California Association of Health Plans

1415 L STREET
SUITE 850
SACRAMENTO, CA 95814

916.552.2910 P
916.443.1037 F
CALHEALTHPLANS.ORG

April 22, 2016

Tim Engelhardt
Director
Medicare Medicaid Coordination Office
Centers for Medicare and Medicaid Services
Baltimore, Maryland 21244

VIA ELECTRONIC MAIL
Tim.Engelhardt@cms.hhs.gov

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

Re: 2016 CCI Program Proposals

Dear Mr. Engelhardt & Ms. Brooks:

The California Association of Health Plans ("CAHP") represents 48 public and private health care service plans that collectively provide coverage to over 25 million Californians. Our membership includes all of the plans that provide coverage under the Coordinated Care Initiative (CCI) and Cal MediConnect (CMC). We look forward to working with you on ways to improve the CCI and CMC and ensure that the program is sustainable and available for beneficiaries that are eligible to participate and would benefit from a more coordinated system of care.

Following are comments on the specific areas where the Department of Health Care Service (the Department) requested stakeholder feedback on the 2016 CCI program proposals that were released last week. We are available at your convenience to discuss any of the items outlined in this letter.

Streamlined Enrollment

The plans participating in the CCI are ready to serve new members entering the CMC program and support efforts to streamline the enrollment process. In order to make the CCI sustainable enrollment in the program must increase- as was noted in the Governor's 2016-2016 Budget. The proposed streamlined enrollment improvements will help grow enrollment from the more than 120,000 California dual eligibles already receiving their Medicare and Medi-Cal services through CMC today, allowing the program to grow and maintain its viability.

Streamlined enrollment will give CCI plans the opportunity to do targeted outreach to members that are already enrolled in that plan's Medi-Cal product but could benefit from having all of

their services under one plan with a medical home, more coordinated care, and a wealth of supports across the continuum of care in the CMC program. It is clear from the focus groups and the experience of the CMC plans that beneficiaries appreciate having more than just a pamphlet in the mail, and that receiving information in-person or over the phone with the opportunity to really allow them understand the benefits is preferred. Streamlined enrollment will give these members the ability to learn more about the CMC program directly from the plan that already provides their Medi-Cal benefits, and make a decision to enroll if they feel it best meets their needs. This type of personal outreach allows the member and the plan a chance to identify if the providers will be in the network, establish continuity of care needs, identify any other needs, and assign case managers to ease the transition into managed care.

Under the streamlined enrollment proposal for the first time all plans are allowed to enroll beneficiaries into the CMC program, streamlining the process, allowing the plans to quickly and efficiently enroll interested parties and prevent any losses associated with people who do not successfully complete the process on their own. Health plans have reported that a large percentage of enrollees (up to 55% in some instances) that discuss enrollment in CMC with a plan never actually enroll through the Department's enrollment broker, Health Care Options (HCO). While some of those who expressed an interest in enrollment may have ultimately not been eligible or may have changed their minds, it is unlikely that such a high percentage fall into one of those categories, which indicates that having to take that extra step for enrollment is a barrier for many beneficiaries that are eligible for and could benefit from CMC. Streamlined enrollment could reduce this burden for beneficiaries.

We understand that there are concerns from some stakeholders about the role of the health plan under the streamlined enrollment proposal, but there is sufficient evidence to show that not only is the CCI meeting the expectation for improved, streamlined and enhanced care, but beneficiaries report overall satisfaction with the program. In surveys, beneficiaries that were enrolled in CMC report satisfaction with care coordination, lower out of pocket costs, improved access to behavioral health, and the extension of long term services and supports [source]. Additionally, there are many beneficiary protections in place to ensure that plans are not abusing the streamlined enrollment process or acting in a manner that is irresponsible and does not serve the beneficiary.

Plans want to work with DHCS, CMS, and other stakeholders to identify and resolve any concerns related to CCI and strive to ensure it remains a successful component of California's health system and payment reform improvements. Following are some of the current protections that are in place to demonstrate a commitment by plans to a transparent and successful streamlined enrollment process:

- Medicare Marketing Guidelines include strong beneficiary protections. Rules strictly regulate marketing and enrollment activities for Medicare beneficiaries, which CMS closely monitors.
- Because this is a Medicare enrollment CMS audit functions for Medicare that look at enrollments to verify that the beneficiary made the choice will be in place.
- Plans will have signed forms on file for those who enrolled in person, or voice recordings of all telephonic enrollments, which can be audited and verified by DHCS/CMS at any time.
- CMS also has the following safeguards in place for all MMP products:
    - Secret shopping.

    - Scope of appointment forms.
    - Ride-Along with sales staff to in-home appointments or group presentations.
    - A complaint tracking module (CTM) system is in place for the collection and resolution of issues. CMS can monitor the CTM for patterns, outliers or concerns.
    - Plans are required to have compliance staff investigate, report, and resolve any allegations or concerns about illegal or inappropriate marketing practices.
    - All sales staff must be state-licensed and all terminations must be reported to the state.
    - Plans are not permitted to engage in unsolicited direct contact with the beneficiary.
    - Sales activities may only occur in common areas of care facilities - not in doctor's offices or at the point of sale in pharmacies.
    - Individual sales appointments may only be set up at the request of a beneficiary or their authorized representative.
    - All promotional activities or items provided to beneficiaries must be below the $15 non-cash threshold and must be offered to all people regardless of if they choose to enroll.
- Additional steps that plans currently take to protect the beneficiary include:
    - Post enrollment verification calls to ensure the beneficiary understands details of their plan of choice, benefits, and how to access care.
    - Recruiting staff familiar with the unique needs of this population and the key community-based organizations that may help them.
    - All sales representatives, upon confirmation of a clean background check, are licensed by the California Department of Insurance. In addition to the specifics of the Cal MediConnect plan, sales representatives are trained on Medicare and Medi-Cal products, rules, and regulations.
    - Sales staff receives training on HIPAA and ethics.

Passive Enrollment

The CCI plans are supportive of efforts to continue passive enrollment for those beneficiaries that have become eligible for CMC since the end of passive enrollment for the first year. While there have been some challenges with passive enrollment there have also been many improvements and lessons learned and it is an important component of the overall success of the CCI and the promise of delivery and payment system reform. Below are some of the changes that plans have made as a result of the experience with the first round of passive enrollment:

- Outreach to members prior to enrollment to inform them of the benefits and services available, as well as to identify continuity care needs and arrange for the services to avoid disruption. Ideally plans would have the information from DHCS as early as 120 - 90 days before enrollment for the best outreach opportunities.
- Update operational processes to include best practices and lessons learned from initial passive enrollment including but not limited to:
    - Updating call scripts to align with member feedback/ focus group feedback, stakeholder feedback, etc.
    - Enhanced oversight reporting on key and complex processes, such as HRA, to ensure all outreach attempts and modalities for completion are exhausted.

    - Ensure departments are staffed appropriately to handle additional volume of new members and train health plan staff, delegated provider groups, and vendors supporting the program of any process changes
- Deploy a field based team prior to the enrollment effective date to find members and conduct health risk assessments.
- Work closely with delegated Provider Groups to identify high opt out providers from initial passive enrollment and provide pointed outreach / education.
- Update Member and Provider Educational Materials

From our experience with the first round of passive enrollment it is clear that plans need a minimum of 120 days to do outreach to these members to help avoid transition issues, confusion, and disruptions in care. Additionally, some plans, in certain counties, are concerned with the volume of members being transitioned in the two-month period. In order to ensure that this process is as seamless as possible we request additional discussions with the Department to determine the best way to provide flexibility to handle these specific situations and provide the best experience for the consumer.

The Department specifically asked for feedback on how beneficiaries should be enrolled during the two month passive enrollment cycle. The plans do not have a specific preference for how to complete this enrollment process, but would like the Department to make the number of enrollments as even as possible between the two months. This will give the plans the opportunity to more effectively implement the changes noted above and reach as many beneficiaries as possible prior to the actual passive enrollment taking place. Plans believe that beneficiary outreach and education should be the main focus. In order to achieve better results plans are requesting that the Department provide CMC plans with information on the beneficiaries that will be part of the passive enrollment process 120 days before the effective date of the passive enrollment. Based on their experience CMC plans believe this extra month will allow for increased beneficiary satisfaction because there will be more time to locate and contact the beneficiary, develop a relationship, establish continuity of care, and complete the health risk assessment, all of which are key to a smooth transition. We look forward to working with the Department and other stakeholders on the details of this process.

Mandatory MLTSS Enrollment

The CCI plans were very surprised to discover that the implementation of mandatory enrollment into the MLTSS plan was not completed as required under the law. The plans are very supportive of efforts to have these members enrolled into the appropriate MLTSS plan as soon as possible. We request that the Department clarify what systems changes are in place to ensure that this type of enrollment error does not occur again. We will continue to work with the Department to enroll these beneficiaries.

Health Risk Assessment

The CCI plans are supportive of improvements to the transition process and enhancements that will give plans the information they need to ensure that members are connected with the care they need as they transition to managed care. However, there are some concerns over the proposal to standardize health risk assessment (HRA) questions for Managed Long Term Services and Supports (MLTSS). Health plans have had significant experience with the HRA

forms over the past several transitions into managed care and have developed streamlined HRAs based on that experience. Plans have found that HRAs with too many questions are burdensome on providers and beneficiaries and often have no or very limited added benefit.

Plans suggest that work be done with stakeholders to identify areas where current HRAs may be insufficient for identifying MLTSS needs and that each plan be required to update the HRAs based on those suggestions rather than mandating a set of specific new questions for all plans. This would achieve the same goal but not unnecessarily undo all of the hard work that plans have implemented to improve HRAs based on what has shown to be most effective for beneficiaries, providers, and plans. We appreciate your consideration of this request and look forward to a robust stakeholder discussion on how to improve the HRA process.

Targeted Provider Outreach

Plans are very supportive of the Department's proposal to analyze the opt-out data to target certain providers for enhanced education efforts. Plans have done some analysis and outreach and believe that our work can complement this proposal and result in a better understanding of the provider perspective and help educate provider about the benefits of the CCI and CMC and how it may be beneficial for their eligible patients. We look forward to working with the Department and other stakeholders on an effective outreach strategy.

We want to thank you again for taking time to share the proposed changes to the CCI program and we appreciate the opportunity to provide feedback. The CCI plans remain committed to making the program a success and ensuring the long-term viability of the important delivery system and financing reforms that are the foundation of the CCI program.

Sincerely,

Athena Chapman
Director of State Programs

cc: Kerry Branick, CMS