Health Net of California, Inc.
11971 Foundation Place
Rancho Cordova, CA 95670
www.healthnet.com

March 10, 2015

Jennifer Kent, Director
Department of Health Care Services
1501 Capitol Avenue
Sacramento, CA 95814

Via Email: Jennifer.kent@dhcs.ca.gov

Dear Director Kent,

Health Net, Inc. is proud to serve more than 1.6 million Medi-Cal managed care beneficiaries across California through direct contracts with the state and subcontracted arrangements. We believe the relationship between the Department of Health Care Services (DHCS) and its contracted managed care plans provides a level of quality, value, and accountability that would not otherwise be found in a fee-for-services system. As a result, Heath Net is pleased to support DHCS's efforts to renew the 1115 Waiver with increased focus on meeting the goals of the Triple Aim – improved patient experience, better health outcomes and bending the cost curve. Below for your consideration are our recommendations. Please feel free to contact me at any time to discuss these issues in more detail.

I. Managed Care Plan/Provider Incentives

Medi-Cal managed care plans (MCPs) currently engage in a range of quality-related initiatives to improve health outcomes and reduce health care costs. The use of capitation and delegation ensures providers have the incentive to improve quality, reduce unnecessary utilization and maintain a low overall cost of care. To improve outcomes, further investment is necessary to implement strategies that will change providers' approaches to patient care. While non-financial incentives can maintain quality levels, only financial incentives will allow the investment necessary to drive system change and significantly improve outcomes.

In structuring the incentive portion of the waiver, DHCS must consider individual MCP and county historical performance and local environment. Although all MCPs are required to report on the same HEDIS measures, the progress made by individual MCPs is often reflective of local considerations (e.g. practice patterns, demographics, provider data sharing issues, etc.) rather than changes in the actual quality of the care. Alignment of system wide goals is necessary when considering quality strategically across the Medi-Cal program; however, progress will invariably be impacted by the county base line. Incremental progress can occur towards a set of statewide goals, but the milestones are dependent upon the current level of readiness. Further, the approach to meeting each milestone will vary across MCPs and their networks. A "one-size-fits-all" model will result in only a small portion of participants able to meet the objectives.

In terms of the proposals discussed to date, Health Net is generally supportive of the use of shared savings arrangements, as outlined in the Straw Proposal 7, and has been successful using similar arrangements with providers in its commercial line of business to lower the cost of care while improving overall quality. However, the current Medi-Cal managed care rates already assume the lowest possible cost of care. The proposed changes to the rate setting methodology are promising and may provide the additional dollars and flexibility necessary to improve quality. Only a significant increase in the managed care trend would result in a significant enough per member per month infusion of dollars into the health care system to substantively impact care.

In reviewing the prior 1115 waiver cost trends, the average per member per month spending over the course of the waiver in managed care was as follows:

Demonstration Year	PMPM Family – TPM with Waiver	Percent Change Over Prior Year	PMPM SPD – TPM with Waiver	Percent Change Over Prior Year
DY 06	121.56		541.03	
DY 07	125.69	3.40%	654.26	20.93%
DY 08	126.02	0.26%	616.93	-5.71%
DY 09	135.24	7.32%	665.54	7.88%
DY 10	130.30	-3.65%	722.39	8.54%
Average Annual Change		1.83%		7.91%

The high level of variability in the MCPs' rates makes assessing year to year availability of dollars for system improvements or provider rate increases extremely difficult. The proposed changes to the rate methodology could ensure consistency by stabilizing the trend and providing necessary assurances of available dollars to allow long-term planning and investment; however, additional detail as to what trend would be used is required to alleviate concern over the underfunding that currently exists in some areas of the capitation rates.

If DHCS uses the same trend set forth in the "without waiver" expenses (5.3% for family and 7.4% for SPDs), the MCPs would experience significant underfunding for the SPD population. The managed care rates are approximately 30% lower for the family category of aid and 16% lower than the fee-for-service trended costs. While the family costs and rates are generally within an appropriate range, the costs related to SPDs continue to be well above the MCPs' rates despite recent increases. To further the goals of improved quality and increased "non-traditional" services as envisioned in the DHCS proposal, funding should be, not only supplemental, but also sufficiently above the cost of care to impact change into the remaining years of the waiver.

In addition, the DHCS proposal does not provide sufficient detail as to the impact of the new trend on the rate range. Currently, MCPs are paid at the low end of the rate range. The remaining difference between the high and low end is used to pass through additional funds to the public

hospitals using dollars from local intergovernmental transfers. These dollars supplement the public hospitals and provide necessary support of the safety net. Any change to the capitation methodology should consider the impact on these payments and continued participation of the hospitals in the Medi-Cal program.

Health Net further recommends the following:

Recommendation 1: Build upon current quality efforts underway in Medi-Cal managed care with emphasis on specific levels of measureable improvement over designated periods of time (e.g., incentive payments for increases in specified HEDIS measures by 5% over the prior year in the first 12 months of the waiver). Initial investments have been made to improve quality in Medi-Cal. However, these efforts have been stymied by the lack of funds to invest in or encourage system change.

Recommendation 2: If CMS is unwilling to allow expansion of current quality efforts, new quality initiatives should replace current efforts and focus on areas of greatest concern to the population. Providers have a limited amount of time to interact with patients and should target those areas of patient care most likely to improve outcomes. As a result, statewide efforts to improve quality should target a large portion of the Medi-Cal population and include high cost conditions where specific interventions have been identified that result in improved outcomes.

Recommendation 3: Incentive payments must be tied to achievable goals based on benchmarks that reflect the local environment and allow for a variety of approaches. No two MCPs or counties are exactly the same, making tailored approaches necessary to ensure progress can be made.

Recommendation 4: The expanded relationships between the MCPs and County Mental Health Plans (CMHP) due to Cal MediConnect and the new Medi-Cal mental health benefit should be leveraged to improve overall program quality. Behavioral health conditions are a significant cost driver for both systems of care. Incentive payments to further the coordination and cooperation between the systems should include:

- State establishment of data sharing and privacy protocols, including those standards necessary for data sharing among entities that fall under the 42 CFR Part 2 restrictions due to receipt of federal funding for the provision of Substance Use Disorder services, applicable statewide and the development of a universal release of information.

- Annual benchmarks mutually agreed to by the MCP and CMHP with a focus on process measure and data sharing in the first year, care coordination in the second year and outcomes in the third, fourth and fifth years of the Waiver.

- As each benchmark is achieved, the MCP and CMHP share the amount allotted for goal achievement.

- CMHPs and MCPs must mutually agree to the benchmarks, a plan to achieve the milestones, and participation in the incentive program. If either party does not make best efforts to meet the milestones as set forth in the incentive plan, the compliant party will not be held liable.

Recommendation 5: Develop an incentive program to increase timeliness and accuracy of encounter data submission by hospitals, affiliated provider organizations, and solo/small practice providers. All providers are required to achieve full compliance with national coding standards and submit timely encounter data to MCPs; however, not all providers have the financial capacity to do so. MCPs have supported efforts to bring providers into compliance but additional resources at the provider level are necessary. Increased timeliness and accuracy of the encounter data submission will increase the quality of the data provided to DHCS and, thereby, accuracy of the rate setting process and quality measurement. Incentives could include:

- Bonus payments for providers meeting completeness and quality standards for submission of encounter data. Payment amount could be based on improvement over prior quarter using current submission standard as a baseline. The MCP would submit a report to DHCS on progress made in data submission and amount paid in order to claim the bonus payments from DHCS annually and be reimbursed the full cost of the bonus payments made to providers within previously agreed upon parameters.

II. Delivery System Reform Incentive Payment (DSRIP) Program 2.0

The overall stated goal of the DSRSIP is to provide funding to transform the public hospital systems (PHS) from event driven care to increasingly focus on quality outcomes and value. As a result, all of the proposed DSRIP 2.0 projects focus on reforms that are wholly under the control of the PHS and its providers. However, as Medi-Cal managed care now serves the majority of the Medi-Cal population, the DSRIP 2.0 must also take into account its interaction with managed care system and align goals in order to ensure overall system change.

Recommendation 1: Align all desired outcomes in the DSRIP projects with those outcomes currently being pursued by the state in Medi-Cal managed care. Through alignment of the program goals, MCPs and PHSs participating in the DSRIP will be working towards the same ends rather than having competing priorities. This alignment will increase the likelihood that goals will be met across the system.

Recommendation 2: Require that, as a standard of participation, all PHSs in the DSRIP coordinate with the individual member's MCP and provide the MCP all data necessary to coordinate services for the beneficiary across the full spectrum of care. Not all PHS systems share information in a timely manner, which hinders MCP responsiveness particularly during care transitions. Effective bi-directional communication will ensure members receive the care they need in a timely manner without gaps in service.

Recommendation 3: Require, as a condition of participation in the DSRIP, that all PHSs must provide MCPs with encounter data for MCP enrollees in a timely manner and in compliance with the DHCS Quality Measure for Encounter Data standards. Include under Domain 1 a project specifically designed to target data system improvement and increased quality of data submission to payers. The project should include completion of the transition to ICD-10 and compliance with national coding standards as well as timely data submission to MCPs. The project could also include:

- Bonus payments for hospitals to increase staffing designated for coding and encounter data submission to MCPs.

- Incentive payments for technology investments, such as electronic health records systems compatible with MCPs, to improve data sharing at the provider level commensurate with the level of investment by the provider.
  Incentive payments for improvement in timeliness, completeness and accuracy of the data submission to MCPs as outlined above.

III. Workforce

The expansion of health care coverage to new populations under the Affordable Care Act has resulted in many more individuals seeking care within the health care system as a whole. Moreover, the continued low reimbursement rates in Medi-Cal make encouragement of providers that do not traditionally treat Medi-Cal enrollees extremely difficult. In order to expand access, a multipronged approach -- as well as higher reimbursement rates -- is necessary. Innovations of care should not be considered cost savings (particularly in the short term), as investments will be necessary.

Recommendation 1: Allow for the use and reimbursement of certified peer behavioral counselors under the supervision of a licensed provider at the discretion of the MCPs. DHCS should establish a fee schedule in fee-for-service and designate appropriate codes for services rendered. Initial payment to MCPs for behavioral health services should remain consistent with the current capitation methodology until a full 24 months of encounter data is collected to demonstrate use of peer counselors provided measurable reductions in cost.

Recommendation 2: Establish a grant program administered by the state for providers and provider groups to purchase and implement the systems necessary to increase or establish telehealth capacity. Providers could apply to the state for the implementation costs if able to demonstrate need based on geographic location or local provider shortages. Providers applying for funds must be partnered with the MCPs in the county to ensure the project impacts the greatest number of Medi-Cal beneficiaries. Although telehealth could be a viable alternative to onsite care, its use has not proliferated widely among Medi-Cal providers as it requires extensive investment in technology as well as staff training.

Recommendation 3: Establish an incentive payment program to assist MCPs and their contracted provider groups in the development of telehealth, eConsult, or other electronic health tools to increase beneficiaries' ability to access primary and preventive services via alternative access points rather than an in-person visit with the goal of reducing unnecessary emergency room utilization.

Recommendation 4: Establish a supplemental funding stream to MCPs to pay specialists that do not traditionally accept Medi-Cal patients to engage with MCPs and their contracted provider groups utilizing eConsults. While some specialty care providers refuse to contract with MCPs, additional funding for special case consultation could help increase willingness to see Medi-Cal patients on a limited basis.

Recommendation 5: Establish a formal training and certification program for In-Home Supportive Services (IHSS) workers including basic medical, first aid, and Managed Care 101 curriculum. Training should be paid for by the state, including the time necessary to attend training, and provided in addition to training already provided by the county public authority. If MCPs establish training programs aligned with the state, DHCS would reimburse the MCPs for the costs that DHCS otherwise would have incurred through its training program.

IV. Housing

Homelessness and housing instability significantly impact an individual's ability to maintain or regain optimal health. Funding for rental subsidies and development of affordable housing may be outside of the scope of the state's 1115 Waiver; however, innovative funding mechanisms, increased partnerships at the local level and targeted pilot programs may help improve outcomes for the highest risk portion of the Medi-Cal population. In addition, strategically targeting at-risk beneficiaries during transitions of care at the inpatient and skilled nursing levels can increase the likelihood of returning to the community at a lower cost.

Recommendation 1: Develop a statewide housing resource center with county-specific information for referrals for housing assistance. Provide MCP case managers training on the available housing resources in the county and increase the state's payment for case management services that are focused on social as well as medical services. Assist MCPs in the development of local relationships with housing assistance organizations. Although MCPs are not funded to pay for housing, education related to local resources can help to ensure MCPs can more effectively assist members in need.

Recommendation 2: Redefine the Long Term Care category under the CCI to include individuals, for up to 90 days, who are transitioning from a skilled nursing facility stay of more than 90 days back to the community – assuming the same level of cost for the individual as if remaining in the SNF. The current structure of the CCI rates does not allow MCPs to invest in the necessary services and supports to move an individual out of a SNF and back into the community. Extension of the LTC definition for a limited period of time will provide the necessary investment in services to stabilize the individual in the community and prevent readmission. After 18 months of cost

data, DHCS could then establish a new transitional rate for individuals transitioning between high intensity health care settings.

Recommendation 3: Pilot the use of mobile care vans to provide outreach and medical services to homeless individuals. Typically chronically homeless individuals do not have a usual source of care, but rely on the emergency room for urgent medical needs. Bringing services directly to those individuals in need may help establish a relationship with the health care system and assist MCPs in identification of individuals who can be served through a network provider.

Thank you for the opportunity to provide our perspective on the 1115 Wavier Renewal. Health Net is committed to the continued success of the Medi-Cal managed care program. We look forward to working closely with you as implementation of the Waiver advances.

Sincerely,

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

CC : Mari Cantwell, Chief Deputy Director, Department of Health Care Services
Claudia Crist, Deputy Director, Health Care Delivery Systems, Department of Health Care Services
Hannah Katch, Assistant Deputy Director, Health Care Delivery Systems, Department of Health Care Services
Sarah Brooks, Chief Managed Care Quality and Monitoring, Department of Health Care Services
Wendy Soe, Senior Advisor for Policy Development, Department of Health Care Services