LOCAL HEALTH PLANS of California

Promoting Health Care For All

Board Chair
John Grgurina

Members

Alameda Alliance for Health
Ingrid Lamirault
Chief Executive Officer

Cal Optima
Michael Engelhard
Interim Chief Executive Officer

CaiViva Health
Gregory Hund
Chief Executive Officer

Community Health Group
Norma Diaz
Chief Executive Officer

Contra Costa Health Plan
Patricia Tanquary, PhD
Chief Executive Officer

Health Plan of San Mateo
Maya Altman
Executive Director

Health Plan of San joaquin
John R. Hackworth, PhD
Chief Executive Officer

Inland Empire Health Plan
Bradley Gilbert, M.D.
Chief Executive Officer

Kern Health Systems
Doug Hayward
Chief Executive Officer

LA. Care Health Plan
Howard A Kahn
Chief Executive Officer

San Francisco Health Plan
John Grgurina
Chief Executive Officer

Santa Clara Family Health Plan
Elizabeth Darrow
Chief Executive Officer

John Ramey
Executive Director

Corky Oakes
Association Coordinator

Lobbyist

james C. Gross
Nielsen-Merksamer et al

PeterV. Lee
Executive Director
California Health Benefit Exchange
2535 Capitol Oaks Drive, Suite 120
Sacramento, CA 95833

Dear Mr. Lee:

Public Medi-Cal Managed Care Plans, including both Local Initiatives and County Organized Health Systems are facing unprecedented challenges over the next 18 months. These challenges include:

- All Local Initiatives are finalizing the transition of mandatorily enrolled Medi-Cal Seniors and Persons with Disabilities that ended May 2012. All of our plans had large numbers of members with complex medical needs, behavioral health diagnoses and psycho-social issues enrolled from June 2011 to May 2012.

- All Medi-Cal Managed Care Plans will be preparing for substantial new Medi-Cal enrollment beginning January 2014 through the increased Medicaid eligibility provision in the ACA.

- Seven public plans in eight counties must prepare for the mandatory enrollment of dually eligible members including Long Term Care and Long Term Support Services (IHSS, MSSP) starting in March 2013, and the passive and voluntary enrollment of dual eligibles for their Medicare benefit starting in June 2013. These changes represent major operational complexities and financial risk for the involved plans.

These significant challenges make it difficult for public plans to consider participating in the Exchange, as that participation would also involve significant operational challenges and financial risk during the same timeframe. Many of the public plans would have to obtain a new license from the Department of Managed Health Care and develop new operational capabilities to perform within the Exchange. Given these challenges, LHPC respectfully requess the Exchange Board to consider the following suggestions/concepts for the Exchange:

1225 Eighth Street, Suite 440 * Sacramento, CA 95814
Phone: (916) 448-8292 *Fax: (916) 448-8293 *Email: lhpc.org

1. Allow any local plan that is not currently providing individual and small group insurance coverage to have the option to join the Exchange as a new entrant in January 2015.

2. The Exchange and the Department of Managed Health Care collaborate to ensure that their respective requirements and timelines as they relate to Qualified Health Plans in the Exchange are aligned, particularly the material modifications/license application requirements. We appreciate that the Exchange may have different/additional requirements beyond DMHC requirements.

3. We are supportive ofthe Exchange's efforts on standardization in benefit offerings and additionally urge the Exchange to use current standard industry standards for network adequacy and rating factors. For example, LHPC believes the Exchange should consider rating up tobacco use only in alignment with the outside market.

4. While many of our member plans have current NCQA accreditation, some do not and will need flexibility on timeline.. LHPC agrees with the Exchange staff recommendation that Option B is preferable to Option A or Option C. However, LHPC urges significant modifications of Option B to the following.

    - NCQA "Interim" or "Provisional" accreditation by 2015.
    - Delete the requirement of "Commendable" accreditation status by 2015.
    - NCQA "Accredited" status by 2016.
    - Exempt Medicaid plans from "Commendable" Status or delay "Commendable" accreditation status to 2018.
    - CAHPS and HEDIS reporting by 2017.

At this point in time, given the time necessary to gain accreditation, new or currently unaccredited plans can really only gain "interim" or "provisional" accreditation by 2014 or 2015. Requiring a "Commendable" NCQA Accreditation by 2015 will be impossible for any new or currently unaccredited health plan to achieve. In its July 5 correspondence with CMS, NCQA indicates that it is unable to give new or unaccredited Exchange plans an accreditation status of "Commendable" or "Excellent" **until2016 at the earliest** and will cap accreditation at the "Accredited" level for the prior years while the Exchange is operating. "Commendable" and "Excellent" require valid performance measures and NCQA will not score Exchange plans on HEDIS or CAPHS results until at least 2016 given that:

a) The first valid Exchange quality data will not be available until June 2015

b) Some measures require more than one year to measure (such as breast cancer screenings which are only recommended every 2 years)

c) Some Exchange plans may have too limited enrollment in the first years for quality measures to be statistically valid.

Given the timing issues and NCQA plans regarding capping accreditation status to "acceptable" accreditation until at least 2016, 2018 is a more reasonable and meaningful timeline. However, LHPC is also concerned that given our plan focus of serving low income populations via safety net providers, our HEDIS and CAHPS scores will likely be lower, making achievement of "Commendable" status a challenge. We would recommend either exempting Medicaid plans from "Commendable" Status entirely or delaying "Commendable" accreditation status to 2018. Lastly, given the lack of meaningful data to report, LHPC also urges that CAHPS and HEDIS reporting should be delayed to no earlier than 2017 for Exchange products.

5. Those local plans that currently have MA-SNPs for dual eligibles do not believe utilizing the Part D standard of two medications per class is necessary. All of us have well constructed Medi-Cal formularies that have processes in place to ensure our members receive necessary medications. The Part D standard of two drugs per class will increase costs without improving care.

6. We do not believe using plan provided contracts to attempt to define a limit for out of network reimbursement for other Exchange members is a good idea. It will put us at significant odds with our providers during the contract negotiation process, which will already be challenging for many of us developing a new commercial network.

We greatly appreciate the Exchange Board and yourself considering the above suggestions and ideas to facilitate the participation of public health plans in the Exchange like those that are part of the LHPC.

Please contact me with questions.

Sincerely,

John Ramey
Executive Director
Local Health Plans of California
jramey@lhpc.org