



Robert C. May
Telephone: (510) 987-0711
Email: robert.may@ucop.edu

*Chair of the Assembly of the Academic Senate
Faculty Representative to the Regents
University of California
1111 Franklin Street, 12th Floor
Oakland, California 94607-5200*

July 30, 2019

**JANET NAPOLITANO, PRESIDENT
UNIVERSITY OF CALIFORNIA**

RE: Request for Medicare Advantage PPO Data Collection

Dear Janet,

At its July 24, 2019 meeting, the Academic Council unanimously endorsed the attached letters from UCFW and its Health Care Task Force asking UC to collect and analyze data related to the experience of the upcoming conversion of the Health Net Seniority Plus HMO Plan to a Medicare Advantage PPO Plan. Council also wants to ensure that any other changes to Medicare plans UC offers to retirees be accompanied by a targeted and purposeful data collection effort.

Please do not hesitate to contact me if you have additional questions.

Sincerely,

A handwritten signature in brown ink that reads "Rob C May".

Robert C. May, Chair
Academic Council

Encl:

cc: Chief Operating Officer Nava
Executive Director Baptista
Executive Director Tauber
Academic Council
Senate Directors



UNIVERSITY COMMITTEE ON FACULTY WELFARE (UCFW)
Sean Malloy, Chair
smalloy@ucmerced.edu

Assembly of the Academic Senate
1111 Franklin Street, 12th
Oakland, CA 94607-5200
Phone: (510) 987-9466
Fax: (510) 763-0309

July 17, 2019

**ROBERT MAY, CHAIR
ACADEMIC COUNCIL**

RE: Possible Adoption of Medicare Advantage Plans

Dear Robert,

The University Committee on Faculty Welfare (UCFW) has agreed unanimously with our Health Care Task Force (HCTF) that any changes to the Medicare plans offered by UC to retirees must be accompanied by a targeted and purposeful data collection effort (see enclosure). Because the situation surrounding the University's retiree health care offerings remains fluid, attaining in advance concrete data illustrating the efficacy and impacts of plan changes is essential. This necessity is underlined by the vulnerability of the retiree population, many of whom are on limited, fixed incomes, despite the generous provisions of the UC Retirement System. In order to maintain the retiree health benefit as one that is sustainable to the employer and meaningful to the retiree, we urge you to call for the careful scrutiny we suggest.

Sincerely,

Sean Malloy, UCFW Chair

Encl.

Copy: UCFW
Hilary Baxter, Executive Director, Academic Senate



UNIVERSITY COMMITTEE ON FACULTY WELFARE (UCFW)
HEALTH CARE TASK FORCE
Lori Lubin, Chair
llubin@ucdavis.edu

Assembly of the Academic Senate
1111 Franklin Street, 12th
Oakland, CA 94607-5200
Phone: (510) 987-9466
Fax: (510) 763-0309

July 9, 2019

SEAN MALLOY, CHAIR
UNIVERSITY COMMITTEE ON FACULTY WELFARE

RE: Medicare Advantage Plan PPO RFP

Dear Sean,

The University Committee on Faculty Welfare's Health Care Task Force (HCTF) has discussed at length the proposed plan to convert UC's Medicare plans to Medicare Advantage plans. The current trajectory of negotiations suggests that UC's Medicare HMO plan, Seniority Plus, which is based on HealthNet, is likely to be converted to a Medicare Advantage plan, while the other plans will remain as options – at least for the short term. In order to best inform our decision-making going forward, we encourage the administration to collect and analyze particular data from the experience of the HMO conversion. In particular, one of the things we hope to learn from this partial transition into the MA PPO plan is how much “friction” the plan causes for members receiving services and how effectively the plan does the care coordination, preventive care and chronic care management it purports to be able to do. To that end, we have outlined some of the data points the University should ask the plan to provide so that we may evaluate the plan's performance most accurately. This data would inform not only the experience of this plan with a subgroup of retirees, but also how the larger retiree population might be impacted if the University chooses to push ahead with an expansion of the Medicare Advantage plans over time.

Thank you for your support,

Sincerely,

Lori Lubin, UCFW-HCTF Chair

Encl.

Copy: UCFW-HCTF
Hilary Baxter, Executive Director, Academic Senate

MONITORING OF MEDICARE ADVANTAGE PPO

The Medicare Advantage PPO purports to create savings to the University by supporting care coordination, chronic care management, and preventive care. Plans vary in how they implement these approaches and, to the degree a plan's approach is effective, it is important for the University to develop an understanding of how widely these approaches are used among eligible enrollees. The greater the penetration of an effective approach is within the enrolled population, the more likely it is that it can return the benefit of reducing unnecessary utilization.

Other actions that a health plan may take to reduce utilization can make it difficult to assess the real value of care coordination, chronic care management, and preventive care. Many plans also employ administrative barriers such as prior authorization to curb utilization. While the goal is to reduce unnecessary services while allowing appropriate ones, the degree to which a plan is able to fine-tune its approach to achieve this outcome—and avoid unnecessary “friction” between patients and their access to appropriate care—can greatly impact an enrollee's experience with the health plan.

The University can improve its ability to assess plan performance on behalf of its retirees by stipulating that a contracted plan provide timely and updated data on the services requested and delivered to the University's retirees covered by the plan. The University would then be in a position to use these data to evaluate how effectively the contracted plan furnishes desirable care coordination, chronic care management, and preventive care as well as how frequently the plan creates barriers to appropriate care through pre-authorization requirements. In order to interpret the information it would be important for the University to not only collect the information detailed below for the MA PPO plan but to have comparable information on the retirees covered by the Medicare PPO and the Medicare High Option plans.

Transitional Care Coordination:

Care coordination involves communication and shared care planning among practitioners in their management of the patients they have in common. Patients are particularly vulnerable at the time of transitions, such as when they are discharged from the hospital back to the community. Medicare has established a transitional care management billing code to provide an enhanced payment to support care coordination surrounding hospital discharges. The University can gain insights into whether its contracted plan is supporting care coordination by monitoring hospital discharge transitions.

This includes:

- Time in days from hospital discharge to first doctor visit. Physician office/clinic visits within 14 days post discharge have been shown to be associated with a reduction in hospital readmission.

- Billing for transitional care management services among those eligible to receive service. This is a Medicare billing code that provides a practitioner payment for contacting patients within 2 business days of a hospital discharge and seeing the patient within 14 days following a hospitalization.
- The number/percentage of eligible enrollees incorporated into any health plan related transitional care management programs – separate from any provider related billing for these services.
- Hospital readmission rate within 30 days post discharge (using the CMS definition of hospital re-admissions which is used in the financially incentivized reduction program) as an indicator of effective transitional care service delivery.

Chronic Care Management:

Beginning in 2015, Medicare established Chronic Care Management (CCM) billing codes as a way to pay practitioners to furnish non-face-to-face care coordination to beneficiaries with chronic conditions. This includes activities such as communicating with patients via phone calls, emails, and other means to monitor and support management of patients’ health conditions. While practitioners can furnish these services without billing for them, the purpose of the billing code is to incentivize practitioners to deliver these services. The University might rightfully expect that if its contracted plan is furnishing chronic care management that there would be evidence of this in the degree to which CCM codes are billed for retirees.

- The University should receive information on the monthly percentage of enrolled retirees who are billed for CCM services within the contracted plan.
- The number/percentage of enrollees incorporated into any health plan related chronic care management programs – separate from any provider related billing for these services

Preventive Care:

Health care plans market their interest in preventive care services but the University lacks information on how effective plans are in accomplishing this shared goal. To that end, the University should establish and maintain a list of preventive services appropriate for the elderly adult population recommended at the A or B level by the US Prevention Services Task Force. This would include services such as breast cancer screening, colorectal screening, and shingles vaccination. A contracted plan should be expected to provide annual rates of receipt of the identified recommended services for the retiree population covered by the plan.

Prior Authorization/Denied Care

To ensure fairness and accountability, the process of prior authorization and denied care should be transparent to the University and its retirees.

This includes:

- An updated and maintained list of what triggers prior authorization.
- Number of prior authorization requests by procedure code (CPT) or drug code, diagnosis (ICD-10), provider location type (office, hospital, ED, etc.).
- Outcomes of prior authorization requests – how many overall and stratified by type of service were approved as originally ordered, approved at a reduced level/amount (for example fewer PT visits approved than were requested), or denied.
- Of those denied or approved at a reduced level/amount than originally ordered, what was the reason for the change from the original order; how many were appealed internally and what was the outcome of that review? Of those denied after internal review how many ultimately went to external review and what was the outcome of those appeals?
- Time from submission to final resolution of prior authorization request overall and stratified by approved as originally ordered, approved at a reduced level/amount, denied without appeal, denied with internal appeal, denied with external appeal.

Enrollee Experience

In addition to the administrative and utilization statistics described above, the University should require its contracted plans to regularly collect and report patient experiences with the plan. MA plans are already evaluated using CAHPS (Consumer Assessments of Healthcare Providers and Systems) as a part of the star rating system, which determines a component of their payment from Medicare. CAHPS includes patients' assessments of the plan and the providers in that plan. While this tool provides an overall assessment of the plan for all of its MA enrollees, it is not specific to University of California employees. As a requirement of a contract with the University of California, we could require that contracted MA plans collect and report to us the results of an annual CAHPS survey derived from a University of California-specific sample of enrollees. These results could be benchmarked against the plan's overall results and against other comparable MA plans.