollment into Cal MediConnect

We recognize the importance of balancing program improvements with sustainable enrollment, and we recommend the following issues be addressed in the process:

- *Coordinate CMC and Mandatory MLTSS enrollment*: The proposed passive enrollment and mandatory MLTSS enrollment processes are complicated, potentially causing confusion and challenges for beneficiaries during their transition. To simplify the process, we recommend that DHCS stage mandatory MLTSS enrollment and CMC passive enrollment concurrently. Specifically, we are concerned that beneficiaries who are eligible beginning January 2016 may face significant challenges with two enrollment periods –one for MLTSS and one for CMC- in less than a year. These beneficiaries will be mandatorily enrolled into MLTSS in August 2016, and passively enrolled into CMC in 2017. Further, the guidebook would not be received until July 2016, giving only 30 days to process the information and make a decision regarding MLTSS enrollment. We anticipate there would be great confusion when these same individuals receive notification about CMC passive enrollment options a few months following. Instead, we recommend that CMC passive enrollment and MLTSS enrollment happen concurrently in 2017.

- *Resource Needs:* Passive enrollment of over 100,000 individuals in 2016 will result in unanticipated demand on organizations such as HICAP and the Demonstration Ombudsman program that play a key role in assisting these individuals in understanding their rights and options. While the proposal indicates that DHCS and CMS would work with HICAP and the Ombudsman program to ensure counselors and staff have the necessary information to support beneficiaries, we recommend that appropriate resources be identified to ensure these organizations have the capacity to meet this population's need, similar to the acknowledged burden on Health Care Options.

- *Clarify Decision Processes:* We recommend DHCS develop decision trees relevant to beneficiaries' perspective for several broad sub-population groupings to help stakeholders clearly understand who is affected at what point and the decisions that will be presented to them. In addition, providing some simple scenarios could help stakeholders to understand the proposed process.

Beneficiary Protections

Cross-walking: DHCS proposes cross-walking beneficiaries into CMC plans that correspond with the beneficiary's Medi-Cal health plan or D-SNP to ensure continuity of providers. Early evaluation results found that while beneficiaries' providers were part of a plan's network, differing network configurations through delegated entities prevented the beneficiary from accessing their provider(s) once enrolled. As such, we recommend DHCS consider working with plans to take the cross-walk analysis a step further to match individuals not only at the plan level, but at the independent practice association (IPA)/provider level as well.

Mandatory Enrollment in MLTSS: DHCS proposes assigning beneficiaries to Medi-Cal plans for MLTSS based on plans' performance measure outcomes. We recommend that DHCS clarify the quality measures that would be

used in assigning beneficiaries to Medi-Cal plans. A Medi-Cal plan may have strong performance ratings in clinical measures, but this cannot be equated with the quality of LTSS referral processes, which is central to the MLTSS delivery system. To this end, we recommend that DHCS identify methods to determine the extent to which plans have demonstrated effective LTSS referral processes and prioritize placement into MLTSS plans based on both performance measure outcomes and quality of LTSS referral processes.

Care Coordination in MLTSS: We believe that care coordination is critical to ensuring beneficiary access to the necessary LTSS, and will also help facilitate understanding of CMC and options. To this end, we recommend that DHCS establish care coordination standards for MLTSS plans. Further, we recommend DHCS develop a plan to ensure MLTSS care coordinators assist beneficiaries in the transition to CMC, including addressing continuity of care issues.

CMC Ombudsman and HICAP: The CMC Ombudsman and HICAP will continue to play a significant role as passive enrollment is extended. We recommend DHCS include the CMC Ombudsman and HICAP contact information on all forms, and that DHCS include a clear description in the new CCI proposals as to how the CMC Ombudsmen and HICAP will be informed of changes to CCI and included in the proposed processes.

Streamlining the Cal MediConnect Voluntary Enrollment Experience

We appreciate DHCS' desire to streamline the enrollment into CMC. However, we believe it is critical that beneficiaries be adequately informed of the range of enrollment options. Therefore, we offer the following suggestions to ensure that the process enables beneficiaries to make informed decisions:

- *Standards for outreach/education:* We recommend that DHCS clarify CMC outreach and education requirements, with CMC plans informing beneficiaries of their range of options, including PACE, Medicare fee-for-service, and other CMC plan(s). In particular, beneficiaries need to understand whether their current provider(s) are not only contracted with the plan, but whether the provider is contracted with a delegated entity/provider group within the plan. Further, we recommend that plans be required to inform beneficiaries on how to dis-enroll and/or select a new plan should they decide to terminate enrollment in the CMC plan. Finally, we recommend that plans be required to provide information on HICAP, the Ombudsman and Health Care Options for further assistance.

- *HCO Processing Time:* We recommend that DHCS clarify the timeframe for HCO to process CMC enrollment submitted by a health plan.

Thank you for the opportunity to comment. Please feel free to contact us for any additional information.

Sincerely,

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President and CEO