



Comments to the Board

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February 26, 2012 Board Meeting

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February 15, 2013

Peter Lee, Executive Director
Covered California/California Health Benefit Exchange
560 J Street, Suite 290
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Via E-mail: info@hbex.ca.gov

Dear Mr. Lee, Covered California Board Members and staff:

The Asian Law Alliance (ALA) and the Asian Pacific American Legal Center (APALC) are submitting these comments in response to Covered California's proposed Assister Program. Our organizations seek to advance a pro-active agenda on health disparities and the right to affordable, quality health services, including implementation of health care reform in California. We are members of the Health Justice Network (HJN), a statewide collaborative comprised of over 30 community-based organization, health care providers, and small business groups. HJN seeks to address the health care needs of the Asian American, Native Hawaiian and Pacific Islander (AANHPI) communities, to ensure culturally and linguistically competent health care services to AANHPI patients, and to increase access to affordable, quality health care for AANHPIs through outreach, education, and advocacy.

On February 7, 2013, we attended the Assister Program webinar and were deeply concerned with the many barriers posed by the Program's requirements on community-based organizations (CBOs) in order to participate in the Individual Assister Program. In order to recruit culturally and linguistically appropriate Individual Assistants, Covered California will have to seek the participation of CBOs who work in the hard-to-reach, immigrant, LEP communities. Unfortunately, many of the CBOs in HJN may not be able to meet the current requirements to become Assistants. Although these small CBOs have the ability to reach out to the limited-English proficient (LEP) communities, they may lack the infrastructure and/or the financial means to participate in this program.

As you may know, both ALA and APALC are non-profit community legal services offices which serve many of the low-income, LEP immigrant community in Santa Clara and Los Angeles Counties. We work with many of the small AANHPI CBOs that assist the LEP communities. These CBOs have a proven track record of reaching out to the hard to reach communities because they have the trust of their

clients. For example, in Census 2010, many of the CBOs serving the LEP community had a late start (early February) to do Census outreach to their communities due to the late funding of their efforts. Despite this barrier, the City of San Jose achieved a Mail Back Participation rate of 74% while Santa Clara County had a 75% rate – second only to Inyo County in California. Why are we mentioning the Census? Because the Census is a much more foreign concept to convey than health care (though the new health care system will be much more complicated) to people who may be fearful of the government. Yet, these CBOs were able to achieve much with very little time due to the trust they have with their community.

Some of the barriers that prevent small CBOs from participating in the Assister program are:

- 1) **Lack of Infrastructure** - Many of the CBOs operate on a very small and tight budget. They may not have a dedicated staff person to simply conduct enrollment all day. They also may not be able to afford the Errors and Omission Insurance (E & O Insurance) or personnel to provide training on ethics or meet the stringent monitoring requirements presented in the webinar.
- 2) **Lack of Financial Resources** – In order to have personnel to take time off from work to study and pass the certification test, the CBO must have enough resources to pay their employees to study and pass the test, as well as, provide the fees for the criminal background check.
- 3) **Low reimbursement for applications** - As we have pointed out before, the maximum compensation paid per successful application is \$58, regardless of the number of individuals enrolled from each application. We strongly believe that \$58 is not enough to adequately compensate for all of the time involved in assisting individuals with eligibility and enrollment. According to one of HJN's direct service partners, Special Services for Groups, it could take up to 3-5 hours or more to do a single application. Staff may have to conduct field-based services because some people cannot get to the enrollment location and incur mileage expenses and time driving. Often, additional time is needed to assist LEP clients, especially if interpreter services are needed, a bilingual staff person is not available, or the LEP client has to return with needed documents. It can take more time to sort through various forms and photocopy the relevant required information before filling out the application. Moreover, if the client is a recent immigrant and unfamiliar with our health care system, it takes additional time to explain the options to the client. For some applications, there is a denial and/or follow-up process that may require further assistance for the clients, which can involve several hours of sitting on the telephone trying to persuade agencies to help, answer questions, or gather additional required documents. Therefore the estimated time used by Covered California of approximately one hour to complete the application is insufficient considering the experience of many CBOs who assist people enrolling into current existing programs.
- 4) **Payment only provided per application, not per enrollee** - We continue to be troubled by the decision limiting the maximum payment per application to \$58,

regardless of the number of individuals enrolled. The time it takes to enroll a family will most likely take longer than it would for one person. For example, if a family of four applies on one application, the Assister must determine eligibility and enrollment for four individuals into possibly four different programs, depending on each person's circumstances. Each may require different documentation and additional time to collect such documentation. This is particularly true for mixed-immigration status families so there is much more work involved than if only one person was applying for health coverage.

5) **Payment only for successful Covered California application** - From our experience with Medi-Cal eligible clients, many LEP applicants are denied health care coverage because their applications fall through the cracks. Many of the LEP clients can not appeal this denial without assistance. This is more likely to happen for those in Covered California who have problems since applicants would not be assigned a specific eligibility worker to assist them with their cases. The responsibility of assisting these clients to appeal decisions regarding their premium tax credits or other subsidies may fall upon the small CBOs that provide language assistance. These CBOs may help the client appeal or refer them to our offices. However, again, there is no mechanism in which they would be paid for their efforts if they assist the clients to apply but through no fault of their own, the application process is not successful. Therefore, they must conduct follow-up and/or appeal Covered California's final determination of any tax credits.

6) **Requirement to provide free application assistance to Medi-Cal and LIHP (Low-Income Health Program) is unfair.** While these CBOs wish they had the funds to provide free work, in reality, small CBOs struggle to make ends meet while doing the much needed work for their communities. Moreover, many of their low-income clients may be eligible for Medi-Cal and/LIHP, in addition to Covered California. The requirement to assist these clients, but not be paid for these efforts is a great deterrent to small CBOs whose employees still need to pay the rent and feed their families.

Recommendations:

Reduce the barriers which prevent small CBOs from participating in the Assister Program by:

- Pairing small CBOs with larger CBOs that have resources to provide the E & O Insurance and trainings on ethics as well as the oversee quality assurance.
- Increasing the amount paid per application and paying for each enrollee, and not just per application
- Paying for the training of Certified Enrollment Assistants (CEAs) who belong to small CBOs to compensate their staff for the extra time and effort spent to learn and pass the certification process or at least a stipend for their time to offset the time to train and certify staff.
- Having Covered California pay for criminal background checks for those who successfully obtain certification, not only for the first year (at a minimum Option #2) but every year for CBOs with small budgets.

- Supplementing funding for those small CBOs with language ability that can provide language and application assistance, regardless which program consumers are found eligible for.
- Providing the Navigator grants beginning at the same time as the CEAs to ensure that all CBOS can become CEAs and provide needed assistance for immigrants and LEP applicants

Covered California should work together with the Center for Medicaid and Medicare Services (CMS) to provide seamless services to the low-income, limited English proficient (LEP) community. The best way to do this is to coordinate funding so that CBOs, especially smaller ones, with language capability may be funded to provide Medi-Cal and LIHP application assistance, and be paid to refer those higher income LEP clients to CEAs who provide help to complete the Covered California application.

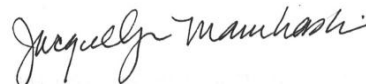
In addition to the above recommendations, we would recommend that the training be offered in additional languages than English and Spanish. At a minimum, we would add at least Chinese (both Mandarin and Cantonese), Korean, Vietnamese, Hmong, Khmer, and other Medi-Cal threshold languages. Covered California can work with CBOs to “train” Certified Eligibility Assistants in additional languages.

If you have any questions, please do not hesitate to contact me.

Sincerely,



Doreena Wong, Esq.
Director, Health Access Project
Asian Pacific American Legal Center



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February 15, 2013

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VIA ELECTRONIC MAIL: info@hbex.ca.gov

Re: Assisters Program Webinar Feedback

Dear Mr. Lee:

The California Association of Health Plans ("CAHP") represents 39 public and private health care service plans that collectively provide coverage to over 21 million Californians. We appreciate the opportunity to provide feedback on the Assisters Program presented via webinar on February 7th. We support Covered California in its goal to develop a robust eligibility and enrollment network and CAHP looks forward to working with you as the roles of Assisters and plans are further defined.

CAHP would appreciate additional information on the partnership between the Qualified Health Plans (QHPs) and Service Center and Assisters/Navigators. For example, it is not clear what will happen when a call goes directly to a QHP and how Covered California expects QHP direct sales team staff to interact with Covered California staff/service centers. Based on the information presented during the Assister's webinar, Covered California appears to imply that internal sales teams at the QHP will be not be considered Assisters.

CAHP believes that all plans should be given the opportunity to utilize their extensive expertise and positioning in the marketplace to ensure that Covered California rapidly expands its membership. We believe no other outreach strategy is as important as the partnership Covered California can establish with health plans as Assisters.

In addition to the role of QHPs, CAHP requests additional clarification on the specific role of Medi-Cal plans in the eligibility and enrollment process. Covered California has previously proposed to allow health plans to conduct education, eligibility, and enrollment starting in early summer 2012. However, we do not see this recommendation in your current Assister Program. We request that the Exchange confirm the policy to allow Medi-Cal health plans that currently provide Medi-Cal/Healthy Families application assistance to conduct these activities with no compensation by Covered California. Currently, Medi-Cal health plans provide application assistance to thousands of uninsured families to apply for Medi-Cal/Healthy Families. Permitting these health plans to provide education and application assistance for Covered California will allow health plans to help the children and their parents (who may be eligible for the Exchange products) and ensure that the entire family gets the coverage to which they are entitled. This

strategy would also support Covered California's enrollment and outreach goal to have "one-stop-shopping" for application assistance.

Eligibility and enrollment assistance by Medi-Cal plans is also a critical outreach and enrollment assistance component for the Medicaid Bridge Option. The new proposed federal regulation on "Application Counselors" allows Covered California flexibility to utilize organizations (for the Exchange application assistance) that currently provide Medi-Cal/Healthy Families application assistance and do not fit into the In-person Assistance Program and Health Navigator categories. We encourage Covered California to build on the existing resources and expertise of plans to ensure that consumers have a simplified eligibility and enrollment process that can be completed regardless of where they enter the system.

CAHP's member plans encourage the Exchange to reconsider the master trainer model. Plans have received feedback from many community partners and agencies that it is preferable to have a classroom format/ in-person training. This provides participants with the opportunity to ask questions and receive immediate answers. These community partners have urged health plans to ask Covered California to reconsider this master trainer model proposed in the webinar and to instead rely on the traditional in-person training program, which has been very successful for the Healthy Families Program. We believe that given the complexity of the new marketplace it is important to ensure that all Assisters get the opportunity to engage in-person training.

Additionally, plans will need to be prepared to provide training on the calculator and to develop the phone queue that will be designated for QHPs to call Covered California teams. The process must be clear so there is no interruption of the service to the consumer. The first impression a consumer has of Covered California is the most important and we want to work with you to ensure that it is a pleasant and informative experience for the consumer.

Again, we appreciate your consideration of our input and hope we can be of assistance as you move forward with the development of the Assister Program. Please contact me if you would like to discuss any of the items in this letter. We look forward to a continued partnership with Covered California.

Sincerely,

A handwritten signature in black ink, appearing to read "Athena Chapman", with a stylized flourish at the end.

Athena Chapman
Director of Regulatory Affairs

cc: Andrea Rosen, Interim Health Plan Management Director
Ken Woods, Senior Advisor for Products, Marketing, and Health Plan Relationships



cchi4families.org



February 14, 2013

Peter Lee, Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Covered California's Assisters Program: In-Person Assistance (IPA) and Navigators

Dear Mr. Lee,

California Coverage & Health Initiatives writes to provide input to Covered California (CC) on the proposed direction of the Assister's Program laid out in the webinar of February 7, 2013. We very much appreciate the opportunity to provide this input. Our network of children's/community health initiatives and partner outreach organizations is present in 54 of California's 58 counties doing on-the-ground outreach and enrollment for Californians into health coverage. We hope our experience over the past decade plus enrolling California's children and families can be of help in ensuring the success of CC's enrollment efforts.

Guaranteeing Program Integrity and Security

We are cognizant of CC's need to insure program integrity and assure public safety and the desire to do so through background checks, however we believe the direction proposed by CC in the webinar should be modified. Several of CCHI's member and partner organizations already conduct background checks on their employees, while the breadth and scope of those background checks vary from organization to organization. We propose, as does the California Primary Care Association in its comments, that Assister Enrollment Entities (AEEs) provide CC with information about the background check process and the results of the background checks for the individuals that will be trained and certified as Assisters. This would be sufficient to uphold the integrity of the Assister Program while providing flexibility to AEEs and not drive potential AEEs away from the program. We also recommend, where AEEs don't currently conduct background checks, that a cost effective model be created that is easy to implement and not overly onerous to the entity. In order to avoid creating unnecessary barriers to entry into the program by potential AEEs, we recommend that CC pay for the first year of background checks and then evaluate the effectiveness of the policy.

CCHI believes that fingerprinting of Assisters is an unnecessary step that will create additional barriers to wide participation by community level organizations and add significant unnecessary costs to the program. If CC moves forward with this proposal, the costs should be borne by CC. With the aggressive enrollment targets CC has developed, the program should be structured to encourage broad participation rather than creating barriers that drive potential AEEs away.

Helping With Recruitment Strategy

CCHI is comprised of over 60 organizations statewide with the missions of enrolling Californians into health coverage through networks of fully-trained Certified Application Assisters, promotoras, and other health outreach workers. Our organizations deploy over 1,000 such assisters in local communities and work in partnership and association with many thousands more. Our outreach, education, enrollment, and retention services are provided in-language, in-community and designed to make the process of finding and keeping health coverage easy for Californians no matter where they live or what language they speak. We stand ready to help CC in any way we can in recruiting AEEs to meet the needs of California's diverse populations who will be eligible for coverage through CC.

Proposed Steering and Monitoring Standards

CCHI's many member and partner organizations have had a very positive experience implementing the code of conduct currently required by the Managed Risk Medical Insurance Board (MRMIB) for CAAs. We strongly recommend that CC take this existing code of conduct as a starting place and improve upon it as needed. Our collective experience is that this code of conduct has worked effectively to hold CAAs to a high standard of providing neutral and unbiased information, has helped avoid steering activity, and has been more than sufficient to provide recourse to MRMIB for any violations of the code up to and including revocation of an enrollment entity's status or revocation of a CAA's certification. We encourage CC to seriously consider adopting MRMIB's code of conduct.

CCHI believes that the monitoring standards laid out in the webinar are reasonable and will go a long way to ensuring program quality and integrity and are not overly burdensome to the potential AEEs.

Training

CC has developed a robust training curriculum. However, we believe that there exist extremely complex issues related to eligibility of immigrants for coverage both in CC and in the State's MediCal program. These issues are sufficiently complex that it will be important to develop a training module to address issues related to immigrant families in some detail.

Insurance Requirements for Assister Entities

CC proposed in the webinar to require AEEs to carry General Liability, Negligence, and E & O insurance and requested stakeholder feedback on this issue. CCHI is very concerned about these

potential requirements and the cost barriers they are likely to pose to AEEs becoming engaged in the program.

Most importantly, in the preamble to Section 155.210 (Federal Register, Vol. 77, No. 59, 18331) CMS clearly prohibited state exchanges from requiring Assistors from carrying E & O insurance. “[W]e clarify that States or Exchanges are prohibited from adopting such a standard, including errors and omissions coverage.” Secretary Sebelius’ letter to Representative Kinzinger dated July 11, 2012 reiterates this point when she states that “requiring errors and omission coverage may serve as a significant barrier to entry for entities that may otherwise be well-qualified.”

If CC intends to require general liability coverage or coverage for negligence, it would be advisable for CC first to work with some existing carriers to determine if such a coverage line is available to insure the scope of work Assistors and AEEs will be doing. Further, CCHI is concerned that CC has not clearly identified the dollar level for the policy required. If CC intends to require any insurance coverage by AEEs, it would need to clearly state the policy levels required and work with carriers to ensure that there are lines of coverage appropriate to the scope of work. In addition, CC will need to ensure that the coverage at the required coverage level is affordable and doesn’t present an insurmountable barrier to participating.

Again, we appreciate the opportunity to state our views regarding certain components of the Assistor Program discussed on the webinar. If you would like to discuss these matters further, please contact Suzie Shupe, Executive Director, California Coverage & Health Initiatives at sshupe@cchi4families.org or 707-527-8867.

Sincerely,

A handwritten signature in blue ink that reads "Suzie Shupe". The signature is written in a cursive, flowing style.

Suzie Shupe
Executive Director
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February 15, 2013

Secretary Diana Dooley, Chair
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California Health Benefit Exchange Board
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Re: Partnerships with Retail Stores and Roles as Assistors

Dear Secretary Dooley and Mr. Lee:

The California Labor Federation would like to offer comments regarding the proposed Partnerships with Retail Stores and Roles as Assistors. We understand that the proposal is based on the goal of enrolling the maximum number of people in affordable health coverage through the Exchange by January 1, 2014. The Labor Federation shares that goal and is committed to maximizing enrollment.

That said, we strongly oppose the proposed partnership with retail stores as written. One of the key factors under consideration in the proposal is whether the retail store shares “similar core values as Covered California.” Given that Covered California’s mission is to “increase the number of insured Californians” we do not believe that any non-union retailer in California shares that goal.

Walmart, the largest retailer in the country, is instituting a policy to deny health benefits to any employee that works less than 30 hours a week. This policy comes on the heels of Wal-mart eliminating health benefits for workers with fewer than 24 hours a week. According to the Kaiser Family Foundation, in 2011 only 47 percent of Walmart employees received health care benefits, and dropping benefits for workers will further decrease that number.

An employer that denies health benefits to more than half of their over employees, and has recently announced they plan to stop offering benefits clearly does not share Covered California’s mission of increasing number of insured Californians. In fact, Walmart is the driving force behind taking insurance away from Californians. This is not a partnership that Covered California could possibly be proud of forging.

We also oppose Covered California’s proposal to offer any payment, co-branding, joint marketing or other economic or PR benefit to retailers. Walmart already benefits tremendously from the taxpayers of California since their model of low-wage, part-time employment dumps many employees onto public assistance. A 2004 study by the UC Berkeley Labor Center found that Walmart workers’ reliance on public health care programs like Medi-Cal and Healthy Families cost taxpayers \$32 million annually. The families of Walmart workers used 40 percent more taxpayer-funded health care programs the families of employees of other large retailers.



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The Affordable Care Act will only exacerbate the trend of retailers, especially Walmart, shifting the cost of health care coverage onto the public. The structure of the employer responsibility penalty in the ACA allows retailers like Walmart to dump workers onto public subsidies but avoid the penalty to reimburse the public for the cost. Part-time workers on subsidized coverage in the Exchange or Medi-Cal do not trigger an employer penalty. The retail industry, and Walmart in particular, rely heavily on part-time labor and closely control workers' schedules. These employers have the ability to reduce their liability for employer penalties by reducing worker hours, in addition to the huge numbers of low-wage, part-time workers they already employ.

Walmart workers may very well be the largest consumers of subsidized coverage in the Exchange because their employer pays low-wages, does not provide benefits and limits hours to part-time. Why would Covered California give Walmart even more public money to make them the face of Exchange outreach?

A partnership with retailers like Walmart would not only tarnish the image of Covered California, it would send a message to other employers that it is acceptable to abdicate their responsibility for health coverage. This partnership would reward Walmart for decades of shifting the cost of health coverage onto the public, a trend that has only increased after the passage of the ACA.

For these reasons, the Labor Federation strongly opposes the proposed partnerships with retailers.

We believe that the most effective strategy for enrollment in the Exchange is to run enrollment like a campaign. Political campaigns post-2008 have harnessed technology to become more targeted, effective and cost-efficient. Micro-targeting is a tool successfully used by the Obama campaign and most recently deployed by the labor movement. It's part of a cutting-edge strategy to precisely target and mobilize target audiences. Using this tool would allow the Exchange to target and reach retailers' consumer base without having to partner or pay those retailers. We look forward to working with the Exchange to develop these tools.

Sincerely,

Sara Flocks
Public Policy Coordinator

SF: sm
OPEIU 3 AFL CIO (31)

COMPETENCIES, SKILLS AND QUALITIES FOR COVERED CALIFORNIA ENROLLMENT/CALL CENTER STAFF: HOW BEST TO SERVE UNDERSERVED AND VULNERABLE POPULATIONS

We are proposing four sets of core/essential competencies for persons Covered California Navigators, Assisters and Customer Service Center staff; within each set there are more specific skills and qualities that are described. While some are general competencies that apply broadly, others are specific to the needs of individuals/families with substance use and mental health treatment needs. (see attached “MH/SUD Unique Needs”). We suggest that the training curriculum for Navigators/Assisters and Call Center staff include components of all of the following:

Basic Knowledge of Mental Health and Substance Use Disorders

Enrollment staff should be able to

- understand the prevalence of various mental health disorders and substance use disorders in the U.S. and the impact of stigma in their communities;
- understand that mental illness is a real organic disease from which recovery is possible;
- understand the etiology of substance use disorders and their classification as a treatable brain disorder from which one can recover.
- appreciate the complexity inherent in understanding mental illness and addiction along with other co-occurring conditions;
- explain simply how mental health and substance use disorder parity and equity laws as they apply to qualified health plans;
- explain simply the scope of mental health and substance use disorder benefits typically available to consumers by QHPs and public coverage option;
- work with the eligibility requirements, exceptions, and processes, for multiple insurance product lines that patients may be moving between;

Ability to Reach Out and Engage Clients

Enrollment staff should be able to

- listen nonjudgmentally using active listening skills that include confirming understanding;
- create a comfortable, safe and respectful environment where the individual feels free to divulge sensitive or difficult personal information;
- utilize approaches to outreach that have been found to be effective in engaging hard to reach populations;
- work in non-traditional settings as guided by leaders of diverse communities;

Sensitivity to the Role of Culture/Diversity in the population seeking help

Enrollment staff should be able to

- be respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse and vulnerable populations
- consider the role of cultural, social, and behavioral factors in the accessibility, availability, acceptability and delivery of benefits enrollment services.
- know the cultural and linguistic composition of the communities they serve;
- recognize community linkages and relationships among multiple factors affecting health;

Generalized Work Skills

Enrollment staff should be able to

- respect the ability and right of individuals to make their own decisions;
- understand complex topics and communicate the information in plain language;
- solve problems quickly and capably;
- practice good judgment and be willing to ask for help and/or advice with complex issues from supervisor;
- be patient with complex processes and procedures, and persistent with processes that are redundant;
- innovate, and develop rationales for assisting exceptional circumstances into traditional processes;
- direct and assist the applicant in gathering needed documentation.

The Unique Needs of Individuals with Mental Health and/or Substance Use Disorders

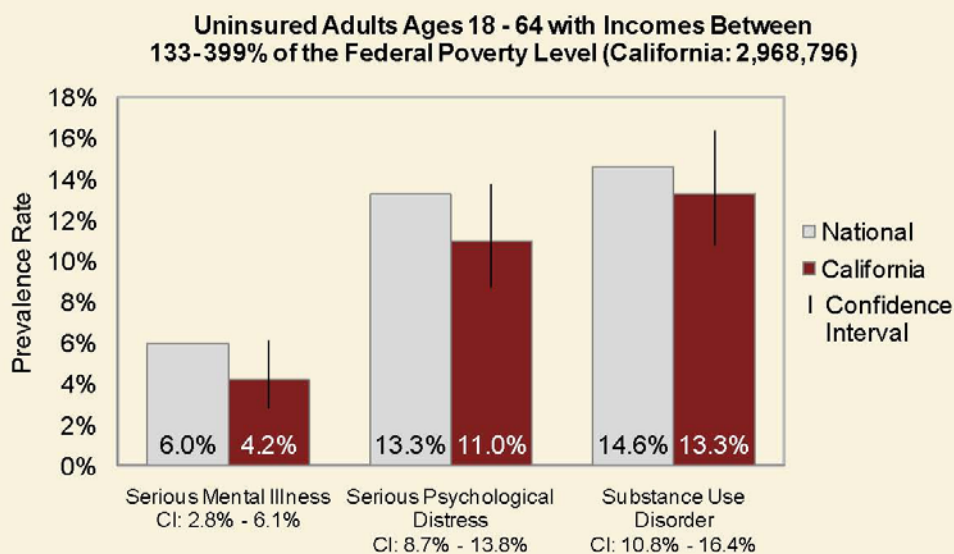
Prevalence of mental health and substance use disorders

An estimated 26.2 percent of American adults over age 18 – or one in four – has a diagnosable mental health disorder, and mental health disorders are the leading cause of disability for those aged 15-44. An estimated 22.2 million Americans over age 12 have an addiction to alcohol and drugs. According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2010 National Survey on Drug Use and Health, one in five (20%) of people with a serious mental health condition are uninsured. A study published in the October 2011 issue of the journal *Psychiatric Services* indicates that 22.6 percent of people with frequent mental distress (indicative of mental illness) were uninsured, compared with 17.7 percent of those with frequent physical distress (indicative of chronic disease).

High Rates of Uninsured Among Health Insurance Exchange Population with MH/SU Disorders in California

In California, according to the 2009 California Health Interview Survey (CHIS), 13.5% of the population with incomes between 138% and 200% of FPL indicated that they had mental health problems or drug/alcohol problems. Of those, 12% were uninsured. For the population with incomes between 201% and 400% of FPL, 15.5 % indicated a mental health or substance use problem. Of those, 19.9% were uninsured. (See table, below). According to the SAMHSA 2010 National Survey on Drug Use and Health, among uninsured adults ages 18-64 with incomes between 133-399% of FPL in California, 4.2% had serious mental illness, 11% had serious psychological distress and 13.3% had substance use disorder. (See graph, below).

Prevalence of Behavioral Conditions Among Health Insurance Exchange Population: California, US



CI = Confidence Interval

Sources: 2008 – 2010 National Survey on Drug Use and Health
2010 American Community Survey

California population with mental health/substance use disorders who were uninsured in 2009, by FPL

| Federal Poverty Level | Percentage of CA population with mental health or substance use disorders | Percentage of MH/SUD population who were uninsured |
|-----------------------|---|--|
| 138-200% | 13.5% | 12% |
| 201-400% | 15.5% | 19.9% |

**2009
California
Health
Interview
Survey**

Unique Needs of This Population in Securing Insurance and Treatment

It is highly likely that targeted and appropriate eligibility, outreach, and enrollment services will be needed to ensure that this population is enrolled in newly available health benefits provided under the Affordable Care Act. A collection of evidence from states that have begun implementing health care reform suggests that consumers with behavioral health or substance use disorders are not well equipped to navigate the health insurance enrollment and reenrollment process or to make choices from among a large set of health plans on their own.

Why This Population Has Unique Needs

Because of cognitive deficits or co-morbid conditions, individuals with mental illness may be more reliant on assistance than others in navigating the health benefits exchange and enrollment process. Because some people with behavioral health and substance use disorders are difficult to reach and engage, and because many of the uninsured are not connected to family, to permanent places of employment or to primary care physicians or clinics, targeted outreach and enrollment is necessary for this population.

Evidence From Other States' Experience

Research confirms that enrollment processes are difficult for those with behavioral health problems. In Massachusetts after health care reform, only 2.6% of the population was still uninsured, but 22% of the uninsured had mental health or substance use disorders. Behavioral health patients in Massachusetts described the process for applying, completing information requests, and reapplying to MassHealth and Commonwealth Care as complex, burdensome and confusing. These patients described the experience taking between 45 minutes to 2 hours to complete the eligibility determination and enrollment forms, not including time for gathering, copying, and mailing supplemental verification documents like pay stubs, birth certificates, and proof of identity.

What Are The Consequences Of Not Fully Enrolling This Population

Without treatment, individuals with a serious mental illness are at an increased risk of hospitalization, poor social and clinical functioning, and diminished quality of life. If an individual is uninsured, he or she is more likely to rely on expensive emergency services. Untreated mental illness can interrupt careers, resulting in disability, poverty, and long-term dependence, all of which are costly and unnecessary. Additionally, extensive data conclusively demonstrate the association between mental illness and other chronic disorders such as cardiovascular disease, diabetes, cancer, asthma and obesity. According to the Centers for Disease Control and Prevention, the occurrence, course and outcomes of chronic disease are affected by a co-occurring mental illness. Those who have a co-occurring mental illness tend to experience worse outcomes than others and their poorer health status correlates with higher healthcare costs.

February 15, 2013

Peter Lee, Executive Director
Covered California

Ms. Kim Belshé, Board Member
Secretary Diana Dooley, Board Member
Mr. Paul Fearer, Board Member
Ms. Susan Kennedy, Board Member
Dr. Bob Ross, Board Member

Re: Covered California—Assisters Program: In-Person Assistance and
Navigator Webinar

Dear Mr. Lee and Board Members:

We offer comments below on the Assisters Program, as it was presented in the February 7, 2013 webinar. In addition to the webinar materials, we include in our comments our response to the Board Recommendation Brief on “Partnerships with Retail Stores and Roles as Assisters,” dated January 17, 2013.

General

Consumers Union, California Pan-Ethnic Health Network, and Western Center on Law and Poverty appreciate many aspects of the proposal as presented on the February 7th webinar. In particular we applaud the Exchange’s commitment to establish a trusted network that reflects the cultural and linguistic diversity of the targeted population; ensure a well-trained and knowledgeable cadre of assisters, provide a robust evaluation and measurement of the impact of assisters on awareness and enrollment, and establish important quality assurance standards and protocols.

We applaud the goal of identifying 3,600 assister enrollment entities with more than 21,000 individual assisters ready and able to provide help to millions of Californians eligible for Exchange coverage. We would appreciate more information about how the Exchange arrived at the moderate production goal that identifies that each assister will produce 4 completed and successful applications per month. In particular, does this assumption accurately reflect the experience of assisters in the HICAP and CHIP programs who undertake these types of activities for different populations?

Partnerships with Retail Stores

We fully appreciate that to accomplish the Exchange's bold ambition to help millions of people (1.4 million in the first year) access health coverage, a wide range of entities and a multi-faceted marketing and mobilization effort will be needed. However, we believe the recommendation in the policy brief for partnerships with retail stores with monetary compensation is misguided and potentially counter-productive. Overall, we support having retailers promote Covered California and afford space for certified assisters to enroll, but not to make payments to such retailers for that purpose. Our more detailed comments are set forth below.

"Key Factors"

It makes sense for Covered California to take into account the factors shown in the webinar slides and Brief, e.g. how many people the partnership has the potential to reach, including the composition of the Exchange's targeted population that shops at the retail store. Most importantly, Covered California should ensure that for-profit retail stores share similar core values with the Exchange.

As for-profit "partners" who stand to benefit monetarily from their association with the Exchange (see "Co-Branding" below), we strongly believe these stores should be held to the highest standards. Partner retail stores, at a minimum, should be those that provide comprehensive and affordable coverage to their workers. Surely large chains that do not provide coverage for their workers, or provide only the skimpiest coverage, cannot be viewed as sharing similar values with Covered California.

We also would like to hear more from staff regarding the standards used to judge whether or not the core values are aligned. Will the Exchange require evidence of alignment in documentation or some other transparent means? If not, what will the standards be to judge whether the retail store has similar core values to the Exchange?

An additional key factor should be added to the standards to include "No Conflicts of Interest," ensuring that retail partners do not have relationships with, issuers, drug companies, retail clinics and others in the health care sector that will benefit from Exchange business and could create steering or other bias concerns in the application and enrollment process.

Co-Branding

We urge the utmost care in allowing others to use the Covered California brand, logos, etc. Your brand will have significant value in the years to come and will be an indicator to the public of quality products and an institution to trust. Allowing others to use it creates an aura of goodwill that Covered California must not squander.

The standards you have proposed to determine the health plans you will contract with are rigorous. If Covered California undertakes co-branding with retail stores, we believe

that there should be similarly strong criteria for such partnerships, review of partnership proposals, and rigorous monitoring to protect the integrity of your brand. Without such standards and oversight, your legal staff will be forced to spend time monitoring the brand's proper use, and once the "genie is out of the bottle," it will be likely impossible to put it back in, to correct mistaken uses or repair erroneous impressions.

If Covered California moves forward with co-branding, we recommend that the Exchange only allow retailers to use pre-approved print messages, including for the use of the logo (e.g. on paper bags and receipts), public service announcements, and ads on in-store television and audio systems.

Monetary Compensation for In-person Assistance

A high quality partnership with appropriate retailers need not involve money changing hands. In fact, some of the most successful partnerships are those based on core value alignment and mutual self-interest. While retailers such as Target and Walmart and other businesses with in-store pharmacies will certainly have access to the diverse populations the Exchange will need to reach, we are concerned about the proposal recommended by staff (Tier 1) that would allow retail stores to be paid for using their employees as in-person assisters.

By analogy, in June 2012, after careful consideration the Board adopted the policy that those entities that derive a direct benefit in providing health care to individuals with coverage (e.g., clinics, hospitals and physicians) should not be compensated by the Exchange. The rationale was that those entities are self-interested, would likely help anyway with enrollment, and would find it difficult to be unbiased. Consumers Union supported the decision not to use the Exchange's consumer assistance funds on those entities that already had an interest in enrolling consumers without compensation.

The same holds true for retail establishments with pharmacies and optical departments, and those that don't have in-house pharmacies or optical departments but may have relationships with issuers, retail clinics, or other industry stakeholders. The Exchange's limited consumer assistance funds should be saved for non-profit groups that would otherwise be unable to provide enrollment assistance without these important dollars.

The potential convenience for consumers to enroll when doing their family errands should be considered, but if in-person assistance is provided on-site at a retail store we urge adoption of one of alternative proposal Tier 2, allowing stores to host certified assisters at booths in their stores, to refer consumers to the Service Center or certified assisters, and to disseminate material on Covered California. ("Partnerships with Retail Stores..." slide 7 states that "no enrollment activities will be performed", but the bullets reference hosting in-person assistance from Certified Assistors approved by Covered California). However, we support this with the caveat that the retail store has provided evidence that it offers comprehensive and affordable health insurance to its employees. In addition, Tier 3 would be an acceptable option to us, with the caveats noted above under "Co-Branding."

Code of Conduct and Ethics Policies

We very much appreciate aspects of the code of conduct as it was presented in the webinar (“Assisters Slide” 27). It is important to identify from the outset that Assisters are obligated not to steer consumers to (or away from) any specific health plan or provider. Just as important is the policy that prevents Assisters from inviting or influencing an employee or her dependents to separate from employer-based insurance.

The code of conduct provision that prevents Assisters from intentionally providing false, deceptive, misleading or confusing information is too narrow. As drafted, it only prohibits *intentional* actions by an Assister, a difficult standard to prove and narrower than the usual standard aimed at curbing deceptive practices. Although we believe most Assisters will be well intentioned, they should be held to a higher standard than just intentional activity. One possibility is bar “Provid[ing] false, deceptive or misleading information in an effort to influence a consumer’s enrollment decision.”

Avoiding conflicts of interest is referred to on “Assisters” slide 28, but we have not seen Covered California’s “conflict of interest policy” for the Assister program entities and individual Assisters. The Federal rules require the Exchange to develop such a policy for navigators and we have yet to see this. With the proposal to begin soliciting applications for Assisters in a few short months, we request an update and copy of the conflict of interest policy and opportunity for public comment as soon as possible.

Monitoring Requirements

It is vital that Covered California and all Assister partner entities undertake rigorous monitoring of Assisters. Any Assister enrollment entity will need the capacity and commitment to evaluate the performance of Assisters, including reporting the underlying data back to the Exchange.

We do not suggest that the Exchange should delegate its primary monitoring responsibility to the entities, but should simultaneously be monitoring, tracking, reporting, auditing, and reviewing Assisters directly to ensure compliance with federal and state rules and policies. For example, the Exchange should not delegate to Assister entities identification and reporting of conflicts of interest, fraud, and other issues. While the entities should be accountable to the Exchange, so should each individual Assister who is trained and certified by the Exchange.

Any monitoring that is also done by an Assister entity must be reportable in a format that includes a specific Assister identification number that can be tracked in the IT system, audit trail, etc. We did not see anything in the webinar that establishes these requirements and urge that they be added.

We agree that Covered California and consumers will need to have the utmost confidence in the trustworthiness of Assisters. To that end, we understand the likely

need for background checks, but we are concerned that, particularly for non-profits, finding the resources to pay for them will be difficult. The \$63 per application fee may well be insufficient and could keep some individuals and entities from applying to be Assisters, with this added responsibility. We encourage the Exchange to explore other options for funding community-based entities for background checks, if in fact they are found warranted. The option for Covered California to take care of those costs in the first year could alleviate this burden.

Training and Curriculum

Considering that Maryland's Exchange will require at least 120 hours of training for their assister program, we are wondering if Covered California's proposal for just 2-3 days (24 hours maximum) per year is sufficient to ensure Assisters understand the intricacies of the insurance world, as well as employer coverage issues, tax implications, etc. We would appreciate further information about the thinking behind the length of training and also about whether the Exchange will consider providing this training in other languages, at a minimum in Spanish.

In addition to the items on "Assister Slides" 31-34, there are a number of topics that should be on the list for the Assister curriculum, including

- The rules and requirements associated with changes in circumstances;
- Tax reconciliation implications around eligibility for advance premium tax credits;
- Reasonable compatibility standards;
- Informal resolution process;
- Due process and appeals rights, including a bifurcated appeals system;
- Marketing and advertising rules and prohibitions;
- Nondiscrimination provisions, including Sec. 1557 in the ACA;
- Access standards for Limited English Proficient individuals; and
- Exchange requirements for reporting of demographic data on race, ethnicity and primary language of Exchange enrollees as it pertains to the Exchange's mission of eliminating health disparities.

Leads from Outreach and Education Grants

It is important to follow up with each and every individual who has learned about Covered California through the outreach and education grants and expressed a potential interest in coverage so that they can be matched up with a trained and certified Assister to help them apply for coverage in Covered California, CHIP, or Medicaid.

We believe these leads, however, should not result in referrals to just any Assister. Rather, leads should be directed to Covered California's Service Center or to nonprofit entities, such as Navigator Entities. We do not think that those Assisters who are positioned to derive substantial direct financial benefit from Covered California coverage should be eligible to receive leads generated by the nonprofit organizations taking on outreach and education.

Conclusion

We look forward to reviewing a more detailed proposal and set of recommendations than the webinar provided last week, and as always will appreciate the opportunity to review and comment upon them.

Sincerely,



Julie Silas
Consumers Union



Cary Sanders
California Pan-Ethnic
Health Network



Vanessa Cajina
Western Center on Law &
Poverty

February 15, 2013

Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Covered California's Assisters Program: In-Person Assistance (IPA) and Navigators

To Whom It May Concern,

The California Primary Care Association (CPCA) respectfully submits comments on Covered California's (CC) Assisters Program, presented during the Stakeholder Webinar on February 7, 2013. CPCA represents over 900 not-for-profit community clinics and health centers (CCHCs) in California that provide comprehensive quality health care services to low-income, uninsured, and underserved Californians. CCHCs are one of the few providers who open their doors to anyone regardless of their ability to pay. By design, CCHCs are located in medically underserved, low-income rural and urban communities and serve as the primary point of care for California's uninsured and Medi-Cal populations.

Comments

I. Background checks

Covered California requested information on whether or not to require background checks for Assisters and in addition whether or not to require that the Assisters or the Assister Enrollment Entity (AEE) pay the fees for the background checks. We appreciate that CC needs to maintain program integrity and ensure consumer rights and safety are protected, but we believe there is a better option than the one proposed during the webinar.

Many CCHCs already conduct background checks on their employees and we propose that these background checks count towards this requirement for CC. Organizations that would like to be AEE's would provide CC with information about the process they conduct on their employees and the results of the background checks for the individuals that will be trained and certified as Assisters. While the process and breadth of the background checks will vary by organization the intent upholds the Assister Program's integrity and is flexible enough to not create a barrier to entry for AEEs. We also recommend that for those organizations that do not currently conduct background checks, CC pay for the first year of background checks and then evaluate the effectiveness of the policy before requiring that the AEEs cover the costs. The enrollment targets are high enough that CC needs every AEE and Assister possible to participate. Any cost barrier that can be eliminated should be eliminated.

II. Recruitment strategies

CPCA would like to offer and suggest that CC work closely with CPCA and our 18 regional consortia to connect with the nearly 300 community clinic and health center corporations in California that can serve as the AEEs. The corporations represent over 900 sites who are serving over 5 million individuals, 1.8 million of whom have incomes over 100% FPL, a subset of whom will be eligible for CC. CPCA and the regional consortia look forward to offering any assistance necessary to ensure all of the willing and interested CCHCs become AEEs.

III. Steering policies and Monitoring standards

CPCA recommends that CC enhance the proposed code of conduct with the current CAA agreement MRMIB requires that the CAAs sign. The agreement can be found here: http://www.healthyfamilies.ca.gov/Publications/EEs_CAAs/CAAAgreementForm_en.pdf. The CAA agreement includes a code of conduct that addresses steering as well as a release of liability so that the state is not liable for the CAA's conduct. This agreement has served MRMIB and the Healthy Families Program effectively, and as this is a proven simple model, we recommend CC adopt it.

In regards to monitoring, the MRMIB Enrollment Entity and CAA monitoring process has been effective and CPCA would recommend that CC adopt a similar program. MRMIB monitors the EE and CAA through the application process, welcome call survey and the Healthy Families Program toll-free number. They have the ability to revoke the status of an EE or CAA should there be any violations to the agreement. They also have the statutory authority to impose a civil penalty of \$500 per occurrence if a CAA is caught charging for his/her services.

Building the Assister Program to mirror the MRMIB CAA Program will help to expedite the enrollment process and ensure that CC can quickly achieve its targets.

V. Training Curriculum

The proposed training curriculum is very comprehensive and will serve as a strong foundation for the Assister Program. The curriculum would be stronger, however, if CC added a module on immigrant eligibility. The rules for immigrants in public programs and QHPs are very complicated and worthy of their own module.

VI. Errors & Omissions insurance requirement

CPCA would recommend against CC requiring that Assisters or the AEEs carry Errors & Omissions insurance. We are very concerned that requiring this insurance would effectively bar many organizations from participating because of the significant cost associated with carrying such a policy. The barriers created by requiring E & O insurance is part of the basis for the Department of Health and Human Services prohibiting States and Exchanges from adopting the requirement for Navigators (see Federal Register Section 155.210, Vol. 77, No. 59). This rationale was further enforced in Secretary Sebelius' letter to Representative Kinzinger dated

July 11, 2012 in which she writes that “requiring errors and omission coverage may serve as a significant barrier to entry for entities that may otherwise be well-qualified.” In her letter Navigators are both agents and brokers and community and consumer-focused nonprofits. The CCHCs that would like to become the AEEs already operate on very thin margins. While some of the larger corporations would be better financially positioned to carry E & O coverage, the smaller ones, particularly in remote parts of California, would not be able to, and it is these sole provider CCHCs that will find it difficult to participate.

Covered California’s success is predicated on large numbers of Californian’s enrolling and securing health coverage, and the only way that can happen is if there are thousands of AEEs covering all sections of California. Developing an Assister Program that mirrors an already successful, well-respected program like MRMIB’s is CC’s best chance of success. The CCHCs in California are very familiar with the CAA model, outreach and enrollment generally, and are ready and able to assist CC in achieving its goals.

Thank you for the opportunity to respond to the above-referenced solicitation. Please do not hesitate to contact Andie Patterson at apatterson@cpca.org or Meaghan McCamman at mmccamman@cpca.org if you have any questions or comments, or if you require any clarification on the comments presented herein.

Assisters Comment Received via E-mail

Subject: Background Check Comment

Fingerprinting background checks: how we make hiring decisions from the information received. Do we classify candidates?

- eligible for hire
- eligible for hire with conditions
- ineligible for hire

The Latino Commission is committed to being a vital participant/partner of Covered California. We are also committed to helping our clients, volunteers, staff and residents in the communities we serve. We are a Recovery Community Organization in that many of our staff are people in recovery who have turned their lives around, and are now providing services to clients in our recovery programs. For Covered California, we will be utilizing staff and perhaps hiring from clients graduating from our programs, who potentially have bad background checks and considered "unemployable". We want to give them an opportunity to work and become proud productive citizens and taxpayers.

For worthy candidates with a bad background, we suggest a person can be "eligible for hire with conditions". In our case, the condition is an 'official professional recommendation' provided by The Latino Commission, a state-licensed service provider.

For decreasing potential harm to innocent applicants:

- Furnish the applicant with a copy of the report before it is given to the employer, so that any inaccuracies can be addressed beforehand; and
- Allow only conviction (not arrest) records to be reported.

Concerns with the validity of background check information (web database vs official records):

As a general rule, employers may not take adverse action against an applicant or employee (not hiring or terminating them), solely on the basis of results obtained through a database search. Database searches, as opposed to source records searches (search of actual county courthouse records), are notoriously inaccurate, contain incomplete or outdated information, and should only be used as an added safety net when conducting a background check. Failure by employers to follow FCRA guidelines can result in hefty penalties.

Doren Martin, Board Member, The Latino Commission
dorensf@msn.com

If "pro" is the opposite of "con", is "progress" the opposite of "congress"?

- Gallagher

February 15, 2013

Mr. Peter Lee, Executive Director
California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

Comments to the Board on the Proposed Assisters Program

Dear Mr. Lee:

The Greenlining Institute is writing to provide comments on the Assisters Program presented on the Covered California webinar on February 7, 2013. As an organization also dedicated to diversifying health workforce opportunities for California's diverse communities, we are pleased that the Board is seeking Assisters that know their respective geography and communities intimately, to promote maximum enrollment into the Exchange. We believe that enlisting Assisters that reflect the communities they serve will improve the Exchange's reach to California's diverse uninsured population through a culturally and linguistically sensitive approach. While we support the intent and purpose of the program, we do have some concerns that some proposed details will not achieve the intended goals of employing Assisters that have no conflict of interest or mirror the population who need coverage for smooth enrollment into the Exchange.

Retailers as Covered California as Assister Enrollment Entities

We support the Board in pursuing options to enlist Assister Entities that build on existing networks and channels to reach eligible people where they live, work, and play. However, as outlined in the webinar, we believe that Retailers as Assisters enters a gray area regarding conflict of interest as entities that may gain direct benefit from enrolling community members. We urge the Board to consider the following in developing their final ruling:

- Develop comprehensive conflict of interest policies to prevent retailers from potentially steering consumers exclusively towards health plans that contract with their business, e.g. pharmacy services.
- Consider whether retail employees truly serve as a trusted resource for consumers, and can move them from an informed to an enrolled individual. Although retailers provide goods and services to diverse consumers, the trust needed for enrolling someone previously uninsured may be lacking in the retailer-consumer dynamic.
- Even if the retail employee establishes trust with the uninsured, there is no guarantee that a consumer will enroll upon first contact in a retail store. Thus, if the retail Assister does not work at the store 24 hours, seven days a week, and the interested consumer returns at a

Greenlining Coalition:

Allen Temple Baptist Church
American GI Forum
AnewAmerica
Asian Business Assn.
Asian Inc
Black Business Assn.
Brightline Defense Project
California Black Chamber
California Hispanic Chambers
California Journal for FIAm

California Rural Legal Assistance
Chicana/Latina Foundation
Chicano Federation, San Diego
Community Child Care Council
Community Resource Project
Council of Asian American Business Assn.
El Concilio of San Mateo County
Ella Baker Center
FAME Renaissance
Greater Phoenix Area Urban League

Hispanic American Growers Assn.
Hmong American Political Assn.
KHEIR Center
La Maestra Family Clinic
Mexican American Grocers Assn.
Mexican American Political Assn.
Mission Language & Vocational School
Mission Housing Development Corporation
National Federation of Filipino American Assn.
Oakland Citizens Committee for Urban Renewal

Our Weekly
Precinct Reporter Group
Sacramento Observer
San Francisco African American Chamber
San Francisco Housing Development
Search to Involve Pilipino-Americans
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later date then the process could begin anew. This potentially inefficient process will not achieve the Board's goal of smooth and cost-effective enrollment for the Assisters Program.

- It is unclear what the buy-in is for the retail worker to serve as an Assister for Covered California. Unlike other proposed Assister Entities who are more traditional stakeholders of their communities, retailers as Assister Entities may have little incentive or purpose for their employees to serve as Assisters outside of the payment for successful employment applications.

In addition, retailers identify locations primarily based on the presence or lack of a profitable market.¹² The significance of community purchasing power in determining where retailers exist could decrease the efficacy of using them as Assister Entities to target California's uninsured populations, as they could have limited reach in California's rural and low-income areas which are less densely populated or have less disposable income, respectively.

Option #1 & #2- Background Clearance and Fingerprinting Requirements for Individual Assisters

We support the Board in ensuring consumer protections and disqualifying dishonest individuals from being Assisters, but we do not agree that proposed clearance requirements will achieve both goals of protecting consumers and enlisting Assisters that reflect the communities they serve. Although details for this process are unclear at this point, we urge the Board to develop security clearance guidelines that do not adversely select out Californians who are disproportionately incarcerated and represent valuable "boots on the ground" as certified Assisters.

Research at the national level generally finds that background checks do not improve an employer's ability to identify risk, and exclude many eligible candidates from employment opportunities. The National Employment Law Project and the Department of Justice have both found that approximately 30 percent of the adult U.S. population has a criminal record.³⁴ This can severely limit the Assisters applicant pool, since a criminal record reduces the likelihood of a job callback or offer by almost 50 percent, an effect inequitably greater for black men versus white men.⁵ The U.S. Equal Employment Opportunity Commission's (EEOC) Enforcement Guidance also found that one in six Latino men, and one in three black men are likely to be incarcerated during his lifetime, disparately larger rates compared to the white male incarceration rate of one in seventeen.⁶

CalSIM modeling predicts that of the four million uninsured in 2019, 66 percent are Latino, and approximately 60 percent are limited English proficient.⁷ However, should background check requirements be overly restrictive, it will limit the Assister Program's ability to provide culturally

¹ Strother SC, Strother BL, Martin BL. (2009). Retail market estimation for strategic economic development. *Journal of Retail & Leisure Property*; 8(2):139-52.

² Mushinski D and Weiler S. (2002). A Note on the Geographic Interdependencies of Retail Market Areas. *Journal of Regional Science*; 42(1):75-86.

³ Rodriguez MN and Emsellem M. (2011). *65 Million Need Not Apply: The Case for Reforming Criminal Background Checks for Employment*. National Employment Law Project.

⁴ Schmitt J and Warner K. (2010). *Ex-offenders and the Labor Market*. Center for Economic and Policy Research.

⁵ Pager D, Western B, and Sugie N. (2007). Sequencing Disadvantage: Barriers to Employment Facing Young Black and White Men with Criminal Records. *The Annals of the American Academy*; 623(1):195-99.

⁶ U.S. Equal Employment Opportunity Commission. (2012). *EEOC Enforcement Guidance. Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964*. No. 915.002.

⁷ CalSIM. Lucia L, Jacobs K, Dietz M, et al. (September 2012). *After Millions of Californians Gain health Coverage Under the Affordable Care Act, Who Will Remain Uninsured?* UC Berkeley Center for Labor Research and Education & UCLA Center for Health Policy Research (Note: CalSIM "base" estimate used).

and linguistically appropriate enrollment services to communities of color that are at higher risk of remaining uninsured.

We propose the Board consider the following to reach a suitable solution that is appropriate and fair, based on evidence and on workforce expertise:

- Incorporate best practices for background checks recommended by entities such as the U.S. EEOC and the National Employment Law Project. For instance, the EEOC provides guidance that background checks must consider the nature of the crime, the time elapsed since the conviction, and the nature of the job.⁸
- Ban requests for criminal histories on initial job applications, delaying the background check until the final stages of the application process; nine California city and county jurisdictions implement some form of a “ban-the-box” policy.⁹
- Drug and DUI offenses should be excluded from the background check as they are unrelated to the work of a Covered California Assister.
- If a background check is conducted, at minimum, legal requirements of the Fair Credit Reporting Act and California’s Consumer Credit Reporting Agencies Act should be met. In addition, if an Assister Entity has their own background check policies, they should be eligible for a waiver to Covered California’s security clearance requirements to streamline the process.
- Regardless of the final security clearance guidelines, there should be an appeals process for an applicant if their background check contains errors, and a special appeals process for applicants whose records show convictions for select offenses that would not endanger consumer protections.

We would be happy to work with the Board to develop language on background checks that mitigates risk but does not inequitably disqualify certain candidates, and can provide more data on this issue upon request.

Best,



Carla Saporta, MPH
Health Policy Director
Bridges to Health

cc: Covered California Board Members
Thien Lam, Deputy Director of Eligibility and Enrollment

⁸ U.S. Equal Employment Opportunity Commission. (2012). *EEOC Enforcement Guidance. Consideration of Arrest and Conviction Records in Employment Decisions Under Title VII of the Civil Rights Act of 1964*. No. 915.002.

⁹ National Employment Law Project. (2012). *Ban the Box: Major U.S. Cities and Counties Adopt Fair Hiring Policies to Remove Unfair Barriers to Employment of People with Criminal Records. Resource Guide*.

Assisters Program Comment Received via E-mail

Subject: Comment on HBEX Outreach and Education Grant Program Application

Because the Board Meeting went long on 1/17 and comments were limited, we would like to submit our comment to the DRAFT Grant Application via this email.

HealthDetail is an information and services provider for healthcare organizations. The company provides cloud based software and services for public and private healthcare programs. The President was the former Director of Medicaid enrollment for UnitedHealthcare of New York's 200,000 Medicaid members. One area HealthDetail has been involved with for more than 7 years is the Facilitated Enrollment Program in New York State.

As you may know, the Navigator and In Person Assister Programs have similar aspects to programs already underway in some states across the country such as CA and NY. The NY Facilitated Enrollment Program also provides grants to CBOs, educational institutions, non-profits, etc to conduct enrollment and outreach activities, largely for New York's public healthcare options, such as Medicaid.

HealthDetail has been performing in person and on site compliance verifications (secret shops) for this program since 2006, and has thus gathered a lot of information around effective training strategies and operational needs. HealthDetail has also recently developed a suite of cloud based online tools, specifically for Navigators and In Person Assisters to use for the HBEX. The tools ensure compliance with tracking, HIPAA, mobility and many other aspects to best meet the goals established for the CA HBEX.

We would ask that the Board reconsider the exclusion of for profit entities to apply as lead agencies for the Outreach and Education Grant. We feel that there are a number of for profit entities, ourselves included, that could efficiently collaborate with the small to medium CBOs, non-profits and other organizations to form an effective Navigator and/or In Person Assister team.

We do understand that for profit entities are allowed to apply as subcontractors, but that would not as easily advance the goal of efficient coordination of the smaller entities. We, and others, can much more effectively do that as a lead agency.

We have read the Federal rules on the Navigator and In Person Assisters Program a number of times and do not feel that this would violate the regulations. Obviously the for profit lead agency would need to display in its grant application that it is supplying a "support" role which would make staffing, customer follow up, contracting and recruitment easier for the HBEX and a more streamlined approach for the operations of the program. The spirit of the rule is not at all violated in this instance.

Thank you for your time and I hope the Board will strongly consider the above recommendation.

Darrell DeVeaux

HealthDetail, Inc

Back Office Cloud Software and Services for Healthcare

An SBA 8(A) and HubZone Certified Company

Phone: [\(678\) 261-7088 x524](tel:(678)261-7088)

Email: ddeveaux@healthdetail.com

Assisters Program Comment Received via E-mail

Subject: IEHP's Feedback on the Assister Program

Good afternoon:

Thank you for giving us an opportunity to provide feedback on the proposed Assister Program. Following are our two recommendations:

- 1) We encourage the Exchange to re-consider the master trainer model. This model will not replace the Exchange's proposed training models, but it will create another training format for many entities and individuals who prefer the classroom format with in-person questions and answers. This model has been very successful for the Healthy Families Program. We have received many feedback from our community partners and agencies, urging us to request the Exchange to re-consider this master trainer model.
- 2) In early Summer 2012, the Exchange proposed to allow health plans to conduct education, eligibility and enrollment. However, we do not see this recommendation in your current Assister Program. We respectfully request that the Exchange re-considers to allow Medi-Cal health plans that currently provide Medi-Cal/Healthy Families application assistance to conduct these activities (and they will not be eligible for compensation.) Currently, Medi-Cal health plans provide application assistance to thousands of uninsured families to apply for Medi-Cal/Healthy Families for their children. By permitting these health plans to provide the Exchange education and application assistance, it will allow health plans to help the children and their parents (who will be eligible for the Exchange products) at the same time, and not turn away the parents. This strategy supports one of the Exchange's enrollment and outreach strategies, which is one-stop-shop for application assistance. It is also a critical outreach and enrollment assistance component for the Bridge Option. The new proposed federal regulation on "Application Counselors" allows the Exchange to utilize organizations (for the Exchange application assistance) that currently provide Medi-Cal/Healthy Families application assistance and not fit in to the In-person Assistance Program and Health Navigator categories.

Please contact me if you have any questions about our recommendations. And again, thank you for your consideration.

Thomas Pham
Director of Marketing & Product Management
Inland Empire Health Plan (IEHP)
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 pham-t@iehpa.org

Assisters Comment Received via E-mail

Subject: Assisters Program: IPA & Navigator Webinar

I have yet another comment to add to the mix in the wake of the Feb. 7 webinar re the assister program.

Fingerprint checks.

My experience with fingerprint checks is that, even with the best fingerprint technician performing the test, this technology is lacking. As a result, I question the wisdom of spending money on this.

When my daughter was in 4-H, I was required to undergo a fingerprint check in order to volunteer for 4-H activities. I went in for a fingerprint check on three different occasions, because my fingerprints could not be read. Because I work out in the yard with my hands in the dirt, and because I have naturally dry skin, the fingerprint machine administered by someone who appeared to me to be knowledgeable and competent was unable on any of the three occasions to read my prints. What ultimately happened is that I was waived from having to have a fingerprint test.

Meanwhile, someone paid the bill for these three tests, and I had to take time out of my day to drive to and from these testing events.

If there are other technologies out there to verify background information for Assisters and Navigators, then I would like to encourage Covered California to explore them as an alternative.

Thanks.

Linda Carpenter

Healthcare Navigator

Private Patient Advocate

Northern California Healthcare Navigators

707-478-2103

Assisters Program Comment Received via E-mail

Subject: Webinar, 2/7- Assister's Program

Hello:

I was glad to be on the Webinar presentation last week. I found it informative and wish I'd been on the Webinar for the education and outreach program the day before. I am eager to participate in the education and outreach efforts on behalf of the Exchange and also the assister training programs. I attended the webinar to learn how these marketing elements were all going to hang together. I still have more to learn by reviewing the slides of both presentations and listening to the webinar again. And I've read the marketing plan Ogilvy and Mather prepared, but as I proceed to see how and where I might find a way to contribute, I still find it difficult to see a clear path through all the moving parts.

I live in Marin County and have been conducting my own information interviews to learn what and who is getting ready for health reform and the implementation of California Covered. So far I have not found much preparation. There is some pessimism about whether the constituencies without insurance are going to be able to afford what will be available on the Exchange, and since many of the clients of our Health and Human Services Department, our public health clinics, are not U.S. citizens, and will not be eligible for coverage on the Exchange, there was doubt and concern about their role in outreach programs. I also learned that there is fear and trepidation among small business owners about the their costs for offering mandated health coverage to their employees. Perhaps there are organizations applying for the education and outreach grants that I have yet to identify in my area, but I see gaps and voids that need to be filled, a significant need for education and outreach where I live.

I also wondered about your estimates for the numbers of people an individual assister will enroll per month. I believe I heard an estimate of four. That seems unrealistic to me. Did I not hear correctly, and the estimate is really 4 a day? Regarding retail outlets, it occurred to me that Costco stores might be likely places to set up kiosks to enroll prospective customers for California Covered. Perhaps also Safeway pharmacies. I am thinking of companies whose values align with the goals of the Exchange.

I look forward to learning much more and achieving a clearer understanding in the days ahead.

Kind regards,
Margaret Ballou

Assisters Comment Received via E-mail

Subject: Distribution Plans

I listened to the webinar conducted 2/6/2013. One of the slides showed the Assister being required to have General Liability, Negligence, and Errors and Omissions Insurance. There are many carriers that offer this coverage. But, it is for licensed insurance brokers who are required to have this coverage in order to be appointed by insurance companies – health, personal, or commercial. In addition, the brokers have to complete 30 units of continuing education every 2 years to maintain their license to continue they appointment with the companies.

I am troubled that Covered California is going to allow individuals giving insurance advice after 2-3 days of training. Frankly, I think this is a recipe for misguidance. I am all for getting everyone insurance coverage, but Assisters negligence will fall back on Covered California-I hope you have insurance. Think about it, you are requiring a non-licensed lay person/entity to purchase professional insurance errors and omissions coverage. You are asking an insurance company to provide errors and omission for a retail store. And, you are requiring the retail store to pay probably \$1,500 minimum premium to acquire the coverage, if they find a company to insured them. Plus this premium will probably be more than their regular business insurance cost. Imagine what the cost for a store with many Assisters. This is naïve.

Please reconsider/revamp your distribution plans. Know I am a strong support of your goals and I want the program to be success. If you like some suggestions, let me know.

At Your Service,

Paul L. White

Principal/CEO
Vantage Business Support & Insurance Services

Assisters Program Comment Received via E-mail

Subject: Feedback on Assister Program from San Mateo County Health System

Dear Covered California colleagues,

The San Mateo County Health System urges you to allow Health Departments to be eligible to serve as Assistor entities. In listening in and reviewing the slides from the Assistor program webinar last week, Slide 19 is confusing and implies that Covered California may not allow Health Departments to serve as Assistor entities. Whether or not Health Departments deliver direct healthcare services, there are mechanisms to assure that the organizational units that perform Assistor functions maintain impartiality, avoid conflicts of interest and are responsible for maintaining program integrity.

For Health Departments that have invested in this capacity to offer "no wrong door" and "culture of coverage" service to consumers that we reach, it directly thwarts Covered California's goals of achieving maximum coverage to disqualify entities that have demonstrated expertise in this arena.

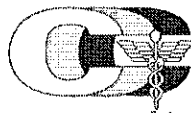
In San Mateo County, the Health System's Health Coverage Unit and Behavioral Health and Recovery Services division have a combined 51 Certified Application Assistors (designated by MRMIB) as part of their staffs. These staff can deliver assistance to consumers with ALL programs that they may qualify for, increasing the efficiency and quality of customer service provided. Collectively, the Health System's Certified Application Assistors represent more than 50% of the CAAs in San Mateo County, and these CAAs are well-positioned to serve as Assistors for Covered California. As one example, we have achieved 95% coverage of children in our community, in part through the work of the network of CAAs. Disqualifying the Health System will result in a need for greater ramp-up and training and, potentially, much reduced Assistor capacity to serve as community-based resources for San Mateo County residents. Training and/or redirection of current staff into different organizational entities would take time away from preparation for ACA implementation at a time when we can least afford to divert focus on our joint goals of maximum enrollment assistance for consumers who will need it.

Also, to the extent that Covered California wants trusted on-the-ground staff to connect with low-income, uninsured consumers, we hope that you consider Assistors working in local health departments as similar to those who work for community clinics or other community-based locations that are a resource for low-income uninsured residents seeking assistance or healthcare.

We also recommend that Covered California continue to consider the Master Trainer model to support online training offered by Covered California. In our experience, local expertise and training support, that can adapt statewide training to the local provider landscape, improves the level of customer service we can provide. The Health System is interested in continuing our role in this arena given the expertise and capacity that we have developed, as a local complement to Covered California's statewide responsibilities.

Thank you for your consideration.

Srija Srinivasan
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650.573.2095



San Francisco Community Clinic Consortium

1550 Bryant Street, Suite 450 • San Francisco, CA 94103 • Phone 415/355-2222 • Fax 415/865-9960 • www.sfccc.org

February 15, 2013

Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Covered California's Assisters Program

To Whom It May Concern,

The San Francisco Community Clinic Consortium (SFCCC) respectfully submits comments on Covered California's (CC) Assisters Program, presented during the Stakeholder Webinar on February 7, 2013. SFCCC represents 11 community-based primary care clinics with 19 clinic sites strategically located across the City to meet the health care needs of our most vulnerable residents. SFCCC partner clinics care for more than 94,000 low-income, uninsured and under-insured San Franciscans, more than 10% of the City's population. SFCCC partners offer services in over 20 languages and multiple dialects and employ over 500 health care professionals, including more than 50 trained Certified Application Assisters.

Our partners have been serving their communities for decades, and have built strong and trusting relationships with both their patients and their larger communities. It is common for third and fourth generations in a family to continue to attend the same clinic. The clinics care for the entire family, from newborns to seniors. Our partner clinics are in an ideal position to educate both their existing uninsured patients and the larger community about the benefits of enrolling in the Exchange, and to assist them to enroll.

I. Background checks

Covered California (CC) requested information on whether or not to require background checks for Assisters and whether or not to require that the Assister Enrollment Entity (AEE) pay the fees for the background checks. We appreciate that CC needs to maintain program integrity and ensure consumer rights and safety are protected, but we have some concerns with the options proposed during the webinar.

SFCCC has encountered State law limitations when background checks are required for our AmeriCorps Program members. Therefore, SFCCC highly recommends that CC assure that any required background checks do not violate any State rules governing when employers can require background checks and how the information is shared and stored. Depending on what State law allows, CC may need or prefer to conduct the background checks itself, which could also simplify the entire process. The enrollment targets are high enough that CC needs every AEE and Assister possible to participate. Any AEE cost or administrative barrier that can be eliminated should be eliminated.

II. Steering Policies and Monitoring Standards

SFCCC appreciates the importance of the steering policies and monitoring standards in CC's Assister Program, and we encourage CC to mirror the Managed Risk Medical Insurance Board's (MRMIB) Certified Application Assistant (CAA) Program whenever possible. Developing a similar program will help expedite the enrollment process and ensure that CC can quickly achieve its targets. We recommend that CC enhance the proposed code of conduct with the current CAA agreement that MRMIB requires their CAAs to sign in order to participate in the Healthy Families Program. The agreement can be found on their website: http://www.healthyfamilies.ca.gov/Publications/EEs_CAA/CAAAGreementForm_en.pdf.

The CAA agreement includes a code of conduct that addresses steering as well as a release of liability so that the state is not liable for the CAA's conduct. We believe that this agreement has served MRMIB and the Healthy Families Program effectively. Since this is a proven and fairly simple model, we recommend that CC adopt it.

In regards to monitoring, we believe that the MRMIB Enrollment Entity (EE) and CAA monitoring processes have been effective, and SFCCC recommends that CC adopt a similar program. MRMIB monitors the EE and CAA through the application process, welcome call survey and the Healthy Families Program toll-free number. They have the ability to revoke the status of an EE or CAA should there be any violations to the agreement. They also have the statutory authority to impose a civil penalty of \$500 per occurrence if a CAA is caught charging for his/her services.

III. Training Curriculum

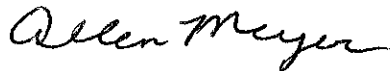
The proposed training curriculum is comprehensive and will serve as a strong foundation for the Assister Program. However, the curriculum is lacking a module on the eligibility rules for immigrants in public programs. These rules are complicated but crucial for Assisters to understand in order to explain the eligibility rules for all of California's potentially eligible populations. We strongly urge CC to add such a section to the curriculum.

IV. Errors & Omissions Insurance Requirement

SFCCC understands the potential benefit that could occur if AEEs carry Errors & Omissions insurance. However, we recommend that CC not make it a requirement, since the cost and administrative burden to obtain such a policy might keep some smaller and potentially important organizations from participating in the program. We recommend that CC work with insurance companies to make certain that appropriate and affordable policies are available for AEEs, and publicize their availability. CC could strongly recommend that AEEs obtain such insurance, but a requirement to obtain a policy might limit potential organizations from participating in the program, which may limit enrollment of important segments of California's populations.

Thank you for the opportunity to respond to the above-referenced solicitation. Please do not hesitate to contact Merrill Buice at mbuice@sfccc.org or 415-355-2234 if you have any questions, or if you require any clarification on these comments.

Sincerely,



Allen Meyer
Vice President of Programs

Assisters Program Comment Received via E-mail

Subject: Comments on Assisters Program

Thank you for inviting feedback on your planning for the Assister Program. I hope that you will consider the following issues:

Small counties may only have one or two entities and these entities may only hire 1 Assister (or, more likely, reassign work and have one or more staff member train as an Assister). With the funding tied to successful applications, and the estimate of an Assister enrolling a limited number of families per month, this is the only feasible way for an entity to approach this.

In geographic areas where the enrollment will be relatively low, the costs carried by entities should be carefully considered. For example, if an entity has only a few Assisters (e.g. <2 FTE), Covered CA should cover costs of background checks and fingerprinting. If staff have already gone through this process as part of the hiring process it should not have to be repeated.

For this reason, also, you should consider a Train the Trainer model for small, rural counties. Travel costs are expensive, as is dedicating staff to a computer training for 3 days, with no grant funding to pay for this. Better yet, training costs should be fully funded, whatever the model used.

If you go forward with working with retail stores as partners, you should focus on quality control issues. Minimum wage retail employees may not be the best equipped to learn the complicated ins and outs of health plans, nor should they expected to be. Perhaps the certification will cover this, but it does come to mind. Non profits and government entities have a history of "demystifying" complex regulations for citizens, WalMart does not. If a store cannot dedicate an employee to that booth on full time basis (because the reimbursement rate would not cover the costs), then the plan would be to pull someone off the floor - and the logistics of that for a retail store are even more complicated than for a non-profit service provider.

Clarity regarding the ability of Public Health Depts to become Assisters would be welcome -- many small county Depts of Public Health do not have full health clinics, but only offer services such as immunizations, etc.

Thank you,
Sheila Kruse

Sheila Kruse
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Assisters Program Comment Received via E-mail

Subject: Assister Program Comment

Hello,

I realize I missed the deadline to submit written comments (the timing for this initiative is really bad for grant writers working with health centers, since the long-awaited and highly competitive federal New Access Point applications for Federally Qualified Health Center [FQHC] funding are in full swing), but here is my comment:

I see from the PowerPoint presentation for the Assister's Webinar that the example given to illustrate how Assisters will interact with the public is for retail stores. As someone who works with a number of FQHCs and other community clinics, I'm wondering if that same model is being planned for the health center network. As far as I can tell, so far, no health center administrators are clear about what their role in this effort will be, and it seems obvious to me that FQHCs are much more appropriate Assister Entities than retail stores.

I didn't attend the webinar, so maybe I'm missing something.

As an aside, the Outreach and Education funding, requiring 33,000 contacts over 20 months is being seen as too ambitious for most of the clinics I work with, and some are scrambling to see if they can collaborate with larger coalitions to be part of the effort. Many, however, are just writing it off as beyond their capabilities, so I fear we may lose this excellent resource for outreach, and I hope we don't lose it for the Assisters program.

Thank you for your consideration of these thoughts,
Susan Dobra

Susan Dobra, Ph.D.

Lead Grant Writer
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United Food & Commercial Workers Union

James Araby, Executive Director · William Lathrop, President · Ronal Lind, Secretary-Treasurer · Rick Eiden, Recorder

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February 15, 2013

Peter Lee, Executive Director

Ken Wood, Senior Advisor for Products, Marketing and Health Plan Relationships

Thien Lam, Deputy Director, Eligibility and Enrollment

California Health Benefits Exchange

560 J St., Ste. 200

Sacramento, CA 95814

Re: Exchange Partnerships with Retail Stores

Dear Mr. Lee, Mr. Wood and Ms. Lam,

The Western States Council of the United Food and Commercial Workers strongly opposes the proposal for the California Health Benefits Exchange to partner with retail stores as assisters and locations for outreach.

Our union represents the workers in retail stores in California and elsewhere in the country: we are proud to have done so for many years. We are disappointed that the staff of the California Health Benefits Exchange has been in conversation with management of retail stores without reaching out to us as the representatives of the workers in these stores. The first we knew of the possibility of the Exchange working with retail stores was when the materials for the January 17, 2013 meeting were posted after 3PM on January 16, 2013.


We oppose the compensation of retail stores as assisters. In our view, these large, for-profit enterprises will benefit from health reform in much the same manner as health insurers, hospitals or other providers. This is especially true of those retail stores that offer pharmacy or optical services: consumers with health insurance will be better able to afford prescription drugs and eye glasses when these are covered benefits. The same questions of conflict of interest and steering of consumers arise in the retail context that arises in the context of a hospital or other provider steering consumers to a particular carrier or a specific product whether or not that carrier and that product is the best fit for a consumer. The Exchange does not propose to permit insurance agents, hospitals, insurers, or other providers to be paid assisters: the same standards should apply to retail stores.

Our union provides good health benefits to our members and our members value those benefits. We are appalled and offended that the Exchange would contemplate partnering with retail stores notorious for failing to provide health benefits to many of their workers and providing substandard benefits to the workers who do qualify for benefits. Some of these retailers are already redesigning work hours in order to evade the employer responsibility requirements of the Affordable Care Act. One of these retailers has informed investors that the health benefit it provides meets a minimum

value of 60%, exposing its minimum wage workers to 40% of costs of health care. ASPE found that 94% of American employers provide benefits with a minimum value of 80% or better. Co-branding would allow retailers to take credit for providing health benefits to consumers and presumably their own workers while shifting the cost of health benefits from the employer to the taxpayer.

The United Food and Commercial Workers Western States Council asks that the Exchange adopt a policy that it will contract with or employ as assister entities only those entities that provide decent health benefits to their employees. We would look forward to working with the Exchange on developing such a standard.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Araby', written over the word 'Sincerely,'.

James Araby
Executive Director

Assisters Program Comment Received via E-mail

Subject: Comments on Assisters Program from Blue Shield of CA

Thank you for the opportunity to submit comments/questions on the Covered California Assisters Program: In-Person Assistance and Navigators”.

1. “Navigator” vs. “Assisters”

What is the state’s goal in only allowing Navigator Program grantees to conduct “public education activities”? Why won’t Assisters and Assister Entities (AEs) be allowed to conduct public education activities? Example: A church decides to give an evening education presentation to its congregation on the options under Covered California. In that the church is an approved AE, is this scenario unacceptable?

Are Navigator grantees required to undergo the same training, background, fingerprinting and insurance requirements as Assisters? If yes, why would the state require Navigators to pass leads to the state for follow-up when the Navigator could handle the application process immediately? Passing leads to the state will increase the staffing and burden on the state to handle applications, when they could be focusing on processing enrollment.

The Outreach & Education Grant Program: Bidder’s Conference document states, “Grantees will be required to provide Covered California with **leads** for follow up with consumers or small businesses that are **potentially eligible** and interested in receiving more information about enrolling.” Everyone in California is potentially eligible before proven ineligible, and developing a grant program that credits delivery of “any lead” will burden the system and result in wasted dollars that will delay enrollment for legitimate enrollees. What is the incentive for Navigators to pass only qualified, legitimate leads, rather than passing illegitimate leads that will allow them to reach quotas and burden the state with illegitimate leads that must be worked?

2. Organizations Eligible for Compensation.

It is unclear as to how the state is determining which agencies/organization types can be compensated as Assisters/AEs, and which cannot. For example, community clinics can receive compensation as Assisters/AEs, but not other “providers”, such as county health departments and hospitals. Also, what is the state’s definition of “provider”? Does it include pharmacies, specialty physicians, Planned Parenthood, outpatient labs, chiropractors, acupuncturists, mental health professionals, optometrists/ophthalmologists, and dentists?

3. Concerns Regarding Training & Certification Requirements

Reaching the projected assisters network capacity of over 21,000 Assisters is a daunting task. Our concerns include:

- The potential Assistor has to take up to three days off of work, potentially losing pay, and incurring travel, meals and lodging costs as well. Then, existing Assisters will be required to undergo annual refresher requirements. We are concerned about the numbers of current or former Certified Application Assisters in the Healthy Families Program that would be able to do this.

- There is no discussion of what level of training and other requirements will be required of Navigators.
- The Certified Application Assistants (CAAs) in the Healthy Families Program were never required to undergo background checks or fingerprinting. Why would Assisters in Covered California be different? They are not dealing with any information that wasn't dealt with under the CAA program in the HFP.
- Background checks, fingerprinting and the proposed insurances add tremendous costs into the program regardless of who bears the burden – the AEs/Navigators or the state.
- Insurance agents are not required to carry negligence and liability insurance.

4. Concerns Regarding Lack of Plans for Master Trainers

The state envisions that new Assisters will be made through direct training, until computer-based training is developed, at which time, new Assisters will undergo computer-based training. On the webinar, the state used the Healthy Families Program (HFP) as a model. However, the reality of the HFP's continued CAA training was that computer-based training was not sufficient to educate CAAs enough to perform application assistance. In most cases, those CAAs then underwent face-to-face training with a Master Trainer who was recognized by the MRMIB as qualified to certify both the public and health plan personnel. To develop a self-sustaining model that continues to provide an adequate pool of Assisters in future years, there must be a Master Training program developed.

Although health plans were not addressed in this webinar, we feel strongly that health plans must be able to have Master Trainers on staff to train their Sales and Customer Service staff – staff the plan cannot allow to leave for offsite trainings.

Additionally, If the state determines where trainings are held, and health plans do not have a Master Trainer that they can send at their own expense to reach certain targeted populations, then the health plan's membership growth is at risk. For example, the state may not find it cost-effective to have training in many counties. However, a health plan participating in Del Norte has a vested interest in having Assisters. It could result in a region having unfavorable risk that would jeopardize health plan participation (and therefore coverage and choice) in certain regions and/or counties.

5. Additional Types of Entities That Should be Considered

- Property and Casualty insurance agencies
- State agencies (OSHA, DMV, etc.)
- Libraries
- Unemployment offices

6. Retail Partnerships

We support the idea of partnerships with retail organizations with paid Assisters as an especially great way to reach the masses, but also specific ethnic communities. For example, partnerships with grocery stores (e.g., Asian, Latino, middle Eastern, etc.).

7. Suggested Recruitment Strategies.

Allow health plans to help recruit Assisters. Health plans participating in HFP and Medi-Cal have deep community ties and can help recruit. Blue Shield's Master Trainers have certified thousands of CAAs in the HFP over the existence of the program.

8. Suggestions on Steering Policies

The state needs to come up with a definition of “steering” as any “activity that seems to promote one health plan choice over another.” The definition of “steering” must be connected to activities of the Assistors or AEs.

Some examples of what should NOT be considered steering:

- A doctor’s office tells a current patient which health plans to choose from if the patient wants to enroll and continue seeing that doctor.
- A health plan taking a call from a prospect who wants to sign up for that plan.
- A health plan paying for a booth at a fair, Branded as the health plan, using Assistors to help applicants, provided that the Assistors write applications regardless of which health plan is chosen.

The most important thing to focus on when considering what constitutes “steering” is whether the applicant understands and acknowledges that they had choices and weren’t given any monetary incentive (or any gift) to sign with a particular health plan.

In order to ensure that health plan marketing dollars can be spent to direct benefit of enrollment, health plans should be allowed to purchase or sponsor booths, tables, sponsorships, health fairs, etc., that while clearly identifying the specific health plan as the sponsor, should be allowed to use Assistors or Navigators to staff these events. This ensures that AEs have an abundance of opportunity to reach applicants and maximize enrollments.

What **should** be considered “steering”?

- An AE or Assister who favors one health plan over others in enrollment.
- An Assister who accepts monetary remuneration incentives from health plans.
- An Assister or AE who doesn’t inform all applicants of their health plan and metal level choices.
- An Assister or AE who disparages any particular health plan.
- An Assister or AE who offers any kind of incentive to the applicant for enrolling in any plan.

9. Suggestions on Monitoring Standards

We support the monitoring of the AEs and Navigators to ensure Californians are informed of their choices accurately. We believe that monitoring of the Assistors and Navigators is placing the appropriate emphasis in the appropriate place.

10. What Additional Factors Should Covered California Consider?

Every decision regarding assistance of any kind should take into consideration that ultimately, Covered California must be self-sustainable. Therefore, any Assister program must become self-sustaining. New Assistors must be made continuously and they must receive some kind of payment.

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January 14, 2013

Peter Lee, Executive Director
California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

Submitted Electronically to David.Panush@hbex.ca.gov

Subject: Bridge Plan Discussion Draft

Dear Mr. Lee:

On behalf of our over 400 member hospitals, the California Hospital Association (CHA) appreciates the opportunity to respond to your request for input on the Board Recommendation Brief that proposes a Bridge Plan to help achieve continuity of care and affordability. We applaud your efforts in providing the opportunity to engage with stakeholders on such an important issue. California's hospitals play a vital role in providing medically necessary care to all residents, especially those less fortunate with lower incomes or uninsured.

The proposal described in the Discussion Draft is complex and warrants additional thought and contemplation, especially in relation to other state activities such as the Governor's budget proposal released last week. However, we recognize your continued desire to move quickly on these important issues so we are providing you with our initial reaction – which could be modified as we learn more and discussions become further developed.

Summary

We are framing the discussion on the "Bridge" plan in a manner that describes our understanding so that our feedback is best understood. From our viewpoint, we identify three main areas of discussion:

- Should there be a "Bridge"?
- What is the size of the Bridge?
- Should there be special rules for the Bridge?

The Bridge represents the continuous pathway that links Medi-Cal managed care with Covered California. Since many Medi-Cal managed care beneficiaries are expected to move back and forth between being eligible for Medi-Cal and Covered California, the Bridge is intended to make that transition seamless, keeping more people insured without disruption.

The size of the Bridge will depend on if it needs to accommodate just the population that moves back and forth between being eligible for managed care Medi-Cal and Covered California, or if it needs to be large enough to accommodate everyone that is eligible for subsidized coverage in Covered California (up to 200 percent of the federal poverty level – FPL).

The third area for discussion indicates that the Bridge plans may already be on fragile ground due to other system stresses and pressures; therefore, perhaps the plans creating the Bridge should be given special relief from regulatory and other provisions. The relief is intended to encourage participation from all plans that currently provide managed care Medi-Cal to offer a Bridge.

Discussion

If a Bridge is properly constructed, it could be helpful in keeping people enrolled in health care coverage and ensuring their access to a broader range of providers than if they were uninsured. The larger the Bridge, the greater the stresses and pressures that will be put on the infrastructure. Instead of relaxing standards for developing a Bridge, the opposite is necessary to ensure that those on the Bridge will have a reliable product and will not have access to care jeopardized, especially when they need it most. While the goals of continuity of care and affordability are good, the underlying approaches to achieving those goals include some debatable points as to their merit.

The Discussion Draft indicates that Covered California would use its selective contracting process to provide more affordable options for low income Californians. Practically speaking, the selective contracting process seems to result in a purposeful establishment of a below market rate for a Silver level plan. Because federal subsidies are based on the second lowest Silver level plan, the federal funding is anticipated to be sufficient to cover most or all of the cost of the Bridge plan premium and cost sharing. Selective contracting gives the appearance of establishing premiums with no regard to the cost of providing care. This process would place additional downward pressure on provider rates or it would result in a precarious financial situation for the Bridge plans. Either way, this method places additional pressure on an already challenged system.

Further, the Discussion Draft speaks to the challenges currently faced by plans that would potentially be offering these Bridges. The Draft fails to address the challenges currently facing hospitals and the health care safety net. California's hospitals provide care to the State's Medi-Cal beneficiaries at an annual loss of more than \$5 billion. That challenge is not addressed in the Draft. California's hospitals are facing more than \$22 billion in payment reductions over the next ten years to help pay for reducing the number of uninsured and lowering government deficits. The Discussion Draft does not list this challenge. There are many facets of the health care safety net that are stressed and would benefit from relaxed oversight or requirements. However, in order to ensure consumers/enrollees have access to the care they need, when they need it, oversight should not be scaled back.

Of particular concern to hospitals is the concept of providing relief to plans because "establishing a provider network and negotiating rates to the extent the plan does not use existing Medi-Cal contracts and needs to negotiate different terms". Covered California is not Medi-Cal. Any

proposal that includes a provision for existing Medi-Cal provider networks and contractual obligations with hospitals to be mirrored into a Bridge plan is not supported by CHA. Hospitals should have the opportunity to make independent decisions about their ability to broaden their service to this population and what rates would be acceptable. As indicated above, Medi-Cal underfunds the hospitals by over \$5 billion a year and that level of reimbursement would lead to further cost shifts to the private sector – further weakening the delicate and fragile balance that exists today. Covered California should not support a mechanism that increases the cost shift. This would be in direct conflict with the vision of the California Health Benefit Exchange “to improve the health of all Californians by assuring their access to affordable, high quality care.”

To add complexity to the Bridge plan discussion is the concept included in the Governor’s budget proposal for 2013-14 for the Medi-Cal expansion. The budget outlines two possible approaches to the expansion – a state-based approach or a county-based approach. Each approach would have an impact on how the Covered California Bridge plan would be implemented. It seems premature to be making a decision on the development of a Bridge plan without knowing how the California State Legislature will decide on how to roll out the Medi-Cal expansion.

Recommendations

Depending on what new information we may learn, including how California will expand its Medi-Cal program, CHA acknowledges the benefits that could result from creating a “narrow” Bridge for the population that moves back and for the between eligibility for Medi-Cal and Covered California.

However, the Bridge plan must not force providers to accept payment and participation terms that were negotiated under a Medi-Cal contract.

- CHA could support a “narrow” Bridge with no requirement that providers must accept previously negotiated Medi-Cal contractual payment and participation terms.

Consumers must have access to adequate networks as deemed by the appropriate regulatory body. Bridge plans must not be exempt from adhering to network adequacy requirements. Streamlining procedural red-tape for administrative issues could be considered – for the first year - but consumers must have adequate access to necessary health care providers regardless of the plan they choose.

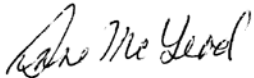
- CHA could support some streamlining for red-tape for administrative processes for Bridge plans (in the first year), but do not remove or relax regulatory oversight to ensure adequate provider networks.

Extending the size of the Bridge to a broader population will only weaken the already stressed system of plans and providers. Broadening eligibility for a Bridge plan would be placing more Californians in a coverage product with a sub-market premium established without regard to the cost of providing safe, effective, high-quality patient care. The broader population does not have the same “churning” concerns that are inherent to the population that moves between eligibility for Medi-Cal and Covered California.

- CHA has concerns over a “wider” Bridge option and federal approval should not be pursued.

CHA appreciates the opportunity to provide our initial comments on the Bridge plan proposal and we look forward to further discussion to enhance our understanding of the risks, benefits and other implications that need to be carefully considered. If you have any questions, please do not hesitate to contact me at amcleod@calhospital.org or 916-552-7536.

Sincerely,



Anne McLeod
Senior Vice President, Health Policy



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January 31, 2013

Covered California and California Health Benefit Exchange Board
Attn: David Panush, Director, External Relations
560 J Street, Suite 290
Sacramento, CA 95814

Dear Members of the California Health Benefit Exchange Board:

MCH Access takes this opportunity to comment on the *Bridge Plan: Affordability and Continuity of Care Options for QHPs* (revised Jan. 10, 2013).

Key Recommendations

We strongly support the effort reflected in the bridge proposal to achieve affordability and continuity of care for low-income adults when income is over the federal poverty level (FPL) for full-scope Medi-Cal.

Our key recommendation (background provided below) is that women with income to 200% FPL enrolling in the bridge program also be enrolled into Medi-Cal's 200% FPL program. This is necessary because the scope of benefits in Medi-Cal's 200% program for pregnant women is limited to "pregnancy-related" care under a very narrow, restrictive definition that excludes many benefits that other adults in Medi-Cal receive.

Enrollment in both the bridge and limited scope Medi-Cal program would take effect immediately if the woman is pregnant at the time of application. If she is not pregnant when applying, then the woman would be pre-screened for Medi-Cal's 200% limited scope program, and eligibility for that coverage could be triggered after she becomes pregnant.

The women would have one insurance card and would access all of their care seamlessly through the bridge health plan.

Pregnancy-related benefits would include not only prenatal care and labor and delivery services but also Medi-Cal's other limited scope benefits for pregnant women, such as lactation consultation and breast pumps, and Comprehensive Perinatal Services Program (CPSP) benefits, which include psycho-social services, health education and nutrition counseling. These benefits all work together to reduce overall program costs by protecting both maternal and child health.

Women would not have any cost-sharing for any pregnancy-related care, as is the case under Medi-Cal.

Medi-Cal funds would be allocated to pay for the pregnancy-related care; advance premium tax credits and cost-sharing reductions would be allocated for the women's non-pregnancy-related care through the Exchange's bridge plan program. Behind the scenes, women would be in the two separate programs, but the state would be administering them jointly and seamlessly to the woman.

The Exchange Board's bridge plan proposal complements MCHA's approach to seamless coverage for pregnant women, as all of the plans participating in the bridge would, by definition, be plans that also participate in Medi-Cal managed care. Our proposal also synchs with the goal of the bridge to promote continuity of care for individuals who are likely to move in and out of Medi-Cal eligibility.¹ Waivers may be required for both the bridge plan proposal as well as MCHA's proposal to ensure that women's pregnancy-related care is affordable and that continuity of care is protected by "blending" the two funding streams to create one seamless coverage for women with income at or below 200% of poverty.

Background

Although we strongly support the goals reflected in the bridge proposal to achieve affordability and continuity of care for low-income adults when income is over the 138% FPL limit for Medi-Cal, we are concerned that the consumer cost-sharing proposed with the bridge for individuals with income at or below 250% FPL does not meet the affordability test. Copayments of \$20 for individuals with income from 150% to 200% FPL and \$45 for individuals whose income is 200% to 250% FPL for various health services far exceed what families pay in the Healthy Families program—and in Healthy Families the single biggest reason for disenrollment has been non-payment of premiums.

Of particular concern is the proposed cost-sharing for pregnancy-related care. Women with income from 100% to 150% FPL would have bridge copayments for prenatal visits of \$3 and, for hospital care, copayments of \$300 a day. The proposed cost-sharing burdens for the two other Silver copay plans for pregnancy-related care are \$20/\$600 for women with income 150% to 200% FPL and \$45/30% for women 200% to 250% FPL. Cost-sharing at all three levels for the Silver copay plans for women with income at or below 250% FPL would be a major barrier to accessing prenatal care and would impose great financial hardship for hospitalization costs. If women cannot afford to use their prenatal care benefits and face medical debt for hospital deliveries, Covered California's goals in the areas of prevention and timely access would be significantly undermined.

¹MCHA is making a similar proposal for the 138% Medi-Cal adult expansion program in AB 1X-1 and SB 1X-1 for women with income between 100% and 138% FPL, should coverage under the 200% program for pregnant women remain limited in scope.

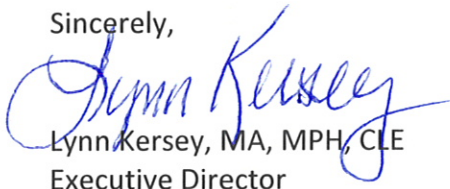
For high-risk populations, intensive prenatal care offers significant cost-savings over conventional care by preventing neonatal hospital and NICU admission rates. Cost-savings from reducing such admissions range from \$1,768 to \$5,560 per infant/mother pair.²

Women with income up to 200% FPL are eligible for Medi-Cal for pregnancy-related care without any cost-sharing. Women should not be required to disenroll from the bridge plan in order to access affordable pregnancy-related care, as disenrollment would interfere with timely access and continuity of care, and pregnancy is already stressful enough. Studies show that additional stressors may contribute to premature labor and delivery and thus low birth weight,³ which is the leading cause of infant mortality. California's maternal mortality rate was a disturbing 49% higher in 2006-2008 than in 1999-2001.⁴ Racial disparities are an urgent problem, with African-American women being four times more likely to die from pregnancy-related causes.⁵

It is also important to note that enrollment systems incur unnecessary administrative costs when eligibility "churns" back and forth between programs. Avoiding costly churning is yet another reason why it is important to make the bridge plan and Medi-Cal's 200% coverage work seamlessly together with blended funding streams for pregnant women.

Thank you for your attention to this important matter. We would be happy to provide further detail or answer questions about our recommendations.

Sincerely,



Lynn Kersey, MA, MPH, CLE
Executive Director

² Reece EA, Lequizamón G, Silva J, Whiteman V, Smith D. Intensive interventional maternity care reduced infant morbidity and hospital costs. *J Matern Fetal Neonatal Med.* 2002;Mar11(3):204-210; Ross MG, Sandhu M, Bernis R, Nessim S, Bradonier JR, Hobel C. The West Los Angeles preterm birth prevention project II. Cost-effectiveness analysis of high risk pregnancy interventions. *Obstet Gynecol.* 1994;83(4): 506-511

³ Latendresse, G., "The Interaction Between Chronic Stress and Pregnancy: Preterm Birth from a Biobehavioral Perspective" *J Midwifery Womens Health.* 2009; 54(1): 8-17.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2651684/> accessed 1-29-13

⁴ California Maternal Quality Care Collaborative: http://www.cmqcc.org/maternal_mortality.

⁵ *The California Pregnancy-Associated Mortality Review: Report from 2002-2003 Maternal Death Reviews*, California Department of Public Health (April 2011)

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POLICY & ACTION FROM
CONSUMER REPORTS



CHILDREN NOW



January 30, 2013

Peter Lee, Executive Director
Covered California

Toby Douglas, Director
Department of Health Care Services

Re: BSD2 – CalHEERS-SAWS-MEDS Interface

Dear DHCS and Covered California Board and Staff:

Thank you for providing us the opportunity to review and comment on the “BSD2 – CalHEERS-SAWS-MEDS Interface” (hereinafter “BSD2”). On behalf of the undersigned, we submit these group comments.

Scope

The scope of the BSD2 is to “extend Health Exchange functionality for California.” We urge that the scope recognize the importance of implementing the systems changes for Medi-Cal and CHIP and the exchange of information for all the affected programs – Medi-Cal and CHIP, as well as the Exchange.

Non-MAGI Screening

In a number of places, the BSD2 refers to an applicant “indicat[ing] they may be eligible for Non-MAGI Medi-Cal,” which triggers a referral from CalHEERS to SAWS for the determination of non-MAGI Medi-Cal. *See, e.g.* 3.1 Business Process Model, page 4; 3.2.4 CalHEERS Access Channel, page 7. Further, in places the document suggests that the consumer has to “authorize a referral.” *See* .2.4 CalHEERS Access Channel, page 7. It is not up to an applicant to know whether they may be eligible for non-MAGI Medi-Cal or to request a referral to the county for processing. Rather, the application and CalHEERS functionality should be structured in such a way as to identify those potentially eligible for non-MAGI, e.g. those 65 or who have a disability, and those applications should be automatically sent to SAWS. As discussed below, the notices of action (NOA) regarding MAGI eligibility should inform the applicant that s/he is being assessed for other types of Medi-Cal.

In several of the scenarios with a non-MAGI path, the BSD2 has a step where SAWS sends a denial to the person applying for non-MAGI Medi-Cal. *See, e.g.* page 11, step 19. We are unclear what this “denial” is when the applicant has already received a NOA about their MAGI eligibility in step 9 and about their non-MAGI Medi-Cal in step 34.

In all of the scenarios with a non-MAGI Medi-Cal path, the figure shows a time lag between SAWS receiving the cases and making a determination. Whereas with a MAGI determination, the outcome desired is articulated as a real-time determination, there is no indication what the time lapse will be for non-MAGI Medi-Cal. The BSD2 should specify the outside windows of 45 days or, if there is a disability determination, 90 days from the time of application.

The document should clarify what is meant by the term “Non-MAGI Medi-Cal.” We assume the term as used in this BSD document means “Medi-Cal without a share of cost.” Is our assumption correct? If not, and if you instead mean to include Medi-Cal “with a share of cost,” then we would have a series of comments and questions.

Based on our assumption that “Non-MAGI Medi-Cal” means Medi-Cal without a share of cost, the BSD has no scenario for what is to happen when SAWS/the county finds the individual eligible for non-MAGI Medi-Cal with a share of cost. Where will those scenarios be addressed?

MAGI Medi-Cal Determinations

In several places, the BSD2 indicates for cases initiated at CalHEERS, that after CalHEERS has made an eligibility determination for a MAGI program, the case will be re-run by SAWS. For example, on page 3, the BSD2 outlines that SAWS will “initiate a re-run of the eligibility determination” for mixed families. Similarly, in Scenario 3.2.4.2 MAGI Medi-Cal with non-MAGI Medi-Cal path, the BSD2 indicates that after CalHEERS has determined the applicant eligible for MAGI Medi-Cal, “SAWS processes the case and confirms the eligibility.” See page 14, step 12. Since there will only be one MAGI Rules Engine that resides in CalHEERS, with the business rules for both APTCs and MAGI Medi-Cal, there is no reason for SAWS to re-run the case. SAWS would simply be running the case back through the CalHEERS MAGI Rules Engine. This step is duplicative, unnecessary, and detrimental to consumers who should be getting their eligibility determinations in real time through CalHEERS with a reasonable opportunity to address income and other verification discrepancies before eligibility is denied.

Mixed Coverage Families

Mixed coverage families, with individuals within the family eligible for different insurance affordability programs (e.g., advanced premium tax credits (APTCs), cost-sharing reductions, Medi-Cal, or CHIP) are those who will most benefit from a smooth interface between CalHEERS and SAWS/MEDS. We have identified a number of areas where we believe the proposed interface is contrary to a single, streamlined eligibility and enrollment system.

The Business Process Model (on page 4) notes that for MAGI Medi-Cal eligible cases, the household data is transferred to SAWS. However, it is our understanding that the newly proposed federal rules require one single, electronic account to store applicant/enrollee data in one shared place. (See our notes in miscellaneous, below). For applications (and families) that have some members eligible for APTCs and others eligible for Medi-Cal, we recommend that the system maintain the electronic account with the full family case information in one place. The proposed NPRM has added a new definition of “electronic account” with corresponding scenarios where the account would be transferred between Medi-Cal and CalHEERS and the BSD2 should be revised to reflect the NPRM. The unified case view (page 39) should be clarified for all channels and reflect the requirements for an electronic account in the proposed Federal regulations.

We also have questions around renewal processes for mixed families, which should be clarified in the BSD2. Will the programs send coordinated renewal packets and operate a coordinated renewal/redetermination processes for individuals with mixed coverage but in the same family? We understand that this may not always be possible, for example if someone has a Medi-Cal annual renewal period in April, but where the Medi-Cal annual renewal period aligns with Exchange Open Enrollment or a special enrollment period, the family should only receive one renewal packet.

Inter-County Transfers (ICTs)

Under section 3.2.5.7 (pages 56-59), the BSD2 states the receiving county would “initiate[] the run of the CalHEERS BRE to determine eligibility.” This is inconsistent with Medi-Cal policy, which emphatically states that a redetermination of eligibility is not a part of the ICT process and prohibits counties from “redetermin[ing] eligibility in the new county of residence solely due to the change in county residence.” See, All County Welfare Directors Letter (ACWDL) No. 03-12 (February 21, 2012); See also, ACWDL No. 04-14 (April 30, 2004). Please clarify in the BSD2 that eligibility will not be redetermined as part of the ICT process, but rather that the consumer’s eligibility for Medi-Cal will simply be moved from one county to the other county.

Notices of Action

We commend both agencies for having the foresight to develop an interface to allow for a single streamlined notice of action (NOA) for all MAGI eligibility determinations, in conformance with the newly released proposed Federal regulations. We think the plan, however, can be strengthened to better communicate to applicants and enrollees the relationship between MAGI and non-MAGI determinations. (We also have questions regarding NOAs and non-health programs, which we’ve included in that section, below.)

In all cases where there are APTC and/or MAGI Medi-Cal/CHIP determinations done by CalHEERS and there is also an indication of possible non-MAGI eligibility such that the case is transferred to a county for a non-MAGI Medi-Cal determination, the MAGI eligibility determination NOA must inform the applicant that her/his case is being transferred to the county system for a non-MAGI determination, in addition to providing information on the APTC and/or MAGI determinations. There are repeated instances throughout the BSD2 where there is no indication that the NOA will inform applicants of the transfer to the county for a non-MAGI determination (e.g., page 10, Table 4, Step 9; page 15, Table 5, Step 17; page 19, Table 6, Step 17). Specifically, we request that in addition to the NOA informing about MAGI Medi-Cal and APTC eligibility, as noted in the BSD2, the NOA also should inform the consumer that she is being considered for other types of Medi-Cal.

There are a number of places in the BSD2 that fail to include a NOA, when one is warranted. For example, Table 8 (pages 26-27) traces the path when a change in data has been reported by the consumer, which could potentially result in a rerun of eligibility and a discontinuance or other result. The proposed path is missing the important step where a NOA is issued to inform the consumer of the outcome of the rerun of eligibility. For example, in instances where an enrollee will change programs because of a change of circumstances, the outlined steps do not include a requirement to issue a NOA. The CalHEERS/SAWS/MEDS interface should provide a NOA with information about the eligibility change and that s/he will be moved to a different program. Similarly, there is no NOA included in the steps for the Mass Eligibility Batch Run (pages 55-56), which might also result in a discontinuance or other change in eligibility status.

Proposed federal regulations allow for consumers to choose that notices be delivered electronically, rather than through paper mail delivery. See 42 CFR 435.918 and 45 CFR 155.230(d). Electronic communication includes an e-mail sent to the consumer informing him/her that an NOA has been posted to his/her account. It should be made clear in the BSD2 that the NOAs are being sent by the method chosen by the consumer. Further, section 435.918(a)(5) provides that, if an electronic communication is undeliverable, a written notice must be sent by regular mail within three business days of the date of the failed electronic communication. CalHEERS and SAWS must be programmed to address these situations where there is a failed electronic communication and be designed to verify that the written notice is sent timely. Ideally, written notice should be sent not only if the e-mail transmission fails, but if CalHEERS determines that the notice posted to the consumer's account has not been accessed within a reasonable time period, e.g. three days. This may indicate a problem with the electronic communication, even if the e-mail transmission did not come back as undeliverable.

Updates and Discontinuances

The "possibilities" for a consumer reporting a change, on page 25, are all scenarios in which the consumer reporting a change in CalHEERS is starting by being enrolled in APTC/CSR. However, a consumer who applied through CalHEERS and was enrolled into Medi-Cal might choose to return to the CalHEERS portal to update her information and should be able to do so. Accordingly, the "possibilities" in this figure should include those starting in Medi-Cal, as well.

We appreciate that the BSD2 envisions that if a mixed coverage family reports a change to one system, that information is sent to the other system. A family should only have to report changes in either CalHEERS or SAWS and have the information transmitted to the other system as needed. (See proposed Federal rules on electronic accounts.)

Plan Enrollment

The BSD2 is largely silent about plan enrollment, but those details that are provided concern us. Consumers have the right to apply through any of the four channels and the application process should include plan enrollment immediately following eligibility determination if the consumer chooses. Without plan enrollment, on the Exchange and CHIP sides, the consumer does not have coverage. If a consumer applies in person at the county and is determined eligible for APTC, she should be able to enroll in a plan at the same visit. However, the BSD2 instead calls for SAWS to send the APTC/CSR case to CalHEERS for Plan Enrollment. See page 33. This is not real-time enrollment. The consumer should be able to enroll immediately in a health plan sitting in the county social services office if she so chooses.

Even in the CalHEERS Access Channel scenarios, there is no detail about how plan choice will occur, where the enrollment information will be stored, and how the interface will function. Just as someone applying at the county determined eligible for APTC/CSR should be able to choose a plan at the county office, someone applying online through CalHEERS and determined

eligible for MAGI Medi-Cal or APTC should be able to pick their plan online and have that information transmitted as needed to MEDS and SAWS.

Regardless of the channel, with family applications each member should be able to select plans all at the same time. For example, if applying through CalHEERS, all family members should be able to be enrolled and select a plan even if the MAGI cases are transferred to SAWS. Similarly, families applying at a county office should be able to select a plan for all family members while there, as opposed to APTC eligible members' cases being sent to CalHEERS for future plan selection.

At what point in the business service process is a MAGI Medi-Cal eligible person "enrolled" in coverage (e.g. receives a BIC number and selects a health plan)? Is it when the CalHEERS or SAWS makes an eligibility determination? Or is the individual expected to wait for the file to be transferred to SAWS, where the case waits in the "transfer from CalHEERS queue" for an eligibility worker to create a SAWS case and SAWS confirms eligibility (steps #10-12 of the table on pages 18 and 19)? Again, what is SAWS "confirming" about eligibility for MAGI Medi-Cal if the BRE for MAGI Medi-Cal is housed in CalHEERS?

"Mass Eligibility Batch Runs"

The descriptions of the Mass Eligibility Batch Runs seem to contemplate running enrollees' information against electronic databases and changing the enrollees' eligibility and enrollment based on the newly acquired information. Nowhere in Table 9 describing this process are the affected enrollees given an opportunity to correct information pulled, given notice and appeal rights or otherwise informed of the changes to their eligibility and enrollment. Perhaps the statement "these outcomes have been described in previous CalHEERS Access Channel scenarios" (p.27) means that those pathways' descriptions of NOAs will be followed. However, it is critical to be explicit about this and to indicate for all pathways when a consumer will have an opportunity to correct information pulled from the federal verification hub or state databases which may be outdated or incorrect, as required by regulations and fair information practice principles.

In instances where mass eligibility batch runs are warranted, on the Medi-Cal side the BSD2 suggest changing the consumers' enrollment regardless of their circumstances and ignoring legal requirements. For example, under California law, children on Medi-Cal are entitled to "Continuous Eligibility for Children," whereby even if their family income goes up they remain on Medi-Cal. In addition to building in the opportunities for consumer correction of information and notice and appeals processes, the BSD2 needs to include a step whereby mass eligibility runs exclude those persons who are entitled to ongoing eligibility, such as children, former foster youth and pregnant women until the end of the postpartum period.

According to the BSD2, Mass Eligibility Batch Runs can result in aid code changes and discountinances. However, there is no information offered about when such a run would be done or what the reason for these runs is. We are strongly opposed to "trolling" for apparent

changes in eligibility. Individuals and families are already required to report changes affecting eligibility.

Verifications

The SAWS Access Channel scenarios include a step after verification through CalHEERS when it is determined whether the verification rules are satisfied. If the electronic verification was not successful, the case is sent back to the eligibility worker for review and potential administrative verification. While we hope, in most cases, verification can be done electronically, we understand that at times administrative verification will be necessary. However, the CalHEERS Access Channel scenarios do not show how administrative verification will be performed and need to spell that out and recirculate the draft for public review and comment. We hope the next iteration will include an explanation of the process and timeframes for all individuals to clarify discrepancies between the electronic verification and the information they have provided on their applications or renewal forms.

In addition, the BSD2 does not address whether the data from the federal and state interfaced systems (the federal data services hub and/or state agencies) will be used for pre-populating applications or renewal forms. For example, scenario 3.2.4 refers to verification of submitted data with no indication of possible pre-population. The recently released draft Federal model application template features a pre-population of income information. What is envisioned for interfacing with data source systems with regard to pre-population of applications and renewal forms? We encourage the systems to allow for the pre-population of applications and renewal forms at least as much as featured in the draft Federal application template.

We are pleased to see that the BSD2 notes real time interfacing (e.g., 4.2.1.1), however, in the last section about technical specifications (4.2) it speaks about real time as between SAWS and CalHEERS, but not with respect to the federal data services hub and other state databases. We look forward to seeing further information about real-time interfacing with these other databases.

Horizontal integration

We appreciate that the system interface is being designed to consider horizontal integration. We have specific suggestions for each of the sections, below:

Section 3.2.4 CalHEERS Access Channel, Scenarios .1-.4

We strongly support that all the scenarios include the following integration of services for consumers:

- CalHEERS will send information to SAWS, including “indication if someone is applying for non-health services programs (e.g. CalWORKS, CalFresh).”
- The Eligibility Worker will run determinations, “if applicable, for other non-health programs,” using the information received from CalHEERS and shared with SAWS.

We believe incorporating these two measures in all cases will provide the consumer with the best access and service to other vital supports for health and well-being, such as CalFresh and CalWORKS.

We look forward to seeing the CalHEERS user interface that presents this functionality. We recommend that it utilize the information already provided to CalHEERS to encourage potentially-eligible consumers to apply for other non-health services and to seamlessly provide consumers with a pre-populated SAWS on-line application for non-health services.

Section 3.2.4.7 Application Referrals

Since in the BSD2, most of this section is incomplete (TBD), we request that we be provided the opportunity to see the detail as it is developed and before it is implemented.

Section 3.2.5 SAWS Access Channel, Scenarios .1-.4

Again, we strongly support that all the scenarios state that the Eligibility Worker will run determinations, “if applicable, for other non-health programs.”

While the scenarios in this section only address “in person” applications at a County Welfare Office, we would like clarity about whether they are handled differently if a person applies:

- Via a SAWS on-line application?
- By telephone, after a call to and quick sort by the Covered California Service Center and transfer to the networked County Call Centers?
- By calling their local county welfare office directly?
- By mailing or faxing their local county welfare office?

Cross-cutting across both CalHEERS and SAWS channels.

We have a number of questions about the consumers’ experience of their health and non-health services as either integrated or siloed:

- Will NOAs issued by CalHEERS on health services (all CalHEERS scenarios) also, where applicable, include determination or information about other non-health services, or will Counties provide separate NOAs on non-health services?
- Will consumers have two case numbers/pins for health services, one in CalHEERS and one in SAWS, but only one, the SAWS case number/pin, to access their non-health services?
- Will all updates/changes that consumers provide to SAWS (3.2.5.5.) be shared with CalHEERS, even if only enrolled in non-health programs via SAWS?
- Will ITC protocols (3.2.5.7) created for Medi-Cal also apply to non-health programs, so both transfer together?

Privacy and security of SAWS

With significant transfers between SAWS and CalHEERS, we think it is important to assure that the same privacy and security measures that we have recommended for CalHEERS are applied to SAWS and MEDS. In particular, both SAWS and MEDS may need to be technically updated to ensure that they have the capacity for Covered California and DHCS to track and monitor activity in the two systems. We want to be sure that SAWS and MEDS have the technical capacity to produce audit trails to ensure that any manual changes made clearly identify the person or user making those changes, with date stamps, and the ability to track what portions of the data has been changed and by whom. To maintain the security and the integrity of the audit trail, each user of the SAWS and MEDS systems should have a unique user identifier. We have made detailed comments about privacy and security measures in CalHEERS. (See our comments on the draft solicitation and subsequent comments to the business requirements.) We would like to be assured that those same protections will be extended to SAWS and MEDS before January 1, 2014.

Miscellaneous

Below are a number of other outstanding issues or questions we raise, which don't fall into the above broader categories:

- We were unclear about what the BSD2 means in regard to the “discrepancy review” (e.g., pages 34, 39, and 45 in both the text and in the charts). From SAWS, the eligibility worker initiates a CalHEERS determination through BRE for MAGI, the results are sent back to the eligibility worker, the eligibility worker reviews the determination for “discrepancy,” and then accepts and saves it. What “discrepancy” does this refer to (pages 34 and 39 in text and in chart)? What are the criteria for the “discrepancy review”?
- The path as described beginning on page 34 describes the situation where a consumer comes to the county welfare office and is determined eligible for MAGI Medi-Cal. However, the detailed path which follows shows the consumer found ineligible for MAGI Medi-Cal. but eligible for APTCs. This is confusing and should be corrected.
- In numerous sections of the BSD2, references to “County Welfare Office” should be replaced with “County Social Services Office” – see section 3.2.5.2 (page 34), and section 3.2.5.3 (page 39).
- We recognize that the BSD2 was drafted prior to the public release of proposed regulations for Medicaid/CHIP and Exchanges. As we have been reviewing those draft regulations, we noted a number of instances where the BSD2 would need to be revised in order to conform to Federal regulations. Assuming the regulations are adopted

similar to what has been drafted, some of the changes required to the CalHEERS/SAWS/MEDS interface would include:

- Design of a single electronic account for each applicant/enrollee where CalHEERS and SAWS would share the storage of information, including information used for a Medicaid fair hearing and a Covered California appeal. (See revisions to regulation section 435.4.)
- Changes to the entire BSD2 to reflect that appeals would not follow the existing process, but would allow for consolidated appeals of Medi-Cal/CHIP and Exchange. In fact, the BSD2 does not seem to address appeals at all. Since they are an integral part of the eligibility, enrollment and retention system and will involve much coordination among the three computer systems, it seems critical that steps regarding appeal processing should be mapped out. Following up on denial NOAs being sent, the systems will have to be able to accept appeal requests, assign tracking numbers and keep track of the appeals as they progress, send notices to applicants/enrollees at various stages of the appeals process, coordinate with agency personnel handling both the informal and formal levels of appeals, allow for acceptance of additional documentation from applicants/enrollees in support of their appeals, and transmit and maintain appeal decisions and documentation relied on for those decisions, among other tasks. All this information will have to be processed and maintained in both systems, so that applicants/enrollees can access the information through whichever port they chose to enter.
- Currently, MAXIMUS manages Medi-Cal (formerly Healthy Families) premium collection. There is no mention anywhere in BSD2 of MAXIMUS or other systems managing the Medi-Cal premiums. Where will this functionality reside and how will it be coordinated among the different systems?
- Throughout the document, there is mention that “other state agencies will verify” information, in addition to the federal data services hub. What other state agencies are envisioned and how will their systems interface with CalHEERS, SAWS and MEDS in the BSD2? Will obtaining data and verification from these state agency data source occur in real time?
- On page 45 in a scenario where a consumer applies at a county office and both MAGI Medi-Cal and APTC/CSR are denied, CalHEERS sends the APTC/CSR denial to MEDS and SAWS sends the MAGI Medi-Cal denial to MEDS. This seems an unnecessary step – when both determinations were based on going through the same MAGI Rules Engine. It would be more administratively simple to have the agency making the MAGI determinations – whether CalHEERS or the counties, send all MAGI determinations to MEDS, rather than separate them.

- In scenario 3.2.5.2 (MAGI Medi-Cal with Non-MAGI Medi-Cal Path), there appears to be unnecessary staff intervention in the determination process as described. In this scenario, when the consumer walks into the county welfare office, the results of the eligibility rules run are “sent back” to the eligibility worker, “reviewed for discrepancy” and “accepted and saved.” Maybe it is envisioned as an automated process, but the way it is worded in the BSD2 seems overly “high touch.” Note, the same worker-intensive framing is used on page 39 regarding a mixed household non-MAGI path.
- Under scenario 3.2.1 (#2), why would an eligibility determination “bypass the Federal Hub Verification Call”? What instance would such a verification not occur?
- When can we expect to see the BSD provisions for application referrals (page 29)?
- If the federal and state databases do not confirm that the income an individual reports on the application is the correct amount:
 - Applicants for APTC/CSR must be given 90 days to resolve the discrepancy. How will the BSD address this?
 - What process will be available to resolve discrepancies for Medi-Cal MAGI applicants, and how will the BSD address it.

Once again, we appreciate having the opportunity to review and comment on important policy issues that are included in the development of information technology systems. We look forward to reviewing further documents, as they become available.

Sincerely,



Elizabeth A. Landsberg
Western Center on Law and Poverty



Julie Silas
Consumers Union

On behalf of:

Alliance to Transform CalFresh
Asian Law Alliance
Asian Pacific American Legal Center
California Food Policy Advocates
California Pan-Ethnic Health Network
Center for Democracy & Technology
Children Now

Community Health Councils
Congress of California Seniors
The Greenlining Institute
Maternal and Child Health Access
National Health Law Program
PICO California
The Children’s Partnership

Cc: Juli Baker

COVERED CALIFORNIA: Stakeholder Questions

CalHEERS Business Services Definition (BSD): CalHEERS – Statewide Automated Welfare System (SAWS) – Medi-Cal Eligibility Data System (MEDS) Interface

COVERED CALIFORNIA welcomes your comments on the CalHEERS BSD for the CalHEERS-SAWS-MEDS Interface. This document provides the business and technical approach for the data exchange between CalHEERS, SAWS, and MEDS Systems. This is a DRAFT document and some sections are still in work (see TBDs).

Please use the table below to provide your input. Please submit your comments to Covered California at info@hbex.ca.gov by close of business Tuesday, January 29, 2012.

| Name | Organization | Email | Phone |
|------------------|---|--|------------|
| Lindsey Angelats | San Francisco Department of Public Health | Lindsey.angelats@sfdph.org | 4155542615 |

| Section Number | Page Number | Comment |
|----------------|-------------|--|
| 3.2.4 | 7 | Please outline specifically what happens when services such as the Federal Data Hub can not verify the eligibility (e.g. income) data entered by the consumer in the CalHEERS consumer portal. This could be due to demographic mis-match or situations in which the client is unknown to the IRS because they are not a tax filer. |
| 2.3.1 | 3 | May be helpful to define what APTC/CSR is for the reader in the document |
| TR105.2 | 69 | As CalHEERS will be programmed to send SAWS information on whether the client is interested in non-health programs (e.g. CalFresh), can CalHEERS be programmed to identify clients who indicate they would like to be referred to County health programs, in the event they are found to be ineligible for both MAGI medi-cal, non-MAGI Medi-Cal, or a subsidy under the exchange? Adding this standard question would expedite a future referral process to the County indigent programs for the residually uninsured, via a regular file transfer of referrals either directly from CalHEERS or from the SAWS to the County. |
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COVERED CALIFORNIA: Stakeholder Questions

CalHEERS Business Services Definition (BSD): CalHEERS – Statewide Automated Welfare System (SAWS) – Medi-Cal Eligibility Data System (MEDS) Interface

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Please use the table below to provide your input. Please submit your comments to Covered California at info@hbex.ca.gov by close of business Tuesday, January 29, 2012.

| Name | Organization | Email | Phone |
|--------------|---------------------------|--|--------------|
| Lucy Streett | Social Interest Solutions | lstreett@socialinterest.org | 510-273-4644 |

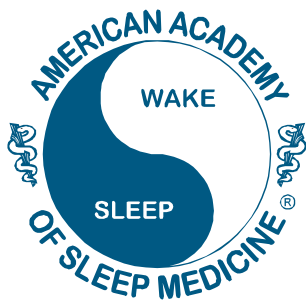
| Section Number | Page Number | Comment |
|----------------|-------------|---|
| 3.1 | 3 | <i>“SAWS initiates the re-run of eligibility determination for a mixed household, defined as containing either APTC/CSR and MAGI Medi-Cal and/or Non-MAGI Medi-Cal members.”</i> To clarify, does this mean that all mixed family members have to be redetermined by SAWS regardless of the disposition from CalHEERS? This would seem to conflict with federal rules that disallow duplication of any eligibility and verification findings (45 CFR 155.345). |
| 3.2.1 | 6 | <i>“The transfer function can include, but not limited to, the following: Non-health programs indicator such as CalFresh and CalWORKs.”</i> How will potential eligibility for CalFresh and CalWORKs be assessed? Will it be assessed for every applicant in every enrollment channel (i.e. online, phone, in-person)? Will this potential eligibility impact the timing of when the applicant/family get transferred to the county? |
| Fig. 2 | 9 | When a case is sent to the county and queued for processing (step 14), what are the performance standards for county determination? Specifically, how long will the counties have to establish the case and process eligibility? We have the same question for all of the scenarios in the Business Services Definition document. |
| Table 4 | 10 | <i>CalHEERS BRE determines all APTC/CSR eligibility; subsequently non-MAGI potential individuals sent to SAWS for processing. If applicable, CalHEERS discontinues the individual from APTC/CSR.</i> If an individual is found eligible for non-MAGI Medi-Cal with a share of cost, do they have the option to remain on APTC/CSR, or is that eligibility automatically overridden? Is this circumstance impacted by how large the share of cost is? Or, if the |



COVERED CALIFORNIA: Stakeholder Questions

CalHEERS Business Services Definition (BSD): CalHEERS – Statewide Automated Welfare System (SAWS) – Medi-Cal Eligibility Data System (MEDS) Interface

| Section Number | Page Number | Comment |
|-----------------|-------------|---|
| | | individual is ultimately denied for non-MAGI Medi-Cal, do they qualify for subsidies and Exchange coverage retroactively to the date of their initial CalHEERS or SAWS application? These same questions pertain to many of the other scenarios in the Business Services Definition document. |
| 4.3.4 | 64 | Is an effort to clean up the MEDS database to significantly reduce the existing duplicative records it contains included as part of the CalHEERS development effort? |
| Overall comment | | While it is very helpful to understand the systems interactions based on different business scenarios, it is difficult to provide comprehensive comments without a set of corresponding scenarios illustrating the process flow from the consumer perspective. |
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| | | |
| | | |



American Academy of Sleep Medicine

February 13, 2013

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

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Merrill Wise, MD

Jerome A. Barrett
Executive Director

RE: State Exchange Essential Health Benefits

Dear Mr. Lee,

As president of the American Academy of Sleep Medicine (AASM), a professional society formed in 1975 which currently represents over 10,000 sleep physicians, researchers and health care professionals and 2,500 sleep centers, I am writing to encourage your exchange to include sleep testing and treatment in your essential health benefit benchmark plan.

As you are aware, the Affordable Care Act (ACA) requires exchanges to offer a comprehensive package of items and services, known as “essential health benefits (EHB)”. The EHB must include items and services within at least the following 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management, and
10. Pediatric services, including oral and vision care

The field of sleep medicine is expanding and recently steps were taken to establish sleep as recognized medical specialty. In 2005, the American College of Graduate Medical Education (ACGME) began accrediting fellowship training programs in sleep medicine. In 2007, the American Board of Medical Specialties (ABSM) began offering a certification exam in sleep medicine. Currently, six ABMS member boards offer sleep medicine board certification on a biennial basis. Additionally, in 2011, CMS approved the AASM’s proposal to make sleep medicine a designated specialty.

Sleep medicine physicians treat a variety of sleep illnesses. It is estimated that about 70 million Americans suffer from sleep problems, with nearly 60 percent having a chronic disorder. One sleep illness that has a particularly detrimental impact on health and well-being is obstructive sleep apnea (OSA), which affects an estimated 12-18 million untreated adults in the U.S. OSA an under-diagnosed condition with an estimated prevalence of 4% in women and 9% in men.ⁱ OSA is characterized by episodes of complete or partial airway obstruction during sleep. OSA causes significant daytime impairment and is associated with costly health risks including hypertension and diabetes.^{ii,iii} Board certified sleep medicine physicians diagnose patients with OSA using overnight sleep testing known as polysomnography.

Patients diagnosed with OSA are commonly treated by using a type of durable medical equipment called continuous positive airway pressure (CPAP). The CPAP machine keeps the airway open by providing a constant stream of air through a mask while the patient sleeps. This eliminates the breathing pauses caused by sleep apnea. For patients with OSA, diagnosis and treatment is vital to their wellbeing, making it crucial for HHS to include sleep as an essential health benefit.

The Institute of Medicine (IOM) has outlined five criteria for essential health benefits in its 2011 report, *Essential Health Benefits: Balancing Coverage and Cost*^{iv}. These criteria state that the benefit must: be safe; be medically effective; demonstrate meaningful improvement; be a medical service; and be cost effective. Sleep medicine is a recognized specialty and sleep testing and treatment methods are recognized as being safe, effective and medically necessary.^{v,vi} Additionally, a cost effective analysis found the diagnosis and treatment of OSA per quality adjusted life year to be a good value, especially when compared to other interventions such as blood pressure lowering medications.^{vii} Specifically, sleep testing and treatment would fit into two of the 10 existing benefit categories: laboratory services; and/or preventive and wellness services and chronic disease management.

Sleep illness has reached epidemic proportions. In the past 10 years, Medicare has experienced a more than 250% growth in testing for OSA. OSA is most common in the elderly and obese populations, which are expanding rapidly. The percentage of these at-risk populations in the health care system will continue to grow as 32 million Americans will soon enter the health care system under the Affordable Care Act. These new patients will be looking to state exchanges for plans that cover care that is applicable to their needs. It is important that HHS includes sleep testing and treatment as essential health benefits for these at risk populations.

AASM requests a meeting with you or your colleagues to discuss this important issue. Please contact Ted Thurn, AASM Senior Health Policy and Government Affairs Analyst (tthurn@aasmnet.org) or Carolyn Winter-Rosenberg, AASM Director of Coding and Compliance (cwinter-rosenberg@aasmnet.org) by email or call at (630) 737-9700 to schedule a meeting.

Sincerely,

Samuel A. Fleishman, MD
President

cc: Jerome A. Barrett, Executive Director

ⁱ Young T; Palta M; Dempsey J; Peppard PE; Nieto FJ; Hla KM. Burden of sleep apnea: rationale, design, and major findings of the Wisconsin sleep cohort study. *WMJ* 2009;108(5):246-249.

ⁱⁱ Luyster FS; Strollo PJ; Zee PC; Walsh JK. Sleep: a health imperative. *SLEEP* 2012;35(6):727-734.

ⁱⁱⁱ Young T; Finn L; Peppard PE; Szklo-Coxe M; Austin D; Nieto FJ; Stubbs R; Hla KM. Sleep disordered breathing and mortality: eighteen-year follow-up of the Wisconsin sleep cohort. *SLEEP* 2008;31(8):1071-1078.

^{iv} IOM (Institute of Medicine). 2012. *Essential Health Benefits: Balancing Coverage and Cost*. Washington, DC: The National Academies Press.

^v Kushida, CA; Littner MR; Morgenthaler T et al. Practice parameters for the indications for polysomnography and related procedures: An update for 2005. *SLEEP* 2005;28(4):499-521.

^{vi} Kushida CA; Littner MR; Hirshkowitz M et al. Practice parameters for the use of continuous and bilevel positive airway pressure devices to treat adult patients with sleep-related breathing disorders. *SLEEP* 2006;29(3):375-380.

^{vii} Kapur VK; Alfonso-Cristancho R. Just a good deal or truly a steal? Medical cost savings and the impact on the cost-effectiveness of treating sleep apnea. *SLEEP* 2009;32(2):135-136.



ATTORNEYS AT LAW

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Mary Powers Antoine
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VIA E-MAIL & HAND DELIVERY

February 14, 2013

California Health Benefit Exchange
Attn: Brandon Ross
560 J Street, Suite 290
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Email: info@hbex.ca.gov

Dear Mr. Ross:

On behalf of the California Association of Dental Plans (CADP), I request your consideration of the following comments regarding the proposed regulations regarding pediatric dental health plan solicitation, Title 10, § 6446. Our comments are limited to addressing three Solicitation requirements, numbers 9, 34 and 44. These three requirements are inconsistent with current standards of operations in the dental plan industry and with regulatory compliance obligations imposed upon dental plans by the Knox-Keene Health Care Service Plan Act and the regulations enacted by the Department of Managed Health Care (the Knox Keene Laws).

(9) A successful Bidder must attest that it will use a health assessment tool to identify enrollees who are in need of covered restorative treatment services at the time of enrollment.

While CADP supports the general concept of a health assessment tool, such a tool is not in general use at this time, nor is it required by the DMHC. Compliance with this requirement would require the creation of a new set of processes not currently utilized by dental plans nor approved by the DMHC. This requirement would impose significant new obligations and burdens on dental plan applicants, requiring them to create and implement an untested and unapproved program immediately without scientifically confirmed data affirming the value and effectiveness of the tool.

(34) Confirm that the following programs or services will be made available to enrollees in 2014: risk assessments, disease management programs, and care reminders.

Dental plans will be unable to meet this requirement. No tool for risk assessments exists in the dental plan industry today, nor have any standards been established for the conduct of such risk assessments. CADP supports the development of such standards on an industry-wide basis based upon validated clinical studies, but it is not possible to have such a process in place by 2014.

Likewise, unlike in the full service plan industry, formal disease management programs are not generally available in the dental plan industry – they are not utilized for dental lines of business. Furthermore, there are no recognized or widely validated dental disease risk assessments for the practice of dentistry and the vast majority of dentists do not use risk assessments for their patients. Indeed, the examples of disease management provided in the response to bidder questions isolated diseases that are largely adult conditions (diabetes, heart disease, pregnancy). It is not clear if the imposition of a disease management program would apply to only the pediatric population, or to the entire population. But these types of issues would need to be worked through in order to develop a well-considered program that collects and verifies the proper diagnoses in order to apply a custom benefit for those who qualify, and then assess the efficacy of the program based on the collection of data, all of which needs to be reviewed and agreed to by all the parties involved.

It is noted in the Exchange's response to bidder questions on the dental solicitation that "risk assessment capabilities are not a mandatory component of the dental plan offering at this point, and the absence of such capabilities will not heavily weigh against bidders." (See Q&A number 29 of the Vendor Inquiry Responses: Dental 1.0, issued February 1, 2013.) If this is the position of the Exchange, it does not seem appropriate to include it as a requirement in the regulation.

The dental industry can commit to educational outreach and care reminders, which would not be too difficult to develop for 2014.

(44) Bidder must provide the percentage of Bidder's network providers that have office visit waiting times in excess of 30 days.

The metric of a general 30 day wait time for office visits is inconsistent with the requirements of the Knox Keene Laws. It is not currently used by dental plans, thus making compliance with this requirement inconsistent with current timely access compliance measurements as follows:

Title 28, § 1300.67.2.2 (c) (6) imposes the following accessibility standards for covered dental services as follows:

(A) Urgent appointments within the dental plan network shall be offered within 72 hours of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;

(B) Non-urgent appointments shall be offered within 36 business days of the request for appointment, except as provided in subsection (c)(6)(C); and

(C) Preventive dental care appointments shall be offered within 40 business days of the request for appointment.

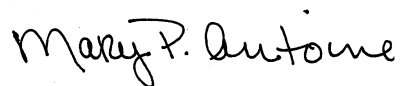
As evidenced by these current access standards, some appointments must be accessed sooner based on urgency of need, while other have a longer access standard. These standards were developed after long and detailed conversations between the DMHC, dental plans and consumer advocates. They reflect the DMHC's best judgment of what is needed to ensure appropriate protections for enrollees. Imposition of a general 30-day wait time standard by the Health Benefit Exchange is neither required by law, nor justified by any objective criteria. Furthermore, by failing to take into account the severity of the needs of the enrollee, the 30-day standard is meaningless and ineffective for measuring consumer protection.

The DMHC requires dental plans to show compliance with the accessibility standards set out in Title 28, § 1300.67.2.2 (c) (6), but it does not mandate that compliance be proven by any specific measurement. Collection of data regarding the *specific percentage* of providers with wait times in excess of 30 days is neither required nor practical. The Department recognized this reality when it drafted the timely access regulations with enough flexibility to permit dental plans to show compliance in many other ways. The DMHC carefully scrutinizes dental plans through filings and surveys to ensure the plans are complying with these access requirements.

In summary, these three requirements go beyond what is currently required of the dental plan industry today. The first two mentioned above will necessitate instituting new, untested and unapproved processes without the benefit of careful thought and development. The third requirement is inconsistent with current regulatory requirements with which dental plans already currently comply.

For all these reasons, CADP urges the Health Benefit Exchange to remove these requirements from the proposed regulation.

Very truly yours,

A handwritten signature in cursive script that reads "Mary P. Antoine".

Mary Powers Antoine
of Nossaman LLP

cc: Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814

February 20, 2013

SENT VIA EMAIL

California Health Benefit Exchange (CHBE)

Attn: Brandon Ross

560 J Street, Suite 290

Sacramento, CA 95814

info@hbex.ca.gov

Office of Administrative Law (OAL)

300 Capitol Mall, Suite 1250

Sacramento, CA 95814

staff@oal.ca.gov

RE: Proposed Emergency Regulations on the Process for Selecting Pediatric Dental Health Plans for the California Exchange

Dear Mr. Ross and OAL Staff:

On behalf of Delta Dental, I am writing to you today to address the emergency proposed regulations filed on behalf of the California Health Benefit Exchange with the Office of Administrative Law ("OAL") as posted on February 15, 2013. These proposed rules are currently under review by the OAL and concern the Exchange's contracting process and standards for selecting and contracting with pediatric essential health benefits ("EHB") dental plans for the offering of dental health insurance in the California Health Benefit Exchange ("Covered California").

In reviewing the proposed Emergency Regulations governing the process for soliciting and accepting bids to offer pediatric dental health plans through Covered California, we noticed the following issues:

- The definition of Pediatric EHB Dental Plans at Section 6446(b)(5) states that such plans "must meet all applicable requirements . . . including . . . prohibiting the imposition of frequency limitations on covered dental care." We believe the use of the term "frequency limitations" is incorrect, and is likely meant to reflect "annual maximums" which are indeed restricted from applying to EHB under the Affordable Care Act (ACA). It is in fact critical that "frequency limitations" in

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San Francisco

compliance with the benchmark limitations be expressly allowed with essential pediatric oral services as such limitations are used to curtail fraud, overtreatment and unnecessary expense.

- Section 6446(c)(9) states ‘A successful Bidder must attest that it will use a health assessment tool to identify enrollees who are in need of covered restorative treatment services at the time of enrollment.’

Response: While we support the general concept of a health assessment tool, no such tool is in general use at this time, there is no industry accepted or scientifically validated standard for such a tool, nor is it required by the DMHC. Compliance with this requirement would require the creation of a new set of processes not currently utilized by dental plans, not approved by the DMHC, and not verified based on evidence-based standards. This requirement would impose significant new obligations and burdens on dental plan applicants, requiring them to create and implement an untested and unapproved program immediately without scientifically confirmed data affirming the value and effectiveness of the tool.

Furthermore, at the time of enrollment, dental plans are in no position to assess the oral health of individuals who are signing up based on self-reported information, which inevitably is the only kind of health assessment that would be possible. Self-reporting at best could identify a history of dental disease, and perhaps whether a person is in pain, but such information is only minimally useful to the plan. Any one in pain knows they need to see a dental professional. The entire point of a dental check-up is to ensure an actual licensed professional is in the position of conducting a health assessment.

- Section 6446(c)(34) states ‘Confirm that the following programs or services will be made available to enrollees in 2014: risk assessments, disease management programs, and care reminders.’

Response: As with the health assessment tool, the lack of any uniform industry standard or scientific validation to implement these tools mean dental plans would in effect be turned loose to try and comply, without direction and unpredictable results. While there is a CDT code for risk assessment in the ADA code set, few dentists are trained to provide formal risk assessments, such assessments occur in the dental office and not with any dental plan involvement, and there exists no actual “disease management programs” in the oral health discipline. Patients at high risk of dental disease are generally counseled by their dentist to get treatment for their caries and or/periodontal disease, and advised by their provider on ways to minimize, avoid or treat reoccurrence of the conditions.

We support the development of such standards on an industry-wide basis based upon validated clinical studies, but to require that such a process be in place by 2014 is to invite wildly varying attempts with no uniform protocols and limited effectiveness. With respect to risk assessments, disease management and care reminders, dental plans lack the same stable of measures that are available to the

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full service plan industry– they are simply not utilized within dental lines of business.

Additionally, it is confusing as to whether disease management is meant to apply to both adult and pediatric coverage. The examples of disease management provided in the response to bidder questions isolated diseases that are largely adult conditions (diabetes, heart disease, pregnancy). It is not clear if the imposition of a disease management program would apply to only the pediatric population, or to the entire population. But these types of issues would need to be worked through in order to develop a thoughtful program that collects and verifies the proper diagnoses in order to apply a custom benefit for those who qualify, and then assess the efficacy of the program based on the collection of data, all of which needs to be reviewed and agreed to by all the parties involved.

Furthermore, it is noted in the Exchange’s response to bidder questions on the dental solicitation that “risk assessment capabilities are not a mandatory component of the dental plan offering at this point, and the absence of such capabilities will not heavily weigh against bidders.” (See Q&A number 29 of the Vendor Inquiry Responses: Dental 1.0, issued February 1, 2013.) If this is the position of the Exchange, it does not seem appropriate to include it as a requirement in the regulation. The dental industry can commit to educational outreach and care reminders, which would not be too difficult to develop for 2014.

- Section 6446(c)(44) states ‘Bidder must provide the percentage of Bidder's network providers that have office visit waiting times in excess of 30 days.’

Response: The metric of a general 30 day wait time for office visits is inconsistent with the requirements of the Knox Keene Act. It is not currently used by dental plans, thus making compliance with this requirement inconsistent with current timely access compliance measurements. Any required reporting should be based on Knox-Keene Act requirements. Current requirements are as follows:

Title 28, § 1300.67.2.2 (c) (6) imposes the following accessibility standards for covered dental services as follows:

- (A) Urgent appointments within the dental plan network shall be offered **within 72 hours** of the time of request for appointment, when consistent with the enrollee's individual needs and as required by professionally recognized standards of dental practice;*
- (B) Non-urgent appointments shall be offered **within 36 business days** of the request for appointment, except as provided in subsection (c)(6)(C); and*
- (C) Preventive dental care appointments shall be offered **within 40 business days** of the request for appointment.*

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As evidenced by these current access standards, some appointments must be accessed sooner based on urgency of need, while other have a longer access standard. These standards were developed after long and detailed conversations between the DMHC, dental plans and consumer advocates. They reflect the DMHC's best judgment of what is needed to ensure appropriate protections for enrollees. Imposition of a general 30-day wait time standard by the Health Benefit Exchange is neither required by law, nor justified by any objective criteria. Furthermore, by failing to take into account the severity of the needs of the enrollee, the 30-day standard is meaningless and ineffective for measuring consumer protection. The DMHC requires dental plans to show compliance with the accessibility standards set out in Title 28, § 1300.67.2.2 (c) (6), but it does not mandate that compliance be proven by any specific measurement. Collection of data regarding the *specific percentage* of providers with wait times in excess of 30 days is neither required nor practical. The Department recognized this reality when it drafted the timely access regulations with enough flexibility to permit dental plans to show compliance in many other ways. The DMHC carefully scrutinizes dental plans through filings and surveys to ensure the plans are complying with these access requirements.

In summary, these requirements go beyond what is currently required of the dental plan industry today, and impose costly administrative burden without any proven benefit for enrollees. The second and third items mentioned above will necessitate instituting new, untested and unapproved processes without the benefit of careful thought and development. The final requirement is inconsistent with current regulatory requirements with which dental plans already comply.

We would welcome any opportunity to meet or speak with you and/or any appropriate staff to discuss these matters. Please know that we stand ready to help when it comes to implementing the dental benefit provisions of the health care reform law.

If you have any questions, please do not hesitate to call me at (415) 972-8418.

Sincerely,



Jeff Album
Vice-President, Public and Government Affairs

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San Diego and
San Francisco

General Comment Received via E-mail

Subject: Testimony for January 17, 2013 Meeting

January 18, 2013

Dear California Health Benefits Exchange Board:

I attended yesterday's Board Meeting in Los Angeles, but was unable to stay until the end of the meeting since I had to catch a shuttle to the airport at 4:45 p.m. Here is my testimony:

My name is Jacquelyn Maruhashi. I am a staff attorney with the Asian Law Alliance (ALA). ALA is a non-profit community law office serving primarily low-income, limited English-speaking immigrants in Santa Clara County.

The Asian Law Alliance is a part of the Health Justice Network, a statewide coalition that works with Asian Americans, Native Hawaiians, and Pacific Islander communities to increase access to health care. I would like to address two topics: The Service Center Option and the Assisters Program.

Service Center Option:

We want a 30 second warm hand-off for Limited English Proficient (LEP) callers. If that is not possible, these callers should have the option to be assisted by the Customer Service Representative under Model 2.

Assisters Program:

We recommend flexibility in defining "leads." It is difficult to anticipate the health coverage eligibility of consumers especially in the uninsured low-income, LEP community. It is in California's best interest to insure as many Californians as possible for a healthier California.

Thank you.

Jacquelyn Maruhashi
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Asian Law Alliance
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California Health Benefit Exchange: Stakeholder Questions
Qualified Health Plans Model Contract

| Name | Organization | Email | Phone |
|---------------|-------------------|-----------------------------|---------------|
| Francene Mori | Anthem Blue Cross | Francene.mori@wellpoint.com | (805)557-5747 |

| Topic (for categorization purposes) | Comments/Questions |
|--|---|
| General Comments | |
| Statutory and Regulatory Compliance - | <p>The Qualified Health Plan Model Contract (“Contract”) is intended to define the contractual relationship between the California Health Benefit Exchange (“Exchange”) and a Health Insurance Issuer (“Contractor”) in relation to the marketing of qualified health plans through the exchange. Any contractor selected by the Exchange will be either an insurer regulated by the California Department of Insurance (“CDI”) or a health plan regulated by the California Department of Managed Health Care (“DMHC”). As a regulated entity, a Contractor will have an independent and ongoing obligation to comply with its applicable regulatory requirements arising under state or federal law notwithstanding any contractual obligations with the Exchange. The Contract contains several provisions that restate or paraphrase statutory and regulatory requirements that a Contractor must comply with. For example, section 39 states a requirement for a Contractor to comply with “the external review medical review process.” This language is inconsistent with current regulatory requirements. Also, by restating the requirement rather than citing the statutory or regulatory, the Contract will not match the applicable requirement in the event there is a statutory or regulatory change. This would result in a Contractor being subject to two separate requirements and potentially contradictory requirements. In such a case, a Contractor may be placed in the untenable position of being unable to comply with both requirements.</p> <p>Our understanding is that this language was included in the Contract to assure that Contractor’s were complying with these specific regulatory requirements. We propose that this goal can be achieved by including a provision that requires the Contractor to comply with applicable statutory and regulatory requirements under state and federal law. If deemed necessary, the provision could provide a non-exhaustive list of specific provisions. For example, for a Contractor regulated by the DMHC, the IMR requirement could be addressed by including a reference to Health and Safety Code § 1374.30 et seq. and the regulations promulgated there under.</p> |
| HIPAA Compliance | <p>Under the Contract, the Contractor would be providing coverage to enrollees and would be acting as a health plan and would therefore fall within the meaning of a covered entity as that term is defined by HIPAA. See e.g., 45 CFR § 160.103. By definition, the Exchange is specifically excluded from the definition of a health plan because the Exchange is not providing coverage and is at most providing funding for coverage through subsidies. Section 22 of the Contract is written on the assumption that the Exchange is a covered entity and because it is not, a Contractor would not be allowed to provide protected health information (“PHI”) to the</p> |

California Health Benefit Exchange: Stakeholder Questions
Qualified Health Plans Model Contract

| Topic (for categorization purposes) | Comments/Questions |
|---|--|
| | Exchange. If PHI was provided to the Exchange, the Contractor would be subject to liability under HIPAA. For these reasons, we recommend that section 22 be removed and compliance with HIPAA be specifically identified in the manner set forth in #1 above. All references to providing PHI to the Exchange in other provisions of the Contract should also be stricken. |
| Indemnification | The Contract is imposing significant contractual obligations on the Contractor. These obligations are in addition to the significant requirements already imposed by statutory and regulatory requirements. As noted above, there are several instances wherein the Exchange is imposing requirements on the Contractor in addition to the already existing regulatory requirements. A Contractor's ability to meet regulatory and contractual requirements are therefore not exclusively in the control of the Contractor and will be dependent on the Exchange performing defined functions in a timely manner. For these reasons the indemnity provision should be mutual. The provision should also be amended to provide for notice of the event giving rise to the claim of indemnity and the option to assume defense of the claim. |
| On/Off Exchange – | <p>The Contract contains several provisions regarding a Contractor's activity outside the Exchange. Section 14B specifically requires a Contractor to offer products outside the exchange. This is not consistent with the requirements of the cited statutes and regulations. To avoid such conflicts, we suggest compliance with these provisions be addressed as set forth in #1 above.</p> <p>Several provisions require a Contractor to provide information pertaining to its activities outside of the exchange. Sections 101 and 102 require a Contractor to provide to the Exchange its marketing activities outside of the Exchange. Such information is neither relevant nor necessary for the administration of the Exchange. Any requirements for the Contractor to provide the Exchange with off exchange activities should be removed.</p> |
| Upstreaming | Section 132 prohibits upstreaming of funds. This provision is unworkable and must be removed. |
| Balance Billing | Section 41 addresses enrollee liability for certain charges. It appears the Exchange is trying to prohibit balance billing and require a Contractor to pay billed charges in certain circumstances. This provision is inconsistent with applicable law wherein the prohibition on balance billing is limited to emergency services for DMHC regulated plans. In addition to not being within the statutory authority provided to the Exchange, this provision is creating an inconsistency and conflict with DMHC's regulatory authority. |
| Administrative Manual, Exchange Protection & Information Policy, Compliance Addendum and other documents not yet released. | Throughout the Model Contract there is reference to an Administrative Manual, Compliance Addendum and other documents not yet released by the Exchange. Although Anthem appreciates the opportunity to make comment on the Model Contract draft it is important that we review every document that is deemed part of the Model contract. The Exchange should not finalize the Model Contract until stakeholders are given the opportunity to review and make comment of the referenced materials. |

California Health Benefit Exchange: Stakeholder Questions
Qualified Health Plans Model Contract

| Topic (for categorization purposes) | Comments/Questions |
|--|---|
| Section 3 – Key Persons & Key Positions | Anthem would seek clarification on the Exchange’s definition of “key person” & “key positions”. Please provide the reason behind “Contractor shall not replace any such Key Person without prior Exchange approval”. Is the intent to provide “notification” to the Exchange or is this requirement truly “approval” from the Exchange? This requirement seems unnecessary since Anthem and other carriers through their normal course of business interview and retain the most competent and qualified associate for positions for their organizations. It is not in the Exchange’s authority to manage personnel within Anthem’s organization. |
| Section 3 – Dedicated Team | Anthem would like to understand what “X” represents and what determining factors will be used to get to a specific number. Anthem strives to provide excellent service to all its member’s and we will determine staffing changes as needed for the Exchange volume and other factors. If the Exchange maintains this provision, Anthem would like to understand the details and responsibilities of the areas specified as the “Dedicated Team”. |
| Section 4 – Required Notice of Contractor Changes | <p>The five (5) day requirement is insufficient amount of time with respect to notification. We would recommend the contractor to provide 30 days notice to the Exchange for changes.</p> <p>Anthem should have the authority and responsibility on staffing requirements and the ability to restructure their organization as they see relevant to changes in the marketplace, volume of membership and other factors. It is unclear to Anthem as to intent of the notifying the Exchange of change in the Account Management team. It is not in the Exchange’s authority to manage personnel within Anthem’s organization.</p> |
| Section 5 Insurance Requirements | Anthem believes this section should be removed from the contract. It will be cost prohibited for the Contractor to purchase Liability and Auto Insurance that covers the Exchange, its Board, contractors, officers, employees, agents and volunteers. |
| Section 6 – No Assignment or Delegation by Contractor | Anthem would need additional details and definition of “delegation” and to understand the justification of this requirement. How does this apply to a capitated delegated model? |
| Section 16 – Books, Records and Data Retention | Anthem would like to understand the data retention requirement. Standard industry requirements seem to differ from the 7 – 10 record retention provision in this section. Anthem should be expected to retain records based on state requirements for record retention. |
| Section 17 – Examination and Audit | Anthem request better clarity on the function of audit and examination. Since the Exchange is not a regulator and carriers are bound by HIPAA requirements the audit function should be removed from the Contract. Examination and audits are currently performed by the state regulators and Anthem will comply with state requirements. |
| Section 19 – Account Profit & Loss | Anthem would like to understand the details and intent of this request. |
| Section 36 – Service Performance Guarantee | If Anthem is subject to an audit by a third-party reviewer, we would like to review all processes/calculations used by the third-party reviewer for the required performance standards. |
| Section 40 – Service Area | Anthem would request guidance from the Exchange on processes that may overlap with existing regulatory |

California Health Benefit Exchange: Stakeholder Questions
Qualified Health Plans Model Contract

| Topic (for categorization purposes) | Comments/Questions |
|--|--|
| | requirements. |
| Section 43 – Submission & Maintenance of service area | Anthem will need additional clarity on the intent of this section. |
| Section 46 – Customer Service Obligation | <p>A. Once the Administrative Manual is released Anthem will be able to review and provided comment on the extended hours and requirements specified in the Admin. Manual.</p> <p>B. Exchange Customer Service Transfers – Anthem would like to understand the details of the transfer process so that we can better support the requirements.</p> <p>D.(iv) The Exchange should expect the contractors to comply with current state and federal translation requirements,</p> <p>G. (iii) Anthem would like the Exchange to consider other methods of delivery of new enrollee packets, including information sent electronically. This delivery method will reduce mailing costs and it will expedite delivery of information to the enrollee. We assume the Exchange will be flexible on the information that is delivered in the packet so long as the information is mailed or sent electronically within the required number of business days.</p> <p>H. Standard reporting, Anthem reserves the right to provide detail comments related to standard reporting once the Admin Manual is released.</p> |
| Section 54 - Communication to Enrollees | Anthem would like clarity on the intent of this section. We believe this will creates an administrative burden to the Exchange and can cause delay of the information to the enrollee. |
| Section 61 – Enrollment and Eligibility | Anthem requests that sections related to enrollment and eligibility of an enrollee can only be effectuated when the premium is remitted with enrollment. Current section does not indicate premium is required. In the Exchange technical meetings an 834 file of the eligibility information is to be provided to the Contractor, please provide clarity on this provision and what is expected from the Exchange related to Enrollment and Eligibility. |
| Section 65 – Conditions of Enrollment | Anthem would like clarity on the specifics Exchange's special enrollment procedures. |
| Section 70 – Consumer Enrollment Period Trial Rights | Anthem is concerned about this provision, if the Exchange can provide the administrative protocol that will be used for enrollees that have received services during this 60-day period and how that will be administered for deductibles and out-of-pocket maximums. |
| Section 74 - Termination of Coverage | Anthem would like to understand the criteria related to the remittance of partial payment. Anthem reserves the right to provide comment on this provision once the Admin. Manual is released. |
| Section 75 – Minimum Participation requirements | Anthem recommends the participation requirement to be 75% which is consistent with the current marketplace. |
| Section 80 – Charges to the Enrollee | The section is unclear Anthem would like the intent of the Exchange receiving the non-sufficient fund fees from the Contractor. |
| Section 84 – Consequences of Non-Payment of Premium | Should the Exchange require specific language on Exchange member notification there is potential to increase costs associated to this provision. System enhancements would be required to separate notifications to Exchange member's vs. non-Exchange members. |

California Health Benefit Exchange: Stakeholder Questions
Qualified Health Plans Model Contract

| Topic (for categorization purposes) | Comments/Questions |
|---|---|
| Section 85 – Schedule rates | E. Rates for Employer will be determined by Employer worksite. Premium rate calculation should be where the employee reside oppose to the Employer worksite. Changes to this calculation will require significant systems enhancement and can create concerns with the administration of Cal-Cobra. |
| Section 86 – Collection and remittance | Anthem expects that the Administrative Manual will provide details of the data files and turnaround times for the information that will be sent from the Exchange to the Contractor. |
| Section 88 – Primary Care and Preventive Services | PPO products do not require a PCP assignment. Anthem understands the intent of this provision; however, the provision would need to be appropriate for both the HMO and PPO model. The Exchange should understand that in some cases enrollees may not need a PCP visit within the first 120 days of enrollment and the carriers are limited in compelling a member to make a PCP appointment. |
| Section 91 – Patient-centered Care initiatives | Anthem would like additional information on this requirement and how the carriers details on how carriers should comply. |
| Section 94 – HEDIS effectiveness o Care Performance Rate | The Medicare population that is referenced in this section should be deleted since these requirements are related to the Exchange population. |
| Section 95 – CAHPs and HEDIS score reporting | The Medi-Cal Managed care Program that is referenced in this section should be deleted since these requirements are related to the Exchange population. |
| Section 100 – Branding Documents | Anthem is concerned that the proposed requirement that Contractors include the Exchange's brand name, logo and tagline on all billing statements and customer communications for those enrolled in QHPs would affect the affordability of products on the Exchange. Such a requirement would necessitate the Contractor to make significant changes to their current IT systems to program and build additional communication templates in order to be able to send different versions of the same communication to members depending only upon how the member elected to purchase their coverage. There is significant lead time that is also required for system development and testing. |
| Section 101 & 102 Marketing | Anthem would like all marketing requirements associated to non-Exchange plans removed from the contract. |
| Section 104 – Contractor's Partnership Responsibilities | In section B it indicates that the Contractors inside sales staff will be required to offer other QHP plans through the Exchange. This was not the policy set by the Exchange, please confirm and provide clarity related to this requirement. |
| Section 118 – No Conflicts or Consent | Anthem would like this section removed. It conflicts with the model contract and regulatory requirements |
| Section 120 – Power and Authority | Anthem believes section C can be a concern depending on when the Model Contract is executed. |
| Section 122 – Assignment of Antitrust Actions | Anthem would like this section removed on the grounds that it is addressed through regulatory oversight or accreditation. |
| Section 123 – 127 | These sections identify processes that are currently governed by the state regulators and therefore should be removed from the contract. |
| Section 125 – Physician/Hospital and Staff | The provider network staff is not employed by Anthem and therefore Anthem is unable to monitor turnover for Physician/Hospital staff. |

California Health Benefit Exchange: Stakeholder Questions
Qualified Health Plans Model Contract

| Topic (for categorization purposes) | Comments/Questions |
|---|---|
| Turnover | |
| Section 129 – Conflict of Interest | Anthem would seek clarification on how a “Key Person” of the Contractor can have fiduciary duty or exclusive loyalty to the Exchange. |
| Section 138 – Time is of the Essence | Unclear to what the intent of this section is. |
| Section 140 - Subcontractors | |
| Section 143 - Legal Action | This provision should only apply to legal action that is applicable to the Exchange. |
| Section 145 – Publicity | Anthem would seek clarification on what the Exchange considers an “announcement” this section seems very broad. |
| Section 148 – Evaluation of Contractor | Anthem would like to understand the detail terms of this section and processes in which the Exchange discontinues the Agreement. What processes will it entail so that there is limited disruption to the enrollees. |
| Attachment 3 - Performance Guarantees | <p>Anthem assumes the Exchange will be required to meet the same set of performance standards as the Contractor. Given the complexity of all the market changes effective in 2014, we believe the performance standards that are set in this provision are unrealistic. At least for the first year we should set reasonable expectations for the performance standards that both the Exchange and the Contractors can strive to meet with the understanding there will be a learning curve for the enrollees and assister, compounded with the implementation of new systems. Anthem would like to partner with the Exchange to create reasonable and appropriate performance standards</p> <p>Anthem would like to better understand the details of the reports being requested and the timing of them. Anthem strives to provide the best in class service and would like to work with the Exchange on identifying reports that will help monitor and reflect service center performance. Reports generated frequently or with information that isn't of value will create a burdensome administrative process for the Exchange as well as the Contractor.</p> |
| Attachment 6 – Required Reports | Anthem would need to understand the requirements and details of the reports listed in order to provide the appropriate recommendation. |



California School Health Centers Association

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Dexter Webster, MBA
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Operations

Executive Director
Serena Clayton, PhD

January 24, 2013

Peter Lee
Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Re: Comments Qualified Health Plan Model Contract

Dear Mr. Lee:

Thank you for the opportunity to comment on the proposed Covered California health plan contract.

We support Covered California's use of HEDIS and CAHPS measures for accreditation and reporting. Additionally, we encourage Covered California to use measures that focus specifically on the particular health needs of children and youth, as their participation in California's Exchange is essential to its success.

- ***We highly recommend using the full set of 24 CMS Initial Core Set of Children's Health Care Quality Measures (CHIPRA).*** The CHIPRA measures were authorized by Section 401(a) of the *Child Health Insurance Program Reauthorization Act of 2009* (CHIPRA) and then expanded and improved upon through the Pediatric Quality Measures Program (PQMP) established by Section 401(b). Many of these measures are not currently used in reporting for Medi-Cal health plans and are essential in tracking the wellbeing of children and youth. Examples include measures focusing on diabetes, asthma, clamidia and weight assessment and counseling.ⁱ
- Because adolescents are well-known as a difficult population to reach and serve, and because they need to be frequently assessed to make sure development is on track, ***we recommend that the Exchange incorporate the Young Adult Health Care Survey (YAHCS) into its plan reporting requirements.*** In California, YAHCS is used to survey teen and young adult subscribers of the Healthy Families Program to assess how well the health care system provides them with preventive care in the following eight categories:
 - Counseling and Screening to Prevent Risky Behaviors;
 - Counseling and Screening to Prevent Unwanted Pregnancy and STDs;
 - Counseling and Screening Related to Diet, Weight and Exercise;



California School Health Centers Association

- Counseling and Screening Related to Depression, Mental Health and Relationships;
- Care Provided in a Confidential and Private Setting;
- Helpfulness of Counseling Provided;
- Communication and Experience of Care; and,
- Health Information

We also encourage Covered California to closely monitor how specific populations fare with regard to access to care provided. Where possible, health plans should report their outcomes for specific populations, including children, teens, the elderly, very low-income populations, and racial/ethnic groups. Should outcomes for these groups indicate insufficient access to care, Covered California should re-evaluate its Essential Community Provider Definition to ensure that the needs of those who rely on the safety net are being met.

Finally, we believe the model contract should include more specificity about the coverage of child populations, including enrollees into child-only plans. This specificity is important because the provider networks (including essential community providers), benefits, quality initiatives, and performance metrics for children are unique and distinct from those for adults. In addition, the premium bid amounts for child-only coverage should be explicitly stated and reflect child and youth populations.

Thank you for your attention to these issues.

Sincerely,

Serena Clayton, Ph.D.
Executive Director
California School Health Centers Association

ⁱ Medi-Cal measures:

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2011/APL11-021.PDF>

Healthy Families Program measures: http://www.mrmib.ca.gov/MRMIB/HFP/2010_HFP_HE_DIS.pdf

Initial CHIPRA Core measures: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResourceManual.pdf>



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Roberta Lawson
RDH, MPH
Executive Administrator

January 18, 2013

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Diana S. Dooley, Board Chair
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Secretary Dooley:

The California Conference of Local Health Officers (CCLHO) urges Covered California to recognize the diagnosis and treatment of tuberculosis (TB) as an essential health benefit for all Californians.

CCLHO was established in statute in 1947 to advise the California Department of Health Services (now California Department of Public Health), other departments, boards, commissions, and officials of federal, state and local agencies, the Legislature and other organizations on all matters affecting health. CCLHO membership consists of all legally appointed physician health officers in California's 61 city and county jurisdictions.

TB in the United States remains a public safety concern, especially in California, which reports more than 20% of the TB cases in the country every year. When a person with active TB disease coughs infectious droplets into the air, anyone in continuous close contact breathing that air can become infected with TB. Even though TB is treatable, every other day a Californian dies with TB, and every week a young child is reported with TB disease in California. Prompt diagnosis, isolation, and treatment of TB is necessary to stop transmission in our California communities.

Because there is no effective vaccine to prevent TB, the only way to stop the spread of TB is to find and treat people with TB. Many people with normal immune systems are able to keep TB infection under control in a state that is not contagious. However, development of a medical condition like diabetes, HIV, cancer, immunosuppressive medical therapy or simply the aging process can cause TB infection to progress to active TB disease. Individuals with TB infection and risk factors for progression represent the reservoir of future active cases. Preventive treatment is the only way to effectively eliminate TB infection in this vulnerable population.

Diagnosis and treatment of TB must be accessible to all Californians as an essential health benefit and preventive care service with no cost sharing for the patient. This would encourage providers to include a TB risk assessment in their routine practice and execute targeted diagnosis and treatment of TB when identified at no additional cost to the patient. Making these services more accessible in all health care settings is critical for reducing the impact of TB in California, since some people with TB infection do not have symptoms. Removing cost sharing for TB diagnosis and treatment minimizes costly delays in detecting TB cases and improves opportunities to offer preventive treatment.

CCLHO recommends that the following services should be considered important preventative services as part of the routine diagnosis and treatment for TB disease and TB infection:

- Diagnostics, including tuberculosis skin tests and Quantiferon, blood work, radiological imaging, and microbiological testing
- Medical visits in the outpatient, emergency, and inpatient settings during evaluation and treatment for TB
- Drugs to treat TB, drug resistant TB, and the adverse effects that can be caused by anti-TB treatment.

Patients should not be required to share costs such as copays and deductibles for appropriate medical evaluation and treatment of TB.

Recognizing that the diagnosis and treatment of TB is an essential health benefit for Californians is central for continued TB control and to advance TB elimination in California. Making the diagnosis and treatment of TB as accessible as possible will aid California communities that are disproportionately affected by TB, and will lead to a healthier and more equitable California.

For more information about TB in California, please contact Julie Higashi, President of the California Tuberculosis Controller's Association at Julie.Higashi@ctca.org.

Sincerely,



Wilma J. Wooten, MD, MPH
President, California Conference of Local Health Officers

cc: Peter Lee, Executive Director, Covered California
Ron Chapman, MD, MPH, Director, California Department of Public Health

January 24, 2013

Peter Lee, Director
Andrea Rosen, Health Plan Management Director
Ken Wood, Senior Advisor for Products, Marketing and Health Plan Relationships
Covered California

Re: Proposed Model Contract

Via: info@hbex.ca.gov

Dear Mr. Lee, Ms. Rosen, and Mr. Wood:

Thank you for the opportunity to provide comments to the proposed Qualified Health Plan (QHP) Model Contract. Below, we offer suggestions on how to ensure that the contract can best serve consumers. We focus our comments specifically on those issues that we believe will have the greatest impact on consumers' experience with Covered California, its contracting QHPs, and the vendors, consultants, sub-contractors, and providers who will work with them.

We believe that the contract can be improved considerably by including stronger provisions on non-discrimination, language access, reporting, privacy and security, and references to California law. The Exchange has approved many recommendations to ensure language access for all Californians through its web portal, call center and written communications. However, for these provisions to be effective they must be strengthened in the Model Contract. Our over-arching, summary recommendations for strengthening are set forth below, followed by comments on selected sections in the order they appear in the Model Contract.

Non-Discrimination

The Model Contract language must be strengthened to ensure Covered California adheres to its mission to eliminate health disparities through equitable access to affordable, quality health care services. As currently drafted, the proposed Model Contract nondiscrimination provision is insufficient to prevent discrimination as it fails to include references to important federal and state consumer protections including Section 1557 of the ACA which expressly prohibits discrimination on the basis of race and national origin.^[1] The U.S. Department of Health and Human Services (HHS) has proposed additional nondiscrimination requirements including at 45 CFR 156.110 and 156.125 which should also be added to the contract. We offer several recommendations below to help strengthen the relevant sections.

Language Access

We appreciate Covered California's commitment to ensuring timely access to language services for California's Limited English Proficient (LEP) consumers who will comprise 40% of those newly eligible for subsidies in Covered California. However, the drafting of the relevant language access provisions in the Model Contract appear to be inconsistent.

We urge Covered California to strengthen these provisions by referencing state law where appropriate and ensuring consistency throughout the various provisions in the contract. We offer several specific recommendations below to help ensure LEP consumers are able to get the care need in a language they understand.

Reporting

There are a number of reporting provisions in the proposed Model Contract that should be strengthened to ensure that Covered California is able to obtain important demographic information and analyses about enrollees' experiences with the Contractor (in most cases, provided in the aggregate). As currently drafted, many of the provisions where the Exchange would benefit from reports on aggregate demographic data do not require such reporting.

In its mission, Covered California stated that it would be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities. To adhere to that mission, it is important for Covered California to collect aggregate data that will help reduce health disparities and to ensure that enrollees from diverse backgrounds are getting their needs met through the contracted QHPs. The model contract must specify that QHPs develop and maintain systems to collect and report data on QHP enrollees by race, ethnicity, gender, primary language, disability status, sexual orientation, and gender identity, and to stratify their quality and claims data by these demographics whenever possible. QHPs should also be required to develop and maintain systems to support the provision of culturally competent care to their enrollees. Without that collection and reporting of data, it will be challenging for Covered California to identify and remedy systemic problems. We note below a number of specific provisions that should be changed to include collection of aggregate data.

Privacy and Security

Health plans contracting with Covered California are covered entities and therefore subject to certain requirements under HIPAA and HITECH. This is acknowledged in the beginning in the proposed Model Contract. Those provisions also note that, with respect to certain administrative services, the plans will also be HIPAA "business associates." However, the provisions of the Model Contract do not distinguish between those obligations that apply to services provided as a business associate from those that apply to the Contractor's overall operations (for example, with respect to references to PHI and ePHI, it's not clear whether they apply to all PHI or ePHI held by the plan or just PHI/ePHI within the scope of the business associate services).

In addition, we question whether the provisions in the proposed Model Contract are sufficient to satisfy the HIPAA requirements for business associate agreements, as clarified by new final HIPAA rules released by the Federal HHS Office for Civil Rights late last week. For example, the contract generally references the scope of work but doesn't specify the permitted uses and disclosures of data relevant to that scope of work; in subsection C, it states that contractors are not permitted to disclose PHI in a way that would violate HIPAA or HITECH; but that statement is then caveated to say "however, Contractor may disclose PHI in a manner permitted pursuant to this Agreement," which seems to contradict the law that HIPAA (and any more stringent CA law) provide the outer boundaries for permitted data use. We suggest that a meeting with Covered California's HIPAA experts, the Center for Democracy & Technology, and Consumers

Union might be warranted to tease out and refine these issues and their solutions. We would be happy to set up a meeting as soon as possible to facilitate a quick discussion.

Specific Recommendations

In addition to the above over-arching issues, we have a number of specific sections of the Model Contract that we would recommend revising:

- Glossary (pages 1-9)
 - B - Administrative Manual (page 1) – a number of provisions reference the Administrative Manual, which was not available for us to review. Is that a public document that can be shared?
 - GG – Family Member (page 4) – the reference to 26 U.S.C. §36B(d)(1) does not fully cover the California definition of who can be covered in an enrollee or employee's family, since it fails to provide for coverage of domestic partners. The definition should be changed to reflect California law.
 - KKK – Patient-Centered Medical Home (page 6) – insert after “A health care setting” language that states, “that is accredited by an accreditor deemed sufficient by Covered California....” Without any parameters on the definition of a Patient-Centered Medical Home, such as accreditation standards, our concern is that consumers will be confused and plans will lack clarity on performance and other requirements.
- #14(C) – State and Federal Requirements - Network adequacy (page 16) – this provision should include not only a reference to federal law, but also to network adequacy requirements of DMHC and CDI.
- #14(E) Applications and Notices (p.18) – This provision referring to the federal requirement under the ACA that QHP issuers provide access to a provider directory under certain parameters should be strengthened by referencing state law as follows: “Contractor shall provide applications and notices to Enrollees in accordance with 45 C.F.R. 156.250 and **California Health and Safety Code Section 1367.04 [which requires health plans to include languages spoken by the provider and by staff.]**”
- #14(F) – Nondiscrimination (19) - This provision should be amended (amendments in red) as follows: “In accordance with ACA Sections 1201 and **1557** and 45 C.F.R. 156.200(e), **[156.110 and 156.125 as proposed by HHS]** and **California Government Code, Section 11135 through 11139.8**, Contractor shall not discriminate with respect to its QHP on the basis or race, color, national origin, disability, age, sex, gender identity, or sexual orientation. **To ensure compliance with Section 1557, Qualified Health Plan issuers shall develop and maintain systems to collect and report information on initiatives to support provision of culturally competent care to their enrollees. Such initiatives shall address cultural competency with regard to race, color, national origin, disability, gender, sexual orientation, and gender identity.**

Additionally Qualified Health Plan issuers shall develop and maintain systems to collect and report voluntary data on Qualified Health Plan enrollees by race, ethnicity, gender, primary language, disability status, sexual orientation, and

gender identity, and to stratify their quality and claims data by these characteristics whenever possible.

Covered California will enforce non-discrimination requirements and monitor for noncompliance. If the Exchange determines that a QHP issuer is not complying with the non-discrimination requirement and will not resume compliance with this provision, all of the contractor's QHPs affected by the noncompliance will be decertified."

- #14(M) – State and Federal Requirements – Marketing Requirements (page 19) – as above, this provision should reference state language and non-discrimination laws on marketing, not just federal laws. Additionally, the provision should explicitly prohibit QHPs from engaging in other types of discriminatory marketing practices that could result in cherry-picking: "Contractor shall not ~~by~~ engage in marketing practices or benefit designs that have the effect of discouraging enrollment in its QHPs by individuals with significant health needs, **race, color, national origin, language preference, disability, age, sex, gender identity, or sexual orientation.**"
- #14(N) – Accessibility and Readability (page 19)-- should conform with state law. We suggest the following amendment: "Contractor shall provide all applications, forms, and notices to Enrollees and applicants in accordance with 45 C.F.R. 155.205(c), 155.230, and 156.250 including (iii) taglines in ~~non-English languages~~ **at a minimum, Medi-Cal Managed Care threshold languages,** indicating the availability of language services."
- #22 – HIPAA, HITECH Act and Other Applicable Provisions (pages 22 – 30) –
 - B – Electronic Protected Health Information (EPHI) (page 26) – there is no definition in the glossary about what is meant by EPHI.
 - E – Reporting of Disclosures of PHI – This provision needs to reflect California state law, Civil Code sections 1798.82 and 1798.29, that require disclosures to enrollees in the most expedient time possible and without unreasonable delay." The current provision provides no time parameters for reporting a breach to the individual affected, contrary to California law. We have attached a memorandum from Center for Democracy & Technology and Consumers Union that provides a detailed description of California law.
 - G – Agreements by Third Parties (page 27) - Contract language should be added to ensure that the federal regulatory requirement on plans to apply the same or "more stringent" privacy and security standards to all vendors, contractors, sub-contractors, issuers, health plans, agents, navigators, and other relevant entities as a condition of contract or agreement (suggested additions in red): "Contractor shall enter into an agreement with any agent, ~~or~~ subcontractor, **vendor, provider, or other relevant entity** that will have ..." and "... which such agent, ~~or~~ subcontractor, **vendor, provider, or other relevant entity agrees to be bound by the same or more stringent privacy and security standards, restrictions, terms and conditions...**"
 - G – Agreements by Third Parties (page 27) - Contract language with third parties must include: 1) common terms and standards that cannot be

- modified; 2) the federal prohibition regarding use and disclosure of Exchange information for non-Exchange purposes; and 3) an explicit prohibition against re-identification of any disclosed de-identified data.
- H – Access to PHI (page 27) - HITECH requires that plans provide PHI to individuals in electronic form, if the data is stored electronically. This requirement should be part of the standard agreement.
 - S and T– Breach of security (pages 29-30) – California law has strong protections and standards to meet when breaches of security occur. A reference to California Civil Code sections 1798.82 and 1798.29 should be included in these provisions. As well, the standards from state law for reporting and remedying breaches should apply. See, for example, our notes on E, above, when there is a breach of unencrypted personally identifiable information, state law requires the breach be reported in "the most expedient time possible, without unreasonable delay," but no longer than 4 days, which is stronger than the proposed Model Contract provision proposed standard that simply requires reporting to the Exchange within 4 days. The QHP should report breaches to the Exchange under the same timelines as required for reporting breaches to the affected individual/s. (See attached Center for Democracy & Technology and Consumers Union memo on California security law.)
- #41—Liability of Enrollee for certain Charges--We very much appreciate and support the Exchange's efforts herein to protect consumers from balance billing when they use out-of-network providers. We also support allowing consumers to use out-of-network providers on a non-urgent, non-referral basis, with a full understanding of the financial implications of doing so. We thus urge you to add to this provision a requirement that (in red): "**Contractor shall provide a plain language notice to enrollees on enrollment of the financial implications of using out-of-network providers.**" We believe the language in #41(A) needs to be refined to clearly reflect enrollee's right to use out-of-network providers, with the caveat of reduced reimbursement, which we understand to be the intent of that provision.
 - #46(A)(ii) – Customer Service Obligations (page 39)-- We strongly support requiring QHPs to include welcome messages in English and Spanish on their telephone system. This provision should be amended to include QHP threshold languages (new text in red): "(ii) Contractor shall use a telephone system that includes welcome messages in English, and Spanish **and Contractor's threshold languages**. The customer service representatives staffing the call center shall include bilingual (~~English and Spanish~~) representatives **in Contractor's threshold languages**, and shall be trained to contact the telephone interpreter service for other non-English speaking Enrollees."
 - #46(A)(iii) – Customer Service Obligations (page 39) There seems to be some confusion regarding state requirements for oral interpreter services versus requirements for written translations. We offer a clarification below. We also recommend that the Exchange collect data on the cost and utilization numbers for interpreter services provided (new text in red): "(iii) ~~Translation~~ **Oral** interpreter services shall be available **at no cost** for non-English speaking or hearing-impaired Enrollees **in any language** during regular business hours. Contractor shall monitor the quality and accessibility of call center services on an ongoing basis. Contractor shall report to the Exchange, in a format and frequency to be

determined by the Exchange, on the volume of calls received by the call center, **cost, and utilization numbers by language for interpreters** and Contractor's ability to meet the Performance Guarantees."

- #46(A)(iv) – Customer Service Obligations (page 39) – We support strongly the importance of including an obligation on the QHP to provide extended customer service hours to correspond to the Exchange's Service Center, during open enrollment periods.
- #46(C)(i) – Customer Care (page 39) Amend to include federal citation here: "(i) Contractor shall comply with the requirements of the Americans with Disabilities Act and provide culturally competent customer service to all Exchange enrollees **in accordance with 45 C.F.R. 155.205 and 155.210 [which refer to consumer assistance tools and the provision of culturally and linguistically appropriate information] and related provisions.**"
- #46(D)(iv) – Notices (page 40) – Covered California's interpretation of language access requirements should be amended to reflect state law as follows: "(iv) All legally required notices sent by Contractor to Enrollees shall be translated into ~~the thirteen (13) Medi-Cal~~ **the Contractor's threshold languages. Threshold languages shall be determined by Contractor based on thresholds established by California Health and Safety Code Section 1367.04 or Medi-Cal Managed Care contracts, whichever is lower, every three years as required by law.**"
- #46(G)(i) and (ii) – Plan Materials (pages 40-41) – This provision contains no specified timeline by which the plans must provide materials to the Exchange for review and approval before they are used. Later provisions (e.g., #54 on page 47), however, specify that the Plan must provide enrollee materials to the Exchange for review and approval at least 14 days prior to mailing to enrollees. For new enrollee materials, the contractor shall mail a sample at least 45 days prior to the open enrollment period. The same language should be inserted in these provisions, or cross-referenced.

Additionally, this provision should be amended to ensure consistency with state language access laws. We suggest the following amendments to this provision (new text in red): "(ii) Enrollee materials shall be available in English, and Spanish **and the Contractor's threshold languages.** Contractor shall translate all written materials for Enrollees into **the Contractor's threshold languages. Threshold languages shall be determined by Contractor based on thresholds established by California Health and Safety Code Section 1367.04 or Medi-Cal Managed Care contracts, whichever is lower, every three years as required by law.** ~~Spanish and any language representing the preferred mode of communication for 3,000 or more Enrollees as indicated on the enrollment file.~~ Contractor shall ensure that Enrollees who are unable to read the written materials have an alternate form of access to the contents of the written materials. Enrollee materials shall be written in plain language, as that term is defined in the Regulations. Plan materials that require Exchange review and approval before usage are those that communicate specific eligibility and enrollment information to Enrollees. Such materials include, but are not limited to,

- a. Welcome letters

- b. Billing notices and statements
- c. Notices of action
- d. Termination letters
- e. Postcard regarding Evidence of Coverage
- f. Grievance process materials
- g. Drug formulary
- h. Uniform Summary of Benefits and Coverage
- e. Other materials required by the Exchange”

- #46(G)(iii)(b) – New Enrollee Enrollment Packets (page 41) should be amended to reflect state language access laws as follows: “b. Contractor shall maintain sufficient numbers of enrollment packet materials, Summary Plan Descriptions, claim forms and other Plan-related documents in ~~both English, and Spanish~~ **and Contractor’s threshold languages** to meet all requirements of this Agreement for timely mailing and delivery of Plan materials to Enrollees. Contractor shall be responsible for storing and stocking all materials.”
- #46(G)(iv) – Summary Plan Description (page 41) should be amended to reflect state language access laws as follows: “Contractor shall develop and maintain a Summary Plan Description which shall be available to Enrollees online and shall be sent to Enrollees on request. The Summary Plan Description online and the hard copy sent to Enrollees on request shall be available to Enrollees in English, ~~and Spanish~~ **and Contractor’s threshold languages**.”
- #46(G)(v) – Electronic Listing of Participating Providers (page 42) should be amended to: “Contractor shall create and maintain an electronic listing of all Participating Providers, **including languages spoken by the physician and languages spoken by staff**, and make it available online for Plan Enrollees, potential Enrollees, and Participating Providers, 24 hours a day, 7 days a week.”
- #46(G)(ix) – Secure Plan Website for Enrollees and Providers (page 42) should be amended to reflect state language access laws as follows: “Contractor shall maintain a secure web site, 24 hours, 7 days a week. All content on the secure Enrollee website shall be available in English upon implementation of Plan, ~~and in Spanish~~ within thirty (30) days after the Effective Date **and Contractor’s threshold languages**.”
- #46(H) – Standard Reports (pages 42-43) – In addition to the points of data identified in this section that should be reported to the Exchange, information regarding aggregate demographics should be required as well (e.g., use of plan website by age, race, ethnicity, primary language, location, etc.).
- #47(A) – Agent and General Agent Commissions (pages 43-44)-- We are not certain that “compensation programs” encompasses both dollar amounts/percentages and other terms of compensation, such as fee waivers and other incentives. In case it does not, we suggest the following clarifying language: “Contractor must use the same agent compensation ~~programs~~ **levels and terms** as it uses for business sold outside of the Exchange.”

- #47 – Agent and General Agent Commissions (page 44) –We suggest the following additions:
 - “Contractor shall prohibit higher commissions, or other direct or indirect consideration, in the first year of a policy versus renewal years [in order to discourage churning and promote recertification].”
 - “Contractor shall disclose to the Exchange its payment programs for agents.”
 - The contract should be clear that the Exchange retains its right to post on its website a statement that indicates agents receive compensation, e.g., “Agents receive compensation from the insurer for enrolling you in their Qualified Health Plan.”
- #48(C) – Agent Appointments (page 44) – The language should be revised to require that agents have to be trained by the Exchange (addition in red): “Contractor may appoint an agent to sell Exchange-based products only if the agent is **trained and** certified by the Exchange.”
- #50 and #51 – Network Disruption Policy and Alternate Arrangements (pages 44-46) – The provisions should be revised to provide the protections required under the continuity of care and block transfer provisions of California’s Health and Safety Code (Sections 1373.95 and 1373.96).
- #50(C) – Network Disruption Policy (page 45) – In addition to the points of data identified in this section that should be reported to the Exchange, information regarding aggregate demographics should be required as well; e.g., number of Exchange Enrollees affected by the termination by plan and by county, as well as by age, race/ethnicity, location, etc.
- #54 – Information Mailed to Exchange Enrollees (page 47) – The language should be revised to require Contractors to submit materials in English and the Contractor’s threshold languages to Covered California for review: “Contractors should be required to provide the Exchange with at least one (1) copy **in each of the Contractor’s threshold languages** unless otherwise specified, of any information Contractor intends to mail to all Exchange Enrollees...”
 - #55 – Grievance Process (pages 47-48)—Consumers should get the benefit of the most protective grievance processes in state law. We thus urge that: “Contractor shall afford enrollees a grievance process that shall comply with the standards set forth in California Health and Safety Code, as embellished upon in 28 CCR Article 8.” This would ensure, for example, that urgent complaints be resolved within 72 hours. If this suggestion is adopted, Attachment 3—“Performance Guarantees” chart p. 4, regarding complaint resolution (95% complaint resolution within 30 days) would need to be adjusted.
- #57 – Mailing Responsibility (page 48) - This provision addresses Evidence of Coverage requirements, but we find no mention in the Model Contract of the Federal requirement to provide a **Summary of Benefits and Coverage (SBC)**. A

provision regarding this Federal requirement to provide the SBC to each enrollee should be incorporated into the Model Contract.

- #60 – Out-of-Network Services (page 49, see also #41)
 - This provision should be revised to include a requirement to “... provide enrollees notice **in the Summary of Benefits and Coverage, that payment will be reduced for non-participating providers and that they will be liable for charges in some circumstances.**”
 - We support the requirement that providers inform “every Enrollee” when a network provider proposes to use a non-network provider or facility as well as the expected cost, if any, to the enrollee. This provision should also address language access to require, at a minimum, that the information is provided in both English and Spanish and Contractor’s threshold languages and provides clear information about access to translation and interpretation in other languages.
- #71 – Eligibility for Enrollment (page 52) – As stated regarding definition of Family member in Glossary (D), the reference to “Family Members” should conform to California law to include domestic partners.
- #88 – Consequences for Non-Payment of Premium – (54-55) We recommend that Covered California review or provide written translations of “Exchange-approved” appeals language to ensure accuracy.
- #88 – Primary Care and Preventive services (page 56) – As we stated in our comments to the QHP Advisory Committee:
 - #88(A) - The contract should make it clear that patient self-selection of a PCP or PCMH (including out-of-network PCPs, where allowed) during the enrollment process is preferred and will take precedence over an auto-assignment approach. In cases where enrollees do not select a PCP or PCMH on their own, we would like to see rules with respect to the default algorithm, if any, Covered California will require plans to use for auto-assignment. The algorithm should include patient’s language preferences, gender preferences, geographic location, and shorter appointment wait times.
 - #88(B) - It is not appropriate for enrollees that have a pre-existing relationship with their primary care provider, and are up-to-date on their preventive care, to be subject to the proposed requirement or for plans to be measured on this (even if the enrollee is new to the plan). We recommend a requirement that issuers provide an incentive for enrollees with no pre-existing relationship with their PCP or PCMH to go in for an initial or free preventive care visit to establish a relationship with their new doctor. As stated, it should not be a requirement on the patient, but a requirement on the plans to provide the incentive. The issuer could report to the Exchange how many enrollees, in aggregate, met the criteria for receiving the incentive and how many responded to the incentive.
- #90(A) – Reporting Quality of Care Assessment (page 56) should be amended to require reporting of demographic data as follows: “Contractor shall provide

periodic reports that describe the types of care provided to Enrollees. Report requirements and formats will be outlined in the Administrative Manual. Examples of these reports include: A. Claims and encounter data **by race, ethnicity and primary language**; volume by type of provider.” Additionally, if not otherwise addressed by current state law, Covered California should add a provision that “Contractor shall not permit any contract provisions with providers that prevent disclosure of provider information to the Exchange or to the public.”

- #91(E) – Patient-Centered Care Initiatives and Enrollee Communication (page 57) should be amended to be conform with state language access laws as follows: “Contractor must provide or make arrangements for **language oral interpretation and translation services** for its Enrollees **in accordance with California Health and Safety Code Section 1367.04 including but not limited to** at 1) point of care 2) contacting the QHP, and 3) accessing QHP providers.”
- #91(F) – Patient-Centered Care Initiatives and Enrollee Communication (page 57) should be amended to ensure compliance with state language access laws as follows: “Contractor shall develop and deploy internal systems to ensure **timely access to language services and proficiency of interpreters** ~~the availability of appropriate language proficiency~~ at point of care and Enrollee support/services **in accordance with California Health and Safety Code Section 1367.04.**” Our suggestion for an accreditation requirement is included in our comment on the definition section.
- #92 – Quality and Access (page 57) – While we support innovation for quality improvement, the benefit of such must be weighed against the confusion that variations in benefit plans will create for consumers. As the NORC report commissioned by the Exchange identified, the main feature that consumers interviewed valued in the Exchange was the ability to make apples-to-apples comparisons. Any alternatives, no less an array of undefined variations, will do a disservice to consumers.
- #95 – CAHPS and HEDIS Score Reporting (page 58) – We support Covered California using CAHPS and HEDIS measures. However, Covered California should decide which HEDIS measures will be most appropriate for its eligible populations as they may be different than those required by the Medi-Cal Managed Care program. Also, we urge Covered California to require Contractors to use translated CAHPS surveys to better measure the quality of care for Limited English speaking populations and to analyze CAHPS and HEDIS measures by race, ethnicity and primary language. This information should be made publicly available by the Exchange. The CAHPS and HEDIS Score Reporting provision should be amended as follows: “Contractor shall report its scores on CAHPS, using the English and translated surveys, and HEDIS measures **analyzed by race, ethnicity and primary language. Information should be made publicly available on the Covered California website.** ~~as required the Medi-Cal Managed Care Program.~~”

#98 – Health Assessment (page 59) – We support offering enrollees a Health Assessment tool. However, the Contractor should “track the percentage of Exchange Enrollees that complete a Health Assessment (HA), **including by race,**

ethnicity and primary language during the 2014 plan year, [and] report results quarterly,”

- #99 – Changes Related to Quality of Care (page 60) – We believe the purpose of this provision needs to be clarified as the wording is unclear.
- #100 – 103 – Marketing Requirements and Plan Partnership (pages 60-61) – These provisions are unclear as currently drafted. For example, #101 on review of marketing materials says the contractor shall provide the material to the Exchange annually, where previous provisions require the Exchange to review and approve of marketing materials under specified time frames (e.g., #54 requires 14 days review and approval prior to mailing enrollee materials and 45 days for new enrollee materials prior to the open enrollment period). Additionally, we recommend that Covered California consider requiring QHPs to provide copies of their marketing materials in other languages for Covered California’s review to ensure against inaccuracies in translation, misinformation and other types of deceptive marketing practices.
- #104 – Contractor’s Partnership Responsibilities (page 61) – Language should be revised where noted (in red):
 - (B) – “Agree to have its inside sales staff **trained and** certified as Exchange agents...”
 - (C) – Equalizing commissions for all years, as suggested above, would serve the same purpose as encouraging recertification after the first year. We do not object to requiring plans to reinforce that idea through education, but query whether it is sound policy to encourage consumer sharing of health status information with agents for the purpose of calculating out-of-pocket estimates.
- #116 – Roll Over Program (pages 68-69) – We share the Exchange’s desire to capture as many of the subsidy-eligible “incumbents” in the individual market as possible, and appreciate this effort to solve the thorny problem of getting subsidies to already enrolled individuals. We do have some suggestions about this approach. When estimating the number of incumbents in each target population category, plans should use information they already have for their enrollees, and should not be asked or required to obtain financial eligibility information from their current enrollees. Transition plans for current enrollees should ensure that notices about potential eligibility and roll-over into Covered California should be provided to **all** enrollees, as in general plans will not know which current enrollees or COBRA enrollees will be subsidy-eligible. We presume, but would appreciate confirmation, that this does not envision having plans get access to CALHEERS.

Attachment 3--Performance Guarantees (pages 1-7) – It is not clear to us where these performance standards came from. The Managed Risk Medical Insurance Board has similar types of standards to which we would direct Covered California’s attention. We urge Covered California to require QHPs to develop and maintain systems to collect and report data on performance guarantees by race, ethnicity, gender, primary language, disability status, sexual orientation,

and gender identity, and to stratify measures by these demographics whenever possible.

Attachment 6-- Required Reports (page 1) – The list of required reports should include eValue8 module 1.7 on Health Disparities Reduction and Language Services. We also urge Covered California to require QHPs to report on CAHPS, using the English and translated surveys, and HEDIS measures **analyzed by race, ethnicity and primary language. Information should be made publicly available on the Covered California website.**

Thank you for the opportunity to provide input. We look forward to continuing work with you on the Model Contract. If you have any questions we can be reached at the contact information below.

Sincerely,



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Memorandum

April 26, 2012

The Center for Democracy and Technology (CDT) and Consumers Union (CU) understand that the three agencies are interested in receiving recommendations on how to proceed and what standards to use when/if a breach of security occurs through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). California's security breach notification laws governing a breach of security are some of the strongest in the nation. Unlike HIPAA¹ and other security rules, the California security breach notification law applies to all types of unencrypted², personal information³ stored electronically, not just medical or health information. Additionally, California's security breach notification laws apply to all parties, government agencies, businesses, and people conducting business in California, not just HIPAA-covered entities.

Under California Civil Code sections 1798.82 and 1798.29,⁴ CalHEERS and any of its vendors⁵ are required to disclose a breach of any unencrypted personally identifiable information stored electronically. The disclosure must be made in "the most expedient time possible, without unreasonable delay,"⁶ the highest standard that exists under federal or state law. In situations where the personal information that is breached is not owned by the agency or business, the standard for notification is "immediately following discovery."⁷

Under California law, CalHEERS and any of its vendors will be required to issue a security breach notification,⁸ either on paper or electronically,⁹ that meets the following requirements:

¹ HIPAA's Security Rule, 45 C.F.R. 164, applies to covered entities. Whether or not the Exchange will be a covered entity will depend on the functions it carries out.

² The security breach notification law does not include a definition of encrypted or unencrypted data nor does it set any standard for encrypting data. While HIPAA does not specifically use the word unencrypted, CU and CDT recommend that CalHEERS adopt HIPAA's definition of 'data not secured by a technology' that renders it "unusable, unreadable or indecipherable to unauthorized individuals" in order to set a standard for unencrypted data.

³ Under the security breach notification law "personal information" does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records. Cal. Civ. Code 1798.29(g) and 1798.82(i).

⁴ Cal. Civ. Code 1798.29(a) and 1798.82(a).

⁵ If the vendor is considered a business associate under HIPAA, the vendor has the option to follow HITECH's breach notification requirements set out in Section 13402(f) of the Act. Cal. Civ. Code and 1798.82(e).

⁶ Cal. Civ. Code 1798.29(a) and 1798.82(a).

⁷ Cal Civ. Code 1798.29(b) and 1798.82(b).

⁸ If CalHEERS demonstrates that the cost of providing notice would exceed \$250,000, or the affected class of subject persons to be notified exceeds 500,000, or the agency does not have sufficient contact information, the law provides for substitute notice. Cal. Civ. Code 1798.29(i) and 1798.82(j).

⁹ Further, under the circumstances where CalHEERS is required to issue a security breach notification to more than 500 California residents as a result of a single breach of the security system, CalHEERS or any vendors will also have to electronically submit a single sample copy of that security breach notification,

1. The security breach notification must be written in plain language; and
2. The security breach notification must include, at a minimum, the following information:
 - The name and contact information of the agency, in this case CalHEERS;
 - A list of the types of personal information that were or are reasonably believed to have been the subject of the breach;
 - The date of the notice and, if the information is possible to determine at the time the notice is provided, then any of the following:
 - The date of the breach,
 - The estimated date of the breach, or
 - The date range within which the breach occurred;
 - Whether the notification was delayed as a result of a law enforcement investigation, if that information is possible to determine at the time the notice is provided;
 - A general description of the breach incident, if that information is possible to determine at the time the notice is provided; and
 - The toll-free telephone numbers and addresses of the major credit reporting agencies, if the breach exposed a social security number or a driver's license or California identification card number.

The statute also provides agencies discretion to include additional information in a notification. CDT and CU recommend that CalHEERS make these provisions mandatory for breaches of information held by CalHEERS and its vendors in order to build trust in the new online system. Therefore the security breach notification should also include information about what CalHEERS has done to protect individuals whose information has been breached and advice on steps that the person whose information has been breached may take to protect himself or herself.

The security breach notification laws permit delayed notification only when "a law enforcement agency determines that it would impede a criminal investigation."¹⁰ The laws also require any entity that licenses such information to notify the owner or licensee of the information of any breach in the security of the data.¹¹

Finally, CDT and CU, in line with the structure of the California security breach notification laws, believe that no notice needs to be given, either to individuals or authorities, if the data is properly encrypted because it will be inaccessible.

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Julie Silas, Consumers Union, jsilas@consumer.org (415) 431-6747 ext. 106

excluding any personally identifiable information, to the state Attorney General. Cal. Civ. Code 1798.29(e) and 1798.82(f).

¹⁰ Cal. Civ. Code 1798.29(c) and 1798.82(c).

¹¹ Cal. Civ. Code 1798.29(b) and 1798.82(b).

February 11, 2013

California Health Benefit Exchange
560 J Street, Suite 290
Sacramento, CA 95814

RE: Qualified Health Plan Model Contract – First Draft

To Whom It May Concern:

The California Primary Care Association (CPCA) represents nearly 900 not-for-profit community clinics and health centers in California that provide comprehensive quality health care services to primarily low-income, uninsured, and underserved Californians.

CPCA appreciates the opportunity to provide feedback on the first draft of the Qualified Health Plan Model Contract. We thank the Covered California staff and Board for their efforts to engage and respond to the concerns of stakeholders and look forward to continuing our work together to ensure that the promise of the Affordable Care Act is accessible to all Californians.

1. #60: Out-of-Network Services: PPS Reimbursement for Patients Served

CPCA and our FQHC health centers remain concerned that Covered California's language regarding payment for non-contracted or out-of-network enrollees served by FQHCs fails to ensure payment of federally required PPS reimbursement. CPCA has consistently requested that Covered California issue guidelines that reflect the Center for Consumer Insurance Information and Oversight (CCIIO) guidance that states that "if a QHP issuer does not have a contract with an FQHC, the QHP issuer must pay the FQHC the Medicaid PPS rate for the items and services provided to the QHP enrollee." Unfortunately, Covered California's latest model contract language does not provide the protection referenced in the federal guidance.

CPCA requests that Covered California clarify Section #60 of the QHP Model Contract by stating that the "Contractor shall comply with federal rules requiring that a QHP issuer must pay an FQHC the relevant Medicaid PPS rate for the items and services that the FQHC provides to a QHP enrollee, if the QHP issuer and the FQHC have not contracted upon a mutually agreed upon rate that is at least equal to the QHP issuers generally applicable payment rate."

#84: Consequences of Non-Payment of Premium

CPCA is concerned about the provisions contained in Section #84 which states that contractors must agree to abide by the federal grace period rule for individuals receiving federal subsidies to purchase coverage through the Exchange. The federal rule under 45 C.F.R. §156.270(d)(3) requires QHP issuers to allow a three month grace period for enrollees who have paid at least one month's premium during the benefit year. Upon termination of an enrollee for non-payment of premiums at the end of the three-month grace period, this rule

allows issuers the option to pend and deny claims submitted in month two and three of the grace period, shifting the financial burden of the grace period onto the provider. HHS does allow in the final rule responses that “QHP issuers may still decide to pay claims for services rendered during that time period in accordance with company policy or State laws.”

California state licensing laws prohibit a plan or issuer that authorizes treatment from rescinding or modifying the authorization after the provider renders the service in good faith (see Health & Safety Code §1371.8; Insurance Code §796.04). **CPCA encourages Covered California to include provisions in the Model Contract that bind the issuer to pay claims submitted in the second and third months of the grace period and adhere to state licensing requirements regarding the payment of claims rendered in good faith.**

Thank you for the opportunity to respond to the above-referenced solicitation. Please do not hesitate to contact Meaghan McCamman by telephone at (916) 440-8170 or mmccamman@cpcac.org if you have any questions or comment or if you require any clarification on the comments presented herein.

January 24, 2013

SENT VIA EMAIL

California Health Benefit Exchange (CHBE)
560 J Street, Suite 290
Sacramento, CA 95814
info@hbex.ca.gov

RE: QHP Model Contract

Dear Exchange Staff:

On behalf of Delta Dental, I am writing to you today to address the Qualified Health Plan (QHP) Model Contract released on January 11th. This model contract addresses the Exchange's intended contracting standards for contracting with health plans for the offering of health insurance in the Health Benefit Exchange ("Covered California").

In reviewing the proposed Model Contract, we want to confirm that, as Standalone Dental Plans (SADPs) are not QHPs, this model contract does not apply to SADPs offering coverage in the Exchange. Furthermore, we anticipate that Exchange staff intends to propose a separate model contract for SADPs. We would support this approach as a separate contract would allow the Exchange to clearly delineate the distinct requirements that apply to SADPs as opposed to QHPs.

Additionally, the draft Model Contract contains a provision on page 16 that is worthy of comment. Specifically, the statement that SADPs certified to sell the pediatric dental benefit are not QHPs and therefore may not offer their products outside the Exchange is incorrect. Nothing in federal or state law bars a standalone dental product from being offered outside the exchange. Section 2707(d) of the Affordable Care Act specifically excludes dental only plans from the requirement to offer the Essential Health Benefit Package in the individual and small group market. Additionally, Section 10112.27 (i)(1) of the Insurance Code and Section 1367.005(i)(1) of the Health and Safety Code also exempt excepted benefit dental plans and specialized health care service plans from the requirement to provide the Essential Health Benefit Package outside the Exchange. These provisions do not in any way prohibit the sale of SADPs in the individual or small group market. Preserving the role of SADPs in the small group market is crucial for the large number of small employers who currently obtain coverage from a SADP.

Delta Dental of California
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100 First Street
San Francisco, CA 94105
Telephone: 415-972-8300

Southern California
Sales:
17871 Park Plaza Drive
Suite 200
Cerritos, CA 90703
Telephone: 562-403-4040

Commercial Programs
Claims Processing
Customer Service:
P.O. Box 997330
Sacramento, CA 95899-7330

Offices in:
Cerritos, Fresno,
Rancho Cordova,
San Diego and
San Francisco

Lastly, it would appear inappropriate for a provision regarding SADPs to be included in a contract negotiated by and between the exchange and QHPs, as QHPs are by definition not SADPs. We would suggest that this provision be removed from the QHP Model Contract and be addressed in the future in a SADP Model Contract.

We would welcome any opportunity to meet or speak with you and/or any appropriate staff to discuss these matters. Please know that we stand ready to help when it comes to implementing the dental benefit provisions of the health care reform law.

If you have any questions, please do not hesitate to call me at (415) 972-8418.

Sincerely,

A handwritten signature in black ink that reads "Jeff Album". The signature is written in a cursive, flowing style.

Jeff Album
Vice-President, Public and Government Affairs

Delta Dental of California
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Cerritos, Fresno,
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San Diego and
San Francisco



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JOAN PIRKLE SMITH
Americans for Democratic Action

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CA Black Health Network

ANTHONY WRIGHT
Executive Director

ORGANIZATION LISTED
FOR IDENTIFICATION PURPOSES

January 25, 2013

Ken Wood, Senior Advisor, Health Plan Management
Andrea Rosen, Acting Director, Health Plan Management
California Health Benefits Exchange
560 J St., Ste. 200
Sacramento, CA 95814

Re: QHP Model Contract

Dear Mr. Wood and Ms. Rosen,

Health Access California, the health consumer coalition committed to quality, affordable health care for all Californians for more than 25 years, has reviewed the QHP model contract and offers comments.

For ease of reference, these comments are provided in the order in which the model contract is presented. This does not necessarily reflect the priority of our concerns.

41. Liability of Enrollee for Certain Changes

Health Access supports the proposed contract language on liability of the enrollee for certain charges. We support the language that ensures the enrollee is not liable for payment to a non-participating provider in the case of emergency care, urgent care or care provided upon referral by an actual or ostensible agent of the contractor and that instead the carrier is liable for payment to the non-contracting provider. Health Access acknowledges that Exchange staff and stakeholders have struggled with this issue for some time now. This contract language which protects a consumer from balance billing as a result of emergency care, urgent care or care received as a result of a referral by a participating provider would provide better protections than existing law, particularly the Insurance Code. The proposed contract language would still require a consumer who knowingly sought care out of network to pay the non-network cost sharing for such care.

50. Network disruption policy

This policy does not provide the protections required under the continuity of care and block transfer provisions of the Health and Safety Code (Sections 1373.95 and 1373.96. Is there a reason that the proposed model contract includes a lesser standard than existing law?

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LOS ANGELES: 1930 Wilshire Blvd., Suite 916, Los Angeles, CA 90057 PH: 213.413.3587, FAX: 213.413.8631

www.health-access.org

88. Primary Care and Preventive Services

- A. Contractor s hall demonstrate to the Exchange that all new Enrollees are assigned to a primary care provider or a patient-centered medical home within 45 days of enrollment.

This standard is borrowed from Medi-Cal managed care where it was imposed when large numbers of Medi-Cal enrollees moved from fee-for-service to managed care. It resulted in substantial disruption of care even in that circumstance in which it was intended to facilitate care.

Many Exchange enrollees will previously have had coverage from another source, including employer-sponsored insurance, individual insurance or a public program or have had such coverage with only a brief interruption of coverage (63 days or less). While these may be new enrollees to the Exchange, the enrollees may not be new to the plan. For enrollees with previous coverage, the proposed contract provision may worsen disruptions of care rather than minimize them.

Conversely some enrollees in the Exchange will have been previously uninsured and should be connected to care promptly.

We suggest that this contract provision be amended to differentiate between new enrollees that have not had recent coverage (within 63 days or less) or that do not attest to an established relationship with a contracting provider of the plan selected and those enrollees that were uninsured for a period of time greater than 63 days prior to enrollment.

- B. Contractor s hall demonstrate that at least xx% of new enrollees receive a preventive services or equivalent visit within 120 days of enrollment. The Exchange may substitute this measure with equivalent HEDIS measures.

This proposed provision suffers the same defect as A.: it overlooks the reality that many enrollees new to the Exchange will not be new to coverage and may already be current in terms of preventive care. Further, there is a robust academic literature indicating that annual physicals are not only a waste of money but the precipitating event for unnecessary and wasteful care.

For new enrollees who have been uninsured for more than 63 days and who do not have an established relationship with a provider, an initial meeting in which necessary preventive services are reviewed and then provided as clinically appropriate might be appropriate care.

89. Enrollees with Existing Medical Needs

One means of identifying enrollees who have existing chronic conditions and who were previously covered would be to ask their treating physician for this information. Again,

this approach assumes that all new enrollees in the Exchange were previously uninsured when this is not the case. Again, we recommend that the contract distinguish between those consumers that have previously had coverage or had a brief break in coverage and those consumers that have been uninsured for a longer period of time (over 63 days).

90. Quality of Care Assessment

We trust that in future years, this will become a more detailed section looking at reducing medical errors and adverse events and other quality improvement as suggested in the QHP solicitation.

91. Patient-Centered Care Initiatives and Enrollee Communication

This is an area where the lack of health literacy, the need for cultural sensitivity and the barriers created by languages other than English compound the difficulties. Shared decision making may sound nice sitting in some fancy office but facing a person for whom English is not their first language, where both culture and health literacy may be very different than the bureaucrat making six figures creates real challenges that are not reflected in this objective.

92. Quality and access

Is the Exchange going to decide which quality and access initiatives should be priorities for carriers? Or is this carrier free choice with each carrier emphasizing a different approach?

104. Contractor's Partnership Responsibilities

C. Agree that a prospective Enrollee's health status is irrelevant to advice provided with respect to health plan selection *other than as it informs out-of-pocket calculation estimates*

So the Exchange is asking carriers to steer consumers to products based on the consumer's health status? And to do it specifically based on out of pocket costs? Expected out of pocket costs are an excellent surrogate for health status. This is the very definition of steering. So people with chronic conditions should pick gold and platinum products while people who think they are healthy should pick bronze and catastrophic? It is the intent of the Exchange to direct carriers to sort consumers into products based on anticipated health care needs? Will the Exchange also encourage carriers to market non-QHP products with lower premiums and skinnier benefits in order to skim off lives from the Exchange? It is the same theory.

Carriers should compete on price and quality, not on the excellence of their risk selection.

109. Contractor Insolvency

DMHC has a fiscal solvency board that reports routinely on which health plans face fiscal distress. Surely, the Exchange would wish to cease enrollment in a plan that is in financial distress? Waiting until a carrier is bankrupt is rather like letting the banking system freeze up. While we are less familiar with the CDI process for monitoring financial solvency of health insurers, we would hope that CDI also has information about health insurers in fiscal distress, long before they are bankrupt.

116. Roll Over Program

Health Access strongly supports the proposed roll over program. We are dismayed that there are 600,000 Californians today in the individual market who are paying such a high percentage of their income that they will be income eligible for Exchange subsidies: we very much appreciate the efforts of the Exchange staff to help these Californians get connected to help paying for coverage.

We also appreciate the recognition that moving forward, those Californians whose coverage is terminated for any reason or who are eligible for COBRA should also be connected to the Exchange in order to assure these Californians remain insured and take advantages of any subsidies for which they are eligible. We suggest that the Exchange add Cal-COBRA to these provisions.

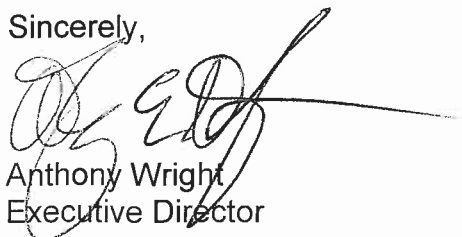
We look forward to seeing the marketing material that will “minimize market confusion” and that we hope will educate consumers about the opportunity get help paying for coverage. We hope that twenty or thirty years from now, applying for Exchange coverage when somebody loses their job or gets divorced or graduates from college is as automatic as applying for Medicare when someone turns 65: the roll over program is as important a step in this direction as the entire marketing and outreach plan.

Missing provision: Insurers as Employers

Where is the provision which requires health plans to provide health benefits to their employees? Health plans should at a minimum meet the employer responsibility requirements of the federal law and not face penalties for failing to offer coverage or offering unaffordable coverage that does not meet the minimum value test.

We look forward to continuing work with you on the QHP model contract. My information is (916) 442-2308 or awright@health-access.org .

Sincerely,



Anthony Wright
Executive Director



January 24, 2013

Mr. Peter M. Lee
Executive Director
California Health Benefit Exchange
Sacramento, CA 95814

RE: Kaiser Permanente Comments Regarding Draft Model Contract Provisions

Submitted electronically via info@hbex.ca.gov

Dear Mr. Lee:

Thank you for the opportunity to comment on the proposed draft model contract between licensed health plans and Covered California. We anticipate productive discussions to arrive at a document to govern what we hope will be a long-term partnership between Kaiser Permanente and Covered California.

Attached to this letter are detailed comments regarding a number of provisions in the draft model contract. We wish to summarize important points below.

Regulator or Active Purchaser?

We are strongly supportive of the expressed philosophy of Covered California leadership to function as an active purchaser, rather than as a regulator. Unfortunately, the extensive inclusion of various state and federal legal requirements into the draft model contract may have the effect of undermining this philosophical direction – even if unintended. We believe the Exchange would be well-served to review the draft model contract with an eye toward provisions that enhance its focus as an active purchaser, versus those that will pull the Exchange toward a more regulatory posture.

A simple approach the Exchange might consider: the law is the law. We see little value in restating these provisions in the draft model contract, other than to place the Exchange in the position of separately adjudicating regulatory matters. We recommend the Exchange focus on ensuring appropriate referrals to regulatory agencies for regulatory matters, rather than restating provisions of state (or federal) law in its contract.

In contrast, the provisions of the draft model contract that define customer service expectations, measures of health care quality including specific outcome metrics, and activities that contracting health plan can undertake to help the Exchange succeed in

gaining broad membership – while potentially quite rigorous – these, in our view, are more consistent with the philosophy of Covered California. Indeed, we believe these provisions should potentially be expanded.

Performance, quality guarantees

We are strongly supportive of customer service performance and health care quality guarantees, as noted above. We believe these provisions should be expanded to leverage health plan marketing efforts, to reward health care quality, and to reduce health disparities. We do, however, regard with considerable reservation draft provisions that would define quality in terms of physical office visits within a specific period of time. In our detailed comments, we note that many Exchange members will have ongoing relationships with providers, and therefore, visits tied to Exchange enrollment may be arbitrary and unrelated to clinical need. Similarly, the Exchange should exercise considerable caution in requiring the use of health care resources for those who are in good health.

Instead, we have a strong preference for extensive health outcomes reporting that tracks the performance of health plans on crucial preventive care and chronic disease management metrics across an entire population. We are interested in discussing with the Exchange evidence-based and efficient approaches to appropriate “on-boarding” of individuals who have not had prior health coverage, or who have or are at significant risk for chronic conditions.

Assisters

We are strongly supportive of the provisions in the draft model contract regarding health plans as “Assisters.” This approach attempts to leverage the unique capabilities and position of health plans in the marketplace that hold great promise in allowing the Exchange to achieve significant membership growth, rapidly and efficiently. We believe the success of health plans in bringing current individual and small group membership to the Exchange when subsidies are available, and their ongoing relationship to the large employer marketplace, which will be an ongoing source of Exchange membership, is vital to the success of Covered California.

Assessment on Off-Exchange QHPs

We have indicated previously are strong opposition to the proposed assessment of “off-Exchange” QHPs. Simply put, this approach penalizes plans that wish to be partners with the Exchange. Moreover, it is at odds with the goal of the Exchange to promote more standardization of benefit offerings in the individual and small group market, since plans will have an overwhelming financial incentive to “dilute” their off-Exchange offerings with as many non-QHP products as possible. Lastly, we must note that the draft Exchange budget does not appear to rely on these funds. Therefore, their purpose is unclear.

We agree that the Exchange will undertake a number of functions that are of significant value to the broader individual and small group markets. Designating QHPs, alone, is not the greatest of these – especially when the proposed assessment would primarily serve to minimize their use.

Operational Requirements – Value Added?

We ask that the Exchange consider the proposed operational requirements carefully to ensure they bring value to Covered California consumers. Provisions requiring extensive filing and review of general communication materials, marketing plans, the specific elements of member ID cards, and other requirements in the draft model contract all add to plan administrative costs and therefore, to the premiums Covered California members must pay. While none of these provisions is devoid of merit, we believe the test for the Exchange is whether the requirement adds significant value. The pennies saved in premium add up.

Moreover, “bandwidth” is a common term these days to describe the ability of organizations to manage complex demands. We submit that requirements the Exchange would impose via its contract with participating health plans, and therefore, that the Exchange must devote resources to track and oversee, should be considered in light of the “bandwidth” of the Exchange. What activities are the “vital few,” as the Exchange seeks to bring significant added value to the health care coverage available for all Californians? Those are the items that deserve a place in the contract. Words matter.

Again, thank you for the opportunity to comment on the draft model contract. We look forward to further discussions – and the opportunity to contribute our part in helping Covered California succeed in its crucial work.

Sincerely,

A handwritten signature in dark ink, appearing to read "Bill Wehrle". The signature is fluid and cursive, with the first name "Bill" being more prominent than the last name "Wehrle".

Bill Wehrle
Vice President, Health Insurance Exchanges

cc: Ken Wood
Andrea Rosen
David Panush, Director of Intergovernmental Relations

Kaiser Permanente Detailed Comments

QHP Draft Model Contract

ADMINISTRATIVE & OPERATIONAL REQUIREMENTS

Section 46 – Customer Service Obligations

G. (iv) Summary Plan Description – These are not used in the individual plan market, we recommend that this requirement be removed.

AGENTS

Section 47 – Agents and General Agent Commissions

D. The requirement to pay all agents the same would violate the contract terms of agents with grandfathered contracts. For some carriers, this requirement would result in much higher average broker agent commissions being paid in the individual market and would work strongly against affordability. We recommend that this requirement be dropped.

Section 48 – Agent Appointments

To streamline the broker sales process it would be prudent to make broker appointment with all participating carriers a requirement of the certification process for the individual exchange.

COMMUNICATIONS TO ENROLLEES

Section 56 - ID cards

The requirement to include the employer name on ID cards is contrary to standard practice and would add administrative complexity and expense for the SHOP, and would likely result in delayed production and availability of ID cards for SHOP members. In addition, we doubt its usefulness to Covered Californian members. We strongly recommend that this requirement be dropped.

ENROLLMENT PROVISIONS FOR SHOP

Section 72 – Initial Group Applications

The requirement to accept new group enrollment effective on the 15th of the month is not standard practice for all carriers and may require expensive system changes to accommodate. We recommend that SHOP effective dates be the first of the month only.

FINANCIAL PROVISIONS FOR SHOP

Section 85 – SHOP Schedule of rates

The requirement to have rates based on employer zip code as opposed to employee zip code will be problematic for carriers wishing to have group level enrollment set up on the SHOP side only (setting up the SHOP as a single large employer in the carrier's enrollment system), this requirement will result in significant additional administrative costs. We strongly recommend against this requirement.

QUALITY IMPROVEMENT AND DELIVERY SYSTEM REFORM

We believe quality improvement strategies should rely on systematic reporting of health outcomes, such as through HEDIS and other measures. Requirements related to physically seeing members within a specified number of days upon Exchange-facilitated enrollment are unlikely to generate substantial gains in the health the Covered California population. This is for two significant reasons. First, many members of Covered California will have ongoing relationships with a physician. Second, the gains for generally healthy individuals from a provider office visit are likely to be quite small.

We wish to explore with the Exchange evidence-based approaches to the “on-boarding” of individuals new to us, and lacking in prior health care coverage. We will emphasize, however, that clinical outcome measures for the entire Exchange population should be accorded the greatest emphasis.

MARKETING REQUIREMENTS AND PLAN PARTNERSHIP

Section 100 – Branding Requirements

We agree with the general intention to co-brand documents provided by the carrier, but would strongly recommend flexibility on those documents with high production/customization costs like ID cards.

Section 101 – Review of Marketing Materials

We are happy to provide copies of exchange related marketing materials to Connected California, but our own internal timelines don't allow for an additional set of reviews prior to release.

Section 102 - Marketing Plan

We are happy to submit an annual (but not quarterly) copy of our marketing plan, although we would not expect it to be for review or approval. Our marketing expenditures are proprietary and we're happy to give ranges, but not a detailed budget.

PARTICIPATION FEE

Section 114 and 115 – Participation Fee for Individual Exchange

The requirement to pay a fee on enrollment in “off Exchange” Qualified Health Plan is poorly conceived policy, and something we strongly oppose. This approach punishes carriers for the act of becoming partners with Covered California by exposing those carriers to potentially tens of millions of dollars in annual assessments for coverage sold outside the Exchange. Moreover, we believe this approach is

significantly at odds with the goal of the Exchange to bring simplified choices and more uniformity to insurance offerings in the individual and small group market. If QHP products sold off-exchange are assessed, carriers will have an incentive to expand their non-QHP portfolios in order to minimize the fee. We suspect this approach, in addition to thwarting a key goal of the Exchange to simplify the market, also will prove fairly effective in minimizing the revenue collected by the Exchange.

Finally, we note that the Exchange draft budgets provided to the public do not rely upon fees for off-exchange assessments. Indeed, the entirety of proposed Exchange activities are supported by assessment on QHPs sold within the Exchange.

We recommend that this requirement be dropped, or that the off exchange fee be applied to all off exchange plans and that the amount assessed be reduced to the point needed to generate only the revenue needed for operations.

Section 115 Participation Fee for the SHOP

The wording seems to assume that SHOP participation fees will be invoiced and paid in the same way as the individual exchange, but elsewhere in the contract collection of gross premiums by the SHOP and payment of net premiums to the carrier is stipulated. We recommend this section be changed to align with the net premium approach.

PERFORMANCE GUARANTEES

We support the idea of performance guarantees and consider agree with the concept of penalties for poor performance balanced with credits for exceptional performance.

We recognize that there is a joint responsibility for the operational performance of issuers and operational performance of the exchange to meet customer needs and expectations. We therefore suggest that issuers not be assessed penalties on operational results that have a direct corollary with exchange operations (e.g. Call Center Operations), if the exchange's own performance on that metric for that time period is not better than that of the issuer.

We agree that the areas covered under the proposed standards below are important, but would suggest that they be expanded beyond call center and enrollment material fulfillment to quality and member satisfaction.

We assume that the performance guarantees are intended to relate to the individual exchange only, and not to the SHOP.

A. Baseline Period

We agree that a baseline period is necessary to understand the new environment in which we will be operating and to appropriately set benchmark targets where none currently exist (interface standards). We understand that the use of the baseline period will be to complete negotiation of a complete set of

standards with both penalty and credit targets, and that actual performance on transactional activity (call center, enrollment fulfillment, and interface) be considered only for the period after baseline (April through December of 2014).

B. 800 Number

We consider service to all of our members to be equally important and do not plan on using a separate 800 number for the exchange population. We plan on providing the same high standard of performance to all members.

C. Reporting

We are in general agreement regarding reporting, but would limit the requirement to monthly and annually, as weekly and daily is too administratively onerous and does not provide meaningful additional oversight value. We expect that any penalties or credits will be based on annual performance.

We cannot agree to direct outside access and monitoring of our call center ACD system as this would be both administratively problematic. We can agree to Covered California having the right to periodic audit, which could include on-site access to call monitoring and review of ACD reporting.

Specified Performance Guarantees are set forth in the Chart below:

As noted above, we support the idea of credits for exceptional performance as a balance to penalties, and propose that the standards be expanded to include quality (HEDIS) and member satisfaction (CAHPS) results. We also note that some of the proposed targets are not industry standard in terms of service level or methodology. We therefore propose the following standards with additions and modifications:

| DESCRIPTION | STANDARD | SERVICE LEVEL CREDITS AND LIQUIDATED DAMAGES | METHODOLOGY |
|-------------------------------------|--|---|---|
| CUSTOMER SERVICE – ENROLLEES | | | |
| Telephone service level | Penalty Target= 80% of calls answered within 30 seconds Credit Target = 85% within 30 seconds | 5% | Measured from ACD system Note: penalty only applies if exchange call center performance is better than |

| | | | |
|--|--|----|--|
| | | | issuer performance. |
| First call resolution | Penalty Target = 85% of Enrollee issues will be resolved within the same business day the issue was received. Credit Target = 90% | 4% | Note: penalty only applies if exchange call center performance is better than issuer performance. |
| Abandonment rate | Penalty Target = No more than 3% of incoming calls in a calendar year Credit Target = 2% | 5% | Measured from ACD system Note: penalty only applies if exchange call center performance is better than issuer performance. |
| Customer satisfaction | Penalty Target = CA state average. Credit Target = CA State 75 th Percentile. | 5% | CAHPS composite measure "Member Satisfaction with Customer Service" Note: statistical significantly above or below @ 95% confidence level. |
| Quality Assurance | Penalty Target = 85% Credit Target = 90% | 2% | Measured internally by Quality Assurance Team Note: penalty only applies if exchange call center performance is better than issuer performance. |
| Line busy rate | We recommend that this standard be deleted as our system does not produce a "busy rate". | | |
| Voice mail response | We recommend that this standard be deleted as our system does not measure voice mail response. | | |
| Email and Correspondence Response Time | Penalty Target = 80% of emails and other written correspondence will be answered in 2 business days Credit Target = 90% | 2% | Note: penalty only applies if exchange call center performance is better than issuer performance. |
| Resolution of Enrollee complaints | Penalty Target = 95% of Enrollee complaints resolved within 30 <i>business</i> days Credit Target = 99% | 3% | Note: penalty only applies if exchange call center performance is better than issuer performance. |
| SUBSCRIBER MATERIAL PRODUCTION AND DISTRIBUTION | | | |
| ID Cards | Penalty Target = 93% sent | 3% | |

| | | | |
|--|---|----|--|
| | within 10 business days of receiving enrollment information from the Exchange Credit Target = 99% | | |
| New Enrollee Materials | We recommend that this standard be deleted as this is not an industry standard measure. | | |
| INTERFACE STANDARDS | | | |
| Confirmation File (999) of all enrollment and payment transactions | The Exchange will receive the 999 file within one business day of receipt of the 834/820 file XX% of the time. Target = TBD Credit = TBD | 2% | Targets and methodology to be determined after pilot period. |
| Confirmation File (999) of all enrollment and payment transactions | The Exchange will receive the 999 file within three business days of receipt of the 834/820 file XX% of the time. Target = TBD Credit = TBD | 2% | Targets and methodology to be determined after pilot period. |
| Effectuation of Enrollment File (834) upon receipt of member's initial payment | The Exchange will receive the 834 file within one business day of receipt of the member's initial payment file XX% of the time. Target = TBD Credit = TBD | 2% | Targets and methodology to be determined after pilot period. |
| Effectuation of Enrollment File (834) upon receipt of member's initial payment | The Exchange will receive the 834 file within three business days of receipt of the member's initial payment XX% of the time. Target = TBD Credit = TBD | 2% | Targets and methodology to be determined after pilot period. |
| Member Payment File (820) upon receipt of member's payment | The Exchange will receive the 820 file within one business day of receipt of the member's payment file | 2% | Targets and methodology to be determined after pilot period. |

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| | XX% of the time. Target = TBD Credit = TBD | | |
| Member Payment File (820) upon receipt of member's payment | The Exchange will receive the 820 file within three business days of receipt of the member's payment XX% of the time. Target = TBD Credit = TBD | 2% | Targets and methodology to be determined after pilot period. |
| Enrollment Change File (834) upon non-receipt of member's payment by due date, 30 day notice, and termination | The Exchange will receive the 834 file within one business day of receipt of change of the members status XX% of the time. Target = TBD Credit = TBD | 2% | Targets and methodology to be determined after pilot period. |
| Enrollment Change File (834) upon non-receipt of member's payment by due date, 30 day notice, and termination | The Exchange will receive the 834 file within three business days of receipt of change of the members status XX% of the time. Target = TBD Credit = TBD | 2% | Targets and methodology to be determined after pilot period. |
| Quality and Member Satisfaction | | | |
| Beta Blocker - Persistence of B Blocker Use after Heart Attack | Target = National Average Credit = National 75 th Percentile | 5% | NCQA HEDIS Measure. Note: statistical significantly above or below @ 95% confidence level. |
| Cervical Cancer Screening Rate | Target = National Average Credit = National 75 th Percentile | 5% | NCQA HEDIS Measure. Note: statistical significantly above or below @ 95% confidence level. |
| Childhood Immunization Rate - Combo 3 | Target = National Average Credit = National 75 th Percentile | 5% | NCQA HEDIS Measure. Note: statistical significantly above or below @ 95% confidence level. |
| Chlamydia Screening in Women (all age | Target = National Average Credit = National 75 th | 5% | NCQA HEDIS Measure. |

| | | | |
|---|---|------|---|
| categories | Percentile | | Note: statistical significantly above or below @ 95% confidence level. |
| Cholesterol Management for Patients with Cardiovascular Conditions (LDL-C <100 mg/dL) | Target = National Average Credit = National 75 th Percentile | 5% | NCQA HEDIS Measure. Note: statistical significantly above or below @ 95% confidence level. |
| Colorectal Cancer Screening Rate | Target = National Average Credit = National 75 th Percentile | 5% | NCQA HEDIS Measure. Note: statistical significantly above or below @ 95% confidence level. |
| Controlling High Blood Pressure – Total | Target = National Average Credit = National 75 th Percentile | 5% | NCQA HEDIS Measure. Note: statistical significantly above or below @ 95% confidence level. |
| Prenatal Care Rate | Target = National Average Credit = National 75 th Percentile | 5% | NCQA HEDIS Measure. Note: statistical significantly above or below @ 95% confidence level. |
| Postpartum Care Rate | Target = National Average Credit = National 75 th Percentile | 5% | NCQA HEDIS Measure. Note: statistical significantly above or below @ 95% confidence level. |
| Overall satisfaction with health plan (CAHPS 4.0 Q# 42 - Percent 8-10) | Penalty Target = CA state average. Credit Target = CA State 75 th Percentile. | 5% | CAHPS composite measure “Member Satisfaction with Customer Service” Note: statistical significantly above or below @ 95% confidence level. |
| Getting Needed Care (Composite: Qs #23, 27; % usually or always) | Penalty Target = CA state average. Credit Target = CA State 75 th Percentile. | 5% | CAHPS composite measure “Member Satisfaction with Customer Service” Note: statistical significantly above or below @ 95% confidence level. |
| | Total | 100% | |

END OF CHART

LEGAL PROVISIONS

The California Association of Health Plans has provided extensive comments regarding legal aspects of the draft model contract. We are in general agreement with these comments. Below are a few additions that, due to time constraints, may be in addition to the points in the CAHP letter:

Indemnification. We suggest the following language for the indemnification provision:

Each party to this Agreement shall indemnify, defend and hold harmless the other and all of the officers, trustees, agents and employees of the party (each an "Indemnatee") from and against any and all losses, costs, liabilities, damages, including interest, penalties and reasonable attorneys' fees, (collectively, "Losses") resulting from a third party claim, to the extent the Losses are caused by or resulting from such party's acts or omissions constituting negligence.

Arbitration. The Exchange needs to facilitate contracting health plans compliance with Health and Safety Code 1363.1 regarding notice of binding arbitration requirements. We suggest the following wording:

In the application for enrollment in the Individual or S.H.O.P Exchange, the Exchange shall, at the Contractor's request, include a provision that sets forth Contractor's requirement to subject certain disputes between an Enrollee and the Contractor (and where applicable, Contractors subcontractors, associates, and affiliates) to binding arbitration. The Exchange shall include a statement regarding Contractor's binding arbitration requirement in all enrollment processes. The content of such statement and its manner of inclusion in all enrollment processes shall be subject to agreement by the parties that the content and form satisfies the legal requirements necessary to effectuate the arbitration provision pursuant to Health and Safety Code section 1363.1, including documentation of the enrollee's agreement, which shall be made available to the Contractor.

February 21, 2013

California Health Benefit Exchange Board and
Mr. Peter Lee, Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

Dear Board Members and Executive Director Lee:

Covered California's leadership on health care reform will result in increased access to coverage for millions of Californians. March of Dimes wants to ensure that this population will be able to effectively utilize their prenatal care and pregnancy benefits so that women will be able to have healthy pregnancies and healthy babies. We have reviewed the *Standardized Benefit Plan Designs* document and take this opportunity to provide comments.

We recognize Covered California's efforts to address affordability for pregnancy-related care by scaling the pregnancy-related cost sharing for different income levels. However, the March of Dimes has two major concerns about the overall proposed cost sharing in the benefit plan designs for prenatal care copayments and pregnancy hospital care.

First, it is our understanding that under the Affordable Care Act, copayments for prenatal care are not allowed for non-grandfathered plans. See this guidance, www.hrsa.gov/womensguidelines/, from the U.S. Department of Health and Human Services that includes prenatal care in the category of well woman visits. Under this definition, non-grandfathered plans and issuers are required to provide coverage for well woman visits without cost sharing. In addition, prenatal care is already included in the list of preventive services as designated by the U.S. Preventive Services Task Force which health plans in the exchange are to cover without cost-sharing.

Second, the cost sharing for prenatal copayments and pregnancy hospital care could prove to be a barrier for many low-income pregnant women. For the Silver Plan, women at 100% to 150% of the federal poverty level (FPL) would have copayments for prenatal visits of \$4 per visit and 10% cost sharing for delivery and inpatient services. For those at 150% to 200%, the rates would be \$20 copay for prenatal care and 20% cost sharing for hospital care. Women at 200% to 250% would have \$45 copayments and 20% cost sharing. As state Medicaid programs have begun implementing cost sharing strategies, early evidence has linked it to a reduction in health care services for vulnerable populations.¹

Studies show that cost sharing can impact utilization of preventive services² and cost sharing for pregnancy services at the three aforementioned income levels could prevent many women from accessing prenatal care and generate significant financial hardship for hospitalization costs. It could also lead to an increase in preterm births as access to timely and quality prenatal care is a key factor in the health of the infant and the mother. California has made tremendous strides in reducing the state's preterm birth rate, including a 10.1 percent reduction over the past four years, and we want to ensure that this progress continues. In addition to the health concerns, the medical costs associated with preterm birth are significantly higher. In 2006, March of Dimes released a report that demonstrated that the average first-year medical costs, both inpatient and outpatient, were \$32,325 for a preterm infant as compared to \$3,325 for a term infant.

Based on these concerns we have two recommendations: (1) Remove the copayments for prenatal care outlined in the standardized benefit plan designs to be consistent with the federal definition of well woman visits and preventative services; and (2) Reexamine and lower the cost sharing for pregnancy hospital care.

If you have any questions, please do not hesitate to contact me at 916-576-2836 or jgarrett@marchofdimes.com. Thank you for your consideration of our concerns.

Sincerely,

Justin Garrett
State Director of Advocacy & Government Affairs
March of Dimes

¹ Wright,BJ, Carlson, MJ, Edlund, T, DeVoe, J, Gallia, C, and Smith, J., The Impact Of Increased Cost Sharing On Medicaid Enrollees, Health Affairs, February 2013.

² Guy,GP. The Effects of Cost-Sharing on Childless Adults, Health Services Research, December 2010.

January 24, 2013

Peter V. Lee
Executive Director
Covered California
560 J Street, Suite 290
Sacramento, CA 95814

RE: Comments on Qualified Health Plan Model Contract- First Draft

Dear Mr. Lee:

The Pacific Business Group on Health (PBGH) appreciates the opportunity to comment on the initial draft of the Qualified Health Plan (QHP) Model Contract. We applaud Covered California's efforts to date to advance payment and delivery system reform through its Board Recommendation Briefs and the QHP Health Plan Solicitation. The Model Contract is a critical opportunity for the Exchange to incorporate its expectations for health plan and provider accountability and performance transparency, especially as this is the initial competitive bidding process. Pacific Business Group on Health serves as a voice for purchasers, leveraging the strength of its 60 member companies, who provide health care coverage to 10 million Americans and their dependents. Our organization was the last administrator of the small business purchasing pool in California, PacAdvantage, so we bring very relevant experience in plan management and quality improvement.

Working in alignment with large public and private purchasers, Covered California has a significant opportunity to address the quality and affordability gaps that exist in today's health care delivery system. Covered California can assume a leadership role in providing consumers and small businesses with meaningful information on how health plans and providers perform on measures of clinical quality and patient experience. Through its contractual requirements, Covered California can establish clear performance requirements and quality reporting that advances the system transformation envisioned through the Affordable Care Act.

We recommend that Covered California incorporate the following elements into its QHP Model Contract:

- 1) QHPs can support a competitive marketplace and operate in a transparent way by:
 - a) Participating in collaborative measurement and reporting efforts to support the availability of consumer information, such as the California Healthcare Performance Information System (see below),
 - b) Report publicly dashboard measures at multiple levels including individual physician and/or facility site and service line,
 - c) Make information regarding the cost of care and potential enrollee out-of-pocket costs available to the public,
 - d) Prohibit participation of providers that use contractual prohibitions on quality and cost differentiation, and consumer access to comparative performance information.

- e) Align contractual performance guarantees and standards with those of large purchasers to advance clinical quality and patient experience – move beyond traditional operational and service metrics.
- 2) As part of the Quality Reporting System required by Section 1311 of the Affordable Care Act, Covered California should adopt a comprehensive measurement dashboard that is consistent with the National Quality Strategy, and which incorporates metrics that are outcomes-focused and patient-centered, including:
- a) Clinical outcomes,
 - b) Functional status,
 - c) Appropriateness,
 - d) Patient experience,
 - e) Care coordination and care transitions,
 - f) Cost, and
 - g) Resource use.

Specifically, Covered California could advance patient safety and availability of patient-reported outcomes by requiring QHPs to implement specific provider contract terms at renewal, such as reporting: 1) patient safety data to The Leapfrog Group, 2) maternity outcomes data to the California Maternal Data Center, sponsored by the California Maternal Quality Care Collaborative (CMQCC), and 3) orthopedic joint replacement data to the California Joint Replacement Registry, developed by the California HealthCare Foundation (CHCF), the California Orthopaedic Association (COA) and PBGH. Advancing use of clinical registries also helps Covered California achieve its goal of embedding shared decision making in care processes, and assuring that the right care is delivered at the right time and place.

- 3) QHPs should support provider systems that provide integrated care delivery and which are at the forefront of care redesign, including providers and provider networks that:
- a) Use a patient- centered, team-based approach to care delivery and member engagement,
 - b) Have a demonstrated strategy to expand primary care access through workforce development,
 - c) Use qualified health professionals to deliver coordinated patient education and health maintenance support, with a track record for improving care for high-risk and vulnerable populations.
 - d) Support physician and patient engagement in shared decision making,
 - e) Provide patient access to their health information.
- 4) QHPs should have an explicit, targeted percentage of provider payments designed to advance payment reform that supports evidence-based care and rewards quality, not quantity, including:
- a) Use of risk-adjusted, episode or bundled payment,
 - b) Participation in shared risk and or gainsharing arrangements,
 - c) Alignment of private sector approaches with public programs, such as the CMS Hospital Value-based Purchasing (HVPB) Program
 - d) Inclusion of model contract language proposed by Catalyst for Payment Reform (http://www.catalyzepaymentreform.org/uploads/CPR_Model_Health_Plan_Contract_Language_011212.docx).

To elaborate on our specific recommendation to require QHPs to participate in the California Healthcare Performance Information System (CHPI), we provide some additional background and context. For many years, PBGH has been engaged with California's largest payers to pool claims data for quality measurement and reporting. As one of six original CMS Better Quality Information pilot sites, PBGH successfully operated a program to integrate commercial PPO data with Medicare Fee-for-Service claims. CHPI represents the next stage in developing a statewide all payer claims database by becoming a CMS Qualified Entity to integrate Medicare FFS data with commercial claims information on an ongoing basis. QHP participation in this effort to develop a common statewide repository of claims data can support a variety of Covered California's operational needs and program goals:

- Improve the availability and quality of information available for consumer decision support in choice of health plan, providers, and treatment;
- Support data needs for required risk assessment and risk adjustment processes (Massachusetts is adopting a similar model);
- Facilitate Covered California-specific quality measurement and reporting by potentially integrating claims data from public and private payers, which can address measurement gaps in a population that expected to have high turnover across programs due to income fluctuation and access to federal subsidies;
- Support QHP efforts to better understand and address provider performance variation, including identification of opportunities to reduce disparities in care;
- Foster integration of diverse plan and provider claims information to support broad population health improvement efforts such as Let's Get Healthy California;
- Engage in multi-stakeholder efforts to advance delivery system reform; and
- Leverage existing infrastructure to achieve economies of scale that support Covered California's measurement, accountability and transparency goals;

We appreciate the opportunity to provide these comments. We also include as an attachment our recent response to the CMS RFI on Health Plan Quality Management in Affordable Insurance Exchanges. Please do not hesitate to contact me if you have any questions or would like to discuss further.

Sincerely,



David Lansky, PhD
President & Chief Executive Officer

Attachment: PBGH Response to CMS RFI Regarding Health Plan Quality Management in Affordable Insurance Exchanges

January 17, 2013

Rebecca Zimmermann
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: CMS-9962-NC: RFI Regarding Health Plan Quality Management in Affordable Insurance Exchanges

Dear Ms. Zimmermann:

The Pacific Business Group on Health (PBGH) appreciates the opportunity to respond to this Request for Information on the ways in which Exchanges can most effectively contribute to improving the quality of care delivered in our health care system, in part by engaging consumers and purchasers to make choices based on quality and value when selecting Exchange Qualified Health Plans (QHPs). PBGH serves as a voice for purchasers, leveraging the strength of its 60 member companies, who provide health care coverage to 10 million Americans and their dependents. Our organization was the last administrator of the small business purchasing pool in California, PacAdvantage, so we bring very relevant experience in plan quality management.

As some of the largest purchasers in their communities, Exchanges have a significant opportunity to address the quality and affordability gaps that exist in today's health care delivery system -- they can provide consumers and employers with meaningful information on how health plans and providers perform on measures of clinical quality and patient experience. Many consumers are not aware of the variations in quality of care and value and how these significant variations affect care delivery and outcomes. In the absence of such information, consumers rely simply on cost comparisons to make their health plan decisions. By providing clear information on the importance of quality to both the individual's care and to the system, exchanges can play a role in improving quality and reducing costs across the board, contributing to the overall system transformation that the Affordable Care Act and other programs and initiatives were designed to achieve.

Our responses to the questions below reflect our belief that there is an urgent need for exchanges to be designed to meet the needs of their beneficiaries including providing useful information on quality, access, and affordability, as well as easy-to-use decision support tools.

1. What quality improvement strategies do health insurance issuers currently use to drive health care quality improvement in the following categories: (1) improving health outcomes; (2) preventing hospital readmissions; (3) improving patient safety and reducing medical errors; (4) implementing wellness and health promotion activities; and (5) reducing health disparities?

Issuers play a key role in driving quality improvement via the following strategies:

- Helping consumers to choose high value services and providers
- Encouraging consumers to improve their own health
- Promoting care coordination and medical homes
- Improving management of chronic diseases
- Targeting interventions for at-risk, populations or high-impact conditions
- Spreading innovations in care delivery that improve access, minimize cost and maximize quality

To promote value-based decision-making, many issuers collect information on the price and quality of services and present that information to consumers when they are making choices at the point of plan enrollment and provider selection as well as at the point of care. This drives demand towards the highest value providers and services, raising the bar for all.

Plans also leverage financial incentives and benefit design to promote better care, including:

- quality bonuses for providers (either retrospective or prospective as part of the contracting process);
- putting provider compensation at risk for performance on quality and total cost measures;
- providing grants for quality improvement activities;
- establishing variable cost sharing or “tiering” for patients;
- bundling payment for a set of services coordinated across providers; and
- providing incentives for enrolling in a wellness program or improving health

In addition to public reporting of performance, we believe that it is important for consumers to have access to information on whether, and if so, which, of these additional strategies listed above are in use by qualified health plans. This will also be important for evaluation purposes – to identify successful plan practices to improve the health of their population and the affordability of their product.

2. What challenges exist with quality improvement strategy metrics and tracking quality improvement over time (for example, measure selection criteria, data collection and reporting requirements)? What strategies (including those related to health information technology) could mitigate these challenges?

The biggest challenge facing purchasers in tracking quality is the lack of a consistent measure set used across programs that provides meaningful information about the quality of providers and the effectiveness of services and improvement initiatives. This limits the ability to compare based on value and increases the inefficiency of data capture and reporting - consumers and purchasers are left with a multitude of measures but no summary indicator of product value upon which to make decisions.

The lack of outcome measures is a serious obstacle for evaluating health plan and provider performance. Process measures clog many performance measurement programs, most of which do not provide meaningful information. The lack of interoperable health information technology makes it difficult, at the very least, to develop measures that collect data from different settings (e.g. hospital, ambulatory, lab, pharmacy, home health) in an effort to provide a comprehensive picture of patient's health and wellness. There is also a severe lack of publicly reported measures using registry-based data that would provide the field with information on change in quality improvement over time.

On top of these challenges is the significant time lag between when the data is collected and when it is made available for accountability purposes, making it difficult to improve systems (e.g. readmissions information available in 2012 is using 2010 data). Furthermore, physician-level data and measures of teams are still mostly unavailable to consumers to use.

CMS could help address these challenges by (1) identifying a consistent set of meaningful quality measures that align with the National Quality Strategy to be implemented across public and private purchasers and payers and (2) strengthening requirements for the electronic collection, analysis and reporting of data.

Another measurement challenge relates to the nature of the Exchange population and the fact that they will churn between different programs and plans over time, limiting the ability to continuously measure their experience or improvement. Therefore, we specifically suggest that six month eligibility should be used for HEDIS/CAHPS measure calculation rather than the current year eligibility cut-off. This will help ensure that we capture the experience of the largest number of patients and do not exclude feedback from vulnerable populations.

3. Describe current public reporting or transparency efforts that states and private entities use to display health care quality information.

- Consumers' CHECKBOOK/The Center for the Study of Services created the [State Exchange Health Plan Comparison Tool](#) which is modeled after the web portal currently used in the Federal Employees' Benefits Health Program (FEHBP). This tool allows consumers to view, easily and quickly, information on cost and patient experience quality data on a number of different health plans. The tool also lets consumers select health plans based on whether or not their providers are in the health plan's network, and allows the user to drill down for more granular information on how patients with various chronic conditions rated the plans.
- Louisiana provides [Coordinated Care Network](#) customers with useful information that is designed in such a way as to prevent customers from becoming overwhelmed. The CCN provides access to enrollment assistors who provide unbiased interpretations of network options.
- Minnesota's Web portal allows consumers to compare provider reimbursement rates. The portal lists the average amount health plans pay to 110 Minnesota health care providers for 103 common medical procedures.
- In Wisconsin, BadgerCare created an easy to use, consumer-friendly web site that includes a report card on plan performance; developed a streamlined health plan selection and enrollment

process; and used brokers, community partners, and other navigators to assist consumers in making informed decisions by providing information on eligibility for programs and subsidies.

- Colorado Business Group on Health is working with Bridges to Excellence to publicly report individual physicians, as well as purchasers and plans that have BTE distinction in cardiovascular care and diabetes care: <http://www.coloradohealthonline.org/cbgh/index.cfm/programs/bte/>
- The New Jersey Health Care Quality Institute produced a surgery safety report: <http://www.njhcqi.org/njhcqinews.php?mode=view&id=630&type=3> and a hospital price transparency report: <http://www.njhcqi.org/njhcqinews.php?mode=view&id=311&type=3>
- Niagara Health Quality Coalition produces a New York state hospital report card: <http://www.myhealthfinder.com/newyork11/index.php> and physician profiles: <http://www.nydoctorprofile.com/>
- Oregon Health Care Quality Corporation (a recently-named QE) offers significant transparency on provider performance: <http://q-corp.org/quality-reports/providers>

4. What opportunities exist to further the goals of the National Quality Strategy through quality reporting requirements in the Exchange marketplace?

Exchange quality reporting is central to achieving the National Quality Strategy (NQS) priorities:

- By reporting on care safety, the Exchanges can play a role in reducing harm caused in the delivery of care. Not only would consumers have the information to choose safer providers but plans could alter their payment to reward safe care.
- By providing consumers with easy-to-interpret quality, experience and price information, they can be more engaged as partners in their care
- By reporting on quality across services and providers, consumers and employers will have better information on the most effective prevention and treatment practices for priority conditions
- Finally, by making prices more transparent and pairing them with quality data, demand will be driven to more affordable care options

To determine whether the “triple aim” is being met, Exchanges will need to promote transparency of performance on outcomes, cost and resource use, patient safety and patient experience.

5. What quality measures or measure sets currently required or recognized by states, accrediting entities, or CMS are most relevant to the Exchange marketplace?

CMS and Exchanges should think about quality reporting initiatives from the perspective of what information purchasers and consumers want and need, and how they use this information. Exchanges should develop their quality initiatives in concert with the development of the web portal, the navigator program, and other consumer assistance tools, to ensure that the quality measurement efforts will support and contribute to the use of this information by consumers.

Evidence indicates that consumers make decisions based on information related to choice of provider, data on patients’ experiences of care and outcomes. We urge that Exchanges be required to collect and report on a comprehensive set of provider-specific measures that include data on:

- patients' experiences of care
- outcomes (including functional status, readmissions and mortality, and patient safety and healthcare-acquired conditions)
- clinical processes tightly linked to outcomes
- appropriateness of care
- cost and resource use

The measure set should evolve as more measures that resonate with those who receive and pay for care become available, including patient-reported outcome measures. Exchanges should be required to collect and report data on patients' experiences of care, and ensure patient-reported and patient-generated data measures become a core component of the Exchanges' quality initiatives, as the use of this data leads to improved outcomes. We also urge the use of measures for which public and private sector purchasers and payers are aligned in data collection and reporting, to further promote alignment across sectors. Exchanges should be empowered to add additional measures based on local, regional, and private sector innovations in quality measurement.

Wherever possible, measures should be reported at the individual-physician level. Physicians may operate as part of a team, but patients and consumers are likely to make health plan choices based on the individual physicians in the QHP's network. Having individual physician-level information "fits" with the way many consumers make health care choices. This is particularly important to the extent there are requirements to include 340B providers in issuer provider networks, as many of these providers have historically not been monitored as closely as in commercial plans. There should be well documented quality information about all providers serving Exchange enrollees. Similarly, QHPs that include patient-centered medical homes in their network should report on key outcomes – such as care coordination, chronic care clinical improvements, and patient experience – at the medical home level.

6. Are there any gaps in current clinical measure sets that may create challenges for capturing experience in the Exchange?

There are significant gaps in current clinical measure sets, most recently identified and catalogued by the Measure Applications Partnership (MAP) in its work to develop "families" of measures for patient safety, care coordination, and cardiac and diabetes care. The most glaring gaps are in the areas of patient-reported measures (including patient experience), cost and resource use, care coordination and transition measures. However, reporting on current measures will provide some level of information while the additional measures are developed.

There are additional gaps in measuring experience with the Exchange itself. In our comments to the Secretary on the development of a patient experience tool, we recommended the following four-pronged approach to collecting more complete and actionable patient experience data:

- 1) Establish an online service where consumers can share feedback in the form of structured responses and commentary
- 2) Create a plan-centric short form survey starting with select elements in the CAHPS Health Plan Survey 4.0H Adult Questionnaire

- 3) Create a doctor/care-centric survey that assesses patient experience with their doctor and care system
- 4) Create a consumer experience survey that assesses consumers' experiences with the Exchange including the eligibility, plan choice, and enrollment services

8. What are some issues to consider in establishing requirements for an issuer's quality improvement strategy? How might an Exchange evaluate the effectiveness of quality improvement strategies across plans and issuers? What is the value in narrative reports to assess quality improvement strategies?

To evaluate the effectiveness of quality improvement strategies across plans, Exchanges will need to collect standardized information on plan activities that seek to control costs, minimize waste, ensure patient safety, close gaps in care and improve health and health care. Some of this information can be gathered through the plan accreditation process, but the assessment of quality improvement strategies is neither sufficient nor consistently captured. This is why healthcare purchasers are requiring issuers to complete the *eValue8* Health Plan Request for Information (RFI). This RFI allows Exchanges to collect data that supports reporting of plans' quality improvement strategies in accordance with the Affordable Care Act. We recommend that CCIIO require Exchanges to capture relevant sections of *eValue8* across issuers as a key part of the quality improvement evaluation strategy.

Also critical to an issuer's quality improvement strategy are the quality of its provider network and the affordability of benefits. Therefore, exchanges should collect some quality information on provider-level performance within plans as well as information on the cost of care (total cost and the member portion). Metrics should include benchmarks and performance thresholds for clinical outcomes, functional status, appropriateness, patient experience, care coordination and care transitions, and cost and resource use. Tracking these metrics over time combined with information on plan quality improvement strategies will shed light on how Exchanges are advancing affordability and quality, per the aims of the National Quality Strategy.

CCIIO should encourage quantitative reporting to indicate the scope and impact of quality improvement programs such as member engagement, the volume of providers, etc. Narrative content is prone to distortion and is not conducive to comparison across issuers, significantly limiting the utility of information.

In establishing requirements for an issuer's quality improvement strategy, Exchanges should also look to private sector purchasers to identify successful purchasing practices that should be replicated across payers. For example, Safeway instituted a reference pricing initiative and saw movement away from expensive providers without impacting outcomes¹. CalPERS contracted with Blue Shield of California to offer a limited-network HMO and significantly decreased per member per month costs.² CalPERS, Pacific Gas and Electric Company, and Boeing introduced an Intensive

¹ Catalyst for Payment Reform. "Action Brief: From Reference Pricing to Value Pricing".

http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Reference_Pricing.pdf

² Catalyst for Payment Reform. "Action Brief: Implementing Global Payment".

http://www.catalyzepaymentreform.org/uploads/CPR_Action_Brief_Global_Payment.pdf.

Outpatient Care Program with demonstrated success in Humboldt County³. Quality improvement and affordability initiatives like these that have demonstrated success in the field should be incorporated into requirements for issuer quality improvement to expand their benefit.

9. What methods should be used to capture and display quality improvement activities? Which publicly and privately funded activities to promote data collection and transparency could be leveraged (for example, Meaningful Use Incentive Program) to inform these methods?

CCIIO should ensure its quality improvement evaluation activities align with Affordable Care Act Measurement Initiatives among other public and private sector measurement efforts to minimize reporting burden and forge a uniform path for measurement and valuation:

- Meaningful Use Incentive Program – CCIIO should take advantage of opportunities to align with incentives for “meaningful use” of interoperable platforms so that data is collected and reported electronically where appropriate
- Medicare Shared Savings Program – CCIIO should ensure performance measures accommodate new contractual structures such as Accountable Care Organizations and Patient-Centered Medical Homes so that their performance can be evaluated
- Measures Application Partnership – this group is drawing consensus around what is important to measure for the purposes of program monitoring, payment and public reporting. Exchange quality reporting requirements should draw from this effort.

CCIIO should leverage the following activities to collect and report quality improvement information:

- All-Payer Claims Databases / Medicare Qualified Entity Program – plans should be encouraged to pool information into all-payer claims databases as these entities are uniquely qualified to aggregate, analyze and report performance information in a manner that is meaningful for consumers, purchasers and providers
- eValue8 RFI – As discussed above eValue8 is a tool to collect benchmark and ongoing information on important plan quality improvement strategies in concert with accrediting bodies
- System for Electronic Rate and Form Filing (SERFF) – Since plans are already familiar with using SERFF to report information, the SERFF should be leveraged as much as possible to collect information in a uniform way and minimize reporting burden

10. What are the priority areas for the quality rating in the Exchange marketplace? (for example, delivery of specific preventive services, health plan performance and customer service)? Should these be similar to or different from the Medicare Advantage five-star quality rating system (for example, staying healthy: screenings, tests and vaccines; managing chronic (long-term) conditions; ratings of health plan responsiveness and care; health plan members' complaints and appeals; and health plan telephone customer service)?

³ Pacific Business Group on Health. “Pacific Business Group on Health, Partners Receive \$19 million Grant from Center for Medicare and Medicaid Innovation to Improve Health for 23,000 Chronically-Ill Californians”. http://www.pbgh.org/storage/documents/CMMI_Grant_06.15.12.pdf.

Quality rating activities should be geared towards helping consumers understand the overall value of plans and to generate a higher value marketplace for consumers. It is critical that any measurement activity result in a summary of product value that is meaningful to consumers. Some of the priority areas for rating plan quality for consumer plan choice include:

| | |
|---------------------------------------|--|
| Clinical ratings | summary ratings for preventive and chronic care |
| Plan service | summary rating that is a composite of ratings for customer service, cost information services and paying claims |
| Access to care | summary rating that is a composite of ratings for ease of getting appointments and getting needed care, tests or treatment |
| Doctor communications and care | includes composite ratings for doctor communications and care, patient and doctor sharing decisions, health promotion, an indicator that care is coordinated and an indicator that health care is highly rated |
| Provider-level quality | whether the plan provides members with hospital and physician-specific quality ratings (clarify physician-level vs. medical group, PCMH, ASO, other organizational levels) |
| Patient-reported information | information gleaned from the patient on outcomes (including functional status), understanding of transition instructions and self-care methods, etc. |
| Accreditation scores | information collected by NCQA to support accreditation |

Further analysis should be completed to determine what subset of information should be displayed on exchange websites as opposed to used by Exchanges for plan management and oversight purposes.

11. What are effective ways to display quality ratings that would be meaningful for Exchange consumers and small employers, especially drawing on lessons learned from public reporting and transparency efforts that states and private entities use to display health care quality information?

The Pacific Business Group on Health has published a report on “Consumer Choice of Health Plan Decision Support Rules for Health Exchanges”⁴ that provides some evidence base for how quality ratings and other information should be displayed on the Exchange web portals to maximize consumer benefit. Key findings include:

- Performance results should be reported as composite, summary ratings. Single plan-level details should be available at a lower level in the information hierarchy as this information is less meaningful to consumers.
- Quality ratings should be presented in the top-most layer of plan comparison information
- Exchanges should help consumers use the quality information to make value-based decisions about their plans and providers

⁴ See <http://www.pbgh.org/key-strategies/engaging-consumers/216-supporting-consumers-decisions-in-the-exchange>

- Exchanges should collect and report real-time consumers ratings of plans and doctors

13. Describe any strategies that states are considering to align quality reporting requirements inside and outside the Exchange marketplace, such as creating a quality rating for commercial plans offered in the non-Exchange individual market.

The California and Maryland exchanges will both be using the *eValue8* RFI as a tool to collect information on health plan quality improvement activities which is in direct alignment with purchaser activities outside the Exchange. The RFI is fielded around the country by regional employer coalitions. For example, in California, six issuers already use eValue8 under the auspices of the Pacific Business Group on Health.

15. What factors should HHS consider in designing an approach to calculate health plan value that would be meaningful to consumers? What are potential benefits and limitations of these factors? How should Exchanges align their programs with value-based purchasing and other new payment models (for example, Accountable Care Organizations) being implemented by payers?

The health system has waited too long to take advantage of meaningful information that can guide consumer and provider decision-making. Measures have been implemented inconsistently and information provided is not actionable by consumers or purchasers to improve care. The Exchanges, as the largest purchasers in their state, have a critical role to play in accelerating the collection of standardized information to calculate health plan value. By providing clear guidance on how Exchanges should consistently implement a quality measurement framework, CCIO will ensure information is collected in a way that is comparable and allows for value-based differentiation.

To be most effective at creating a meaningful quality measurement program, Exchanges should align their programs with existing value-based purchasing efforts in the following ways:

- Collect standardized information and make it transparent
 - Issuers should be required to complete the eValue8 Health Plan RFI to support QHP oversight and reporting of quality improvement strategies. Exchanges should use this information for plan selection, plan engagement and benchmarking.
 - Prohibit provider contracts that include transparency clauses, such as restrictions on the use of administrative data for performance reporting. Without this requirement, Exchange consumers will not have access to critical information they need to make choices about care providers and plans. These anti-transparency clauses constitute a serious weakness in the current performance infrastructure.
- Use information to improve quality and affordability of health care
 - Information should be used to help consumers identify high-value plans that meet their needs – performance information should be summarized and communicated to consumers at the time of plan choice
 - Exchanges should also leverage information for plan selection, to contract with plans that provide the highest value to consumers
 - Exchanges should also use information to identify and spread plan practices that were successful at reducing costs and maintaining quality, such as reference pricing,

revised payment models, and care models that better manage the needs of high-need populations.

- Actively support the expansion of measures to fill gaps
 - CCIIO should collaborate with ongoing public and private sector efforts to fill gaps in information on outcomes, patient experience and care coordination as well as on total cost, appropriateness of care and resource use to improve cost transparency. For example, Exchanges could test the collection and use of these measures.

We appreciate the opportunity to provide these comments. Please contact Bill Kramer, Executive Director for National Health Policy, if you have any questions.

Sincerely,



David Lansky
President & Chief Executive Officer

February 8, 2013

Peter Lee, Executive Director
California Health Benefit Exchange/Covered California

Toby Douglas, Director
California Department of Health Care Services

Will Lightbourne, Director
California Department of Social Services

Frank Mecca, Executive Director
County Welfare Directors Association of California

RE: **Customer Service Center**

Dear Directors,

Thank you for the January 31st webinar presentation on the current status of the Customer Service Center and the opportunity for advocates and other stakeholders to share comments. The Alliance to Transform CalFresh, a coalition of 5 state groups working to end hunger, largely supports the principles, protocols, and metrics that are being developed to provide consumers with:

- Excellent service by telephone by both the Customer Service Center and by the counties and
- A seamless opportunity, via a handoff to the counties, for consumers to access both health and other non-health services -- especially the CalFresh nutrition assistance program for which the majority of Medi-Cal consumers will qualify.

We do have concerns that all “doors” to health coverage – whether through the Exchange or through the counties -- provide the same standards of excellence and seamless connections to both health and non-health programs as detailed here for the telephone calls to the Customer Service Center (and for on-line applications to CalHEERS, in the previously shared “Business Service Definition for CalHEERS/SAWS/MEDS Interface”). To that end, we ask that more information be presented to stakeholders for review and comment -- *whether these decisions are made at the Exchange Board or Staff level, through Inter-Agency Agreements, in ad hoc Work Groups, or via other forums* -- on all of the following consumer access points:

1. Greater detail on the protocols and metrics for **the paper application hand-off between the Customer Service Center and the counties** is needed, similar to those that have been provided for the telephone hand-off between the Customer Service Center and the counties.

2. Protocols and metrics are also needed for **calls that go directly into the counties**. *We were very concerned to learn that the calls routed to the counties from the Customer Service Center are proposed to take priority over calls made directly to the county.* It is not clear why some consumers should receive faster service than others based on the telephone number they dialed. Any consumer seeking assistance -- whether calling the State or calling their county -- should receive the same excellent service (for example, the proposed 30 second wait time, the network with other counties' call centers to handle overflow, etc.). Treating these callers differently will be confusing and frustrating for consumers who do not understand these distinctions, is unfair to those who call their county directly, and could create unintended incentives for call traffic.
3. Similarly, protocols and metrics are needed for **paper applications that go directly into the counties**, to insure the same excellent and seamless experience as those who send paper into the Customer Service Center.
4. Finally, protocols and metrics are needed for two doors not discussed here or in other documents that have been shared with stakeholders: **in-person service by counties** and **on-line applications via SAWS**.
5. While much of this focus is rightly on initial enrollment, ongoing **case management** raises many of the same questions around excellence and seamlessness: how will health coverage enrollees be provided case management services through all doors, whether through direct service by the point of contact or through hand-offs? We are particularly interested in reviewing the plans for how Medi-Cal consumers will be provided ongoing services in a way that supports seamless case management of both their health coverage and their CalFresh (or other non-health) services that they receive.

We do want to acknowledge and appreciate the work that each of your respective organizations has focused on the two new doors anticipated to receive the large majority of consumer interest, i.e. the CalHEERS on-line applications and the Customer Service Center telephone calls. We now ask that advocates be more fully involved in the planning for these and all other doors – specifically, calls directly to counties, in-person service by counties, on-line SAWS applications, and paper applications to both the Service Center and to counties, both for initial application and on-going case management – that will be critical to ensuring excellent and seamless access for all consumers, regardless of where they seek help.

Sincerely,

Kim McCoy Wade

Alliance to Transform CalFresh

Members:

California Association of Food Banks

California Family Resource Association

California Food Policy Advocates

Catholic Charities of California

Western Center on Law & Poverty

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social interest
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Way** 
United Ways of California

February 8, 2013

Peter Lee, Executive Director
Covered California

Ms. Kim Belshé, Board Member
Secretary Diana Dooley, Board Member
Mr. Paul Fearer, Board Member
Ms. Susan Kennedy, Board Member
Dr. Bob Ross, Board Member

Re: Covered California Service Center Protocols

Dear Mr. Lee and Board Members:

We offer our further comments on the latest "Customer Service Center Updates," the PowerPoint slide deck dated January 31, 2013 and the subject of the January 31 webinar, with the hope that decisions will follow a public Board discussion. Our suggestions are set forth in red and at the end of this letter. We note that the January 31, 2013 staff update indicates that Service Center Protocols will be finalized by February 15, 2013 (slide 27). As the next Board meeting is not until February 28, 2013, we respectfully request that the decision date be modified to allow for Board direction. The key evolving policy issues and proposals underlying the Service Center Protocol Models have not yet had the benefit of full analysis, or of complete discussion at a public Board meeting followed by Board action.

Clearly, the staff of Covered California and Department of Health Care Services (DHCS) and county and other stakeholders have been working hard at refining the protocols to ensure applicants have a truly first-class experience. We commend some of the changes we see detailed in this iteration. For many Californians, the first impression they will have of Covered California-- and of the promise of health reform overall—will be when they call the Service Center to apply for affordable coverage. We believe it is incumbent upon the Exchange and DHCS to design policies and operational protocols that are as consumer-friendly as possible, and that reflect a thorough assessment of system readiness, disclosure of all costs, and an explicit contingency plan. We recognize that the application process (by phone or otherwise) initially will not be perfect. Nonetheless, there are elements of due diligence that can and should be performed prior to decision-making that will greatly enhance the likelihood of a consumer-friendly, streamlined experience.

Achieving such a first-class consumer experience requires the use of screening tools that will accurately assess program eligibility and ensure consumers seeking health coverage obtain it as quickly as possible. Consumers should not be subjected to duplicative application questions and unnecessary burdens such as multiple phone calls. Consistent with that principle, and keeping the consumer perspective at the forefront, there is no valid reason to quickly transfer uninsured Californians who contact Covered California's Service Center seeking coverage. And individuals who call the Service Center should only be required to provide the necessary application information one time, on that first call. Thus, the information that consumers supply on the first call should be entered into CALHEERS.

The comments set forth below relate primarily to Covered California's proposed telephone protocols. However, we note here our concern about the Administration's recently proposed amendments to SB 28, the Medi-Cal expansion bill, which offer very limited delegation of authority over Medi-Cal application handling to the Exchange. They appear to allow only very limited Service Center handling of web-based and paper applications, and currently afford no delegation to the Service Center for telephone applications. If amended into the bill and enacted, these provisions would seem to make impossible implementation of the many of the protocols proposed in the Service Center Updates slides. We understand that these are preliminary proposals and we will work in the appropriate forum on them to ensure that any legislative changes comport with establishing a first class consumer experience in applying for all affordability programs.

General Considerations Regarding Service Center Assessment Protocols

We fully support and appreciate the seven "Principles for the Consumer Experience" articulated on slide 2. We suggest an eighth principle: The consumer experience will be the foremost consideration in developing the process and protocols for the Service Center. The adage "The Customer Comes First" should be the mantra for Covered California (and Medi-Cal) and be instilled early on.

On slide 3, the "Service Center Assessment and Transfer Principles," # 2 as operationalized on subsequent slides, continues to trouble us regarding the transfer of potentially MAGI Medi-Cal-eligible consumers. While we understand that staff is

proceeding as if a decision has already been made to utilize a “quick sort” option, subject to federal approval, the single application and CALHEERS are being designed to determine MAGI Medi-Cal eligibility in real time. In addition, the accuracy of a quick screen for “potential eligibility” using income cut-off levels is likely to be highly inaccurate.

We still believe that calls to Covered California’s toll-free number, could and should be handled in a streamlined manner, with calls transferred only after a more complete and full assessment (in which information is retained in the CALHEERS system) where it is clearer who will, in fact, be eligible for Medi-Cal. The proposed protocol for “Multiple Program Families” (slide 19), seems to recognize the value of this approach, at least for the initial open enrollment period, in that it calls for the Service Center to collect all information on the single application, make eligibility determinations, retain Exchange enrollments, and transfer only the data and cases that are Medi-Cal-eligible to the counties. We urge extending the “Multiple Program Families” protocol to subsequent open enrollment periods as well.

However, in the event that the Board decides to stay with the two-step “quick sort” criteria proposed (see especially slide 15), it is imperative that those transfers be done as seamlessly as possible, with real-time transfer of entered data from the quick sort questions, the opportunity to have applications completed on that same call (see “warm hand-off” proposed definition below), and immediate coverage for MAGI Medi-Cal-eligible individuals whenever possible.

We want to specifically comment on one critical protocol and recommendation on Slide 17—Protocol 1E: “Warm Handoff Protocol.” We do not support the recommended Model 1. It does not provide customers with timely assistance and enrollment, and in fact places the follow-up burden on the consumer. Under Model 1, the customer must either make another phone call to, or wait for another phone call from, the county. This is not only inconsistent with a first-class consumer experience, but it does not serve Covered California’s primary goal to maximize enrollments. We recommend Model 2 since it provides for retaining and completing an assessment of the caller if a transfer within 30 seconds is not possible. However, we are concerned with the suggested option in Model 2 to ask if a consumer would prefer to call the county themselves. Covered California should not risk abandoning such a customer, or sacrificing an enrollment opportunity by telling consumers to make a second call.

Notwithstanding our recommendation above, we appreciate the staff goal of managing Service Center workload. Recognizing that goal expressed on the webinar, we offer a possible operational solution:

All calls that cannot be met with a warm hand-off will instead be completed via the Service Center representative on the line with the caller. For workload management, the Service Center will set an assumption that XX% of calls, for example 80%, will receive a successful warm hand-off, and set Service Center workload accordingly on the assumption that the remainder, 20% in our

hypothetical, will likely need to stay with the Service Center representative to complete the application.

An ongoing, weekly evaluation of compliance with the Service Level Agreement (SLA), as envisioned in Model 1, could alert the Service Center to the number (and percentage) of warm hand-offs that did not meet the SLA standard. In other words, the protocol would use Model 2 (with our suggested deletion of the option of telling customers to call the county) to complete the application with the Service Center call representative and use a version of the Model 1 approach to monitor the SLA standard so that the Service Center is not facing unmanageable workload. Under this hybrid approach, the customer retains the opportunity for a seamless application experience with just one call, while the workload for the Service Center could be adjusted promptly as needed.

We appreciate the acknowledgment on Slides #21 and 22 of the need for specific protocols for Limited English Proficient (LEP) and hearing impaired callers. We urge Covered California and DHCS to establish as a protocol that the *same* performance standards will be applied equally to all callers regardless of impairment or language spoken. This includes the same 30 second wait time for a warm transfer to a county agent for those callers who are deemed potentially Medi-Cal-eligible as mentioned in slide #17 in addition to the application of other performance measures. We would also appreciate confirmation that the Service Center will handle calls in cases where there is no county multi-lingual agent available.

Specific Recommendations

We urge the Board of Covered California to take action on, or direct staff to:

1. Add an additional “Customer Service Center Principle” as follows: “The consumer experience will be the foremost consideration in developing the process and protocols for the Service Center.”
2. Carefully review the “quick sort option,” and if maintained narrow the cut-off points for the “quick sort” to the counties (Protocol 1A) to only transfer callers after a more complete and full assessment (which information is retained in the CALHEERS system) where it is clearer who will, in fact, be Medi-Cal-eligible.
3. Enter all information provided by callers to the Service Center, including that given during any “quick sort process,” into CALHEERS.
4. Establish as a protocol that the *same* performance standards will be applied equally to all callers, regardless of impairment or language spoken and regardless of whether their call is handled by the Service Center or a county or consortium of counties.

5. Define “warm hand-offs.” Several Board members have voiced support for the staff recommendation that “warm hand-offs” be required for any telephone transfers. We agree and suggest the following definition:

A warm hand-off means that the transferring agent at the Service Center stays on the line with the customer and introduces him or her to the county agent; and transfers (or provides access) to the county agent of all data provided by the customer and entered into CALHEERS. The county agent personally answers the call within 30 seconds and affords the customer the opportunity to complete the application on that same call. This applies to all callers, including Limited English Proficient (LEP) and hearing or visually impaired callers.

6. As to the “warm hand-offs” protocol (Protocol 1E), establish the following:

All calls that cannot be met with a warm hand-off will instead be completed via the Service Center representative on the line with the caller. For workload management, the Service Center will set an assumption that XX% of calls [e.g. 80%] will receive a successful warm hand-off, and set Service Center workload accordingly on the assumption that the balance will likely need to stay with the Service Center representative to complete the application. Weekly SLA tracking will allow the Service Center to manage its human resource allocations.

7. Establish a policy objective to provide immediate coverage for all applicants whenever possible.
8. Extend the protocol for “Multiple Program Families” (slide 19), beyond the initial open enrollment period to each subsequent open enrollment period so that the Service Center collects all information on the single application, does a full assessment, retains Exchange enrollments, and transfers only the data and cases that are Medi-Cal-eligible to the counties.
9. Support the pilot that staff has proposed (slide 26) to test capacity and performance of all facets of the Service Center experience for all callers including LEP, hearing- and visually-impaired callers.
10. Provide to the public all readiness data, cost estimates and contingency plans related to the Service Center.

Conclusion

As our January 14, 2013 letter pointed out, a report submitted to the Board last summer noted the need to address challenges associated with telephone applications and inquiries related to current program rules and on-the-ground processes. The Board must consider the resources that will be necessary to support the anticipated volume of Covered California Service Center applications, including existing and new obligations, to complete applications for Medi-Cal and all insurance affordability programs over the phone.

Thus, workload projections, as well as capacity and readiness for the Covered California Service Center and all its subcontractors, must be demonstrated as a pre-requisite and due diligence effort on the part of Covered California before the Board approves the Service Center protocols.

Our interest in these matters derives solely from our commitment to getting consumers the coverage which the Affordable Care Act entitles them to, and indeed requires them to have. We look forward to working with you on these matters in the coming months.

For more information, please contact Elizabeth Imholz at Consumers Union (imhobe@consumer.org) or Kathleen Hamilton at The Children's Partnership (khamilton@childrenspartnership.org).

Sincerely,



Elizabeth Imholz,
Special Projects Director
Consumers Union



Kathleen Hamilton,
Director, Sacramento Governmental Affairs
The Children's Partnership

Doreena Wong
Asian Pacific American Legal Center

Gary Passmore, Vice President and
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Congress of California Seniors

Ellen Wu
California Pan Ethnic Health Network

Kimberly Lewis
National Health Law Program

Serena Kirk
Children's Defense Fund - California

Corey Timpson
PICO-California

Mike Odeh
Children Now

Lucy Streett
Social Interest Solutions, Inc.

Sonya Vasquez
Community Health Councils

Judith Darnell
United Ways of California

cc: Toby Douglas, Director of California Department of Health Care Services



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FOR IDENTIFICATION PURPOSES

February 8, 2013

Peter Lee, Executive Director
Julie Baker, IT Director
California Health Benefits Exchange
560 J St., Ste. 200
Sacramento, CA 95814

Re: Customer Service/CalHEERS: Quick Sort Questions and "Smart Calculator"

Dear Mr. Lee and Ms. Baker,

We have reviewed the quick sort questions intended to allow use of the "smart calculator" to acquire the minimum information necessary for CalHEERS.

1. Employer Coverage

Nowhere do the questions ask about whether a consumer is offered health benefits or health coverage by their employer. Yet a consumer who fails to take up affordable, minimum value employer-sponsored insurance is exposed to significant tax liability, indeed tax liability as much as the entire value of any premium subsidy. We strongly suggest that a question be added about whether the consumer or any family member has an offer of affordable coverage from their employer.

2. Income

Income, particularly Modified Adjusted Gross Income, is not a figure that most consumers know. Indeed, we are skeptical that most consumers have any idea what their income is, much less what their adjusted gross income is.

Because most consumers do not know what their family income is, we anticipate that consumers will need assistance in answering this question. Elizabeth Abbott, director of administrative advocacy, began her career as a Social Security customer service representative taking Social Security applications: she reports that less than half of consumers had the basic information needed to initiate a Social Security application. The odds that a consumer will know their Social Security number are far higher than the odds that a consumer will know their adjusted gross income.

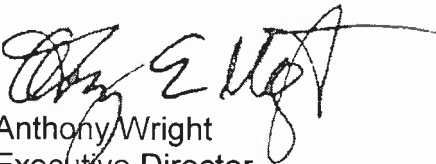
What happens if a consumer has literally no idea what their modified adjusted gross income is?

3. Consumer Testing

The Exchange staff reports a variety of opinion research on consumer attitudes. We recommend that the "smart calculator", including the phrasing of the questions, be subjected to consumer testing. While most of the questions seem fairly obvious from a policy perspective, the phrasing may or may not be understandable by consumers with average literacy.

Thank you for your consideration of these comments. You may reach me at awright@health-access.org or (916) 442-2308.

Sincerely,

A handwritten signature in black ink, appearing to read "Anthony Wright", with a long horizontal flourish extending to the right.

Anthony Wright
Executive Director