August 2, 2013

Department of Healthcare Services
Delivered via email to: info@calduals.org

Re: Comments on the Proposed Enrollment Strategy into Cal MediConnect for Los Angeles County

Greetings:

Thank you for the opportunity to respond to the proposed enrollment strategy for Los Angeles County. Approximately 216,000 dual eligible beneficiaries will receive multiple notices regarding enrollment into Cal MediConnect. Many thousands more will receive notices about enrollment in Medi-Cal managed care only under the Coordinated Care Initiative (CCI). In addition to the sheer number of impacted beneficiaries in LA County, the enrollment strategy also has to consider the diversity of the impacted beneficiaries in LA County with regard to race, language, disability, education and geographic location. Our comments below address ways we feel the current enrollment strategy should be amended to minimize confusion and disruption to beneficiaries in LA County.

Enrollment Timeline

Under the current enrollment strategy, passive enrollment will begin in April 2014. In this month, individuals born in January and April will be subject to passive enrollment, a total of 27,667 beneficiaries. We feel that doubling the number of beneficiaries subject to passive enrollment in the first month is inadvisable. The plans will be responsible for providing enrollment materials, handling consumer calls, and conducting risk assessments for thousands of individuals in the first month alone. In fact, plans in LA County will be responsible for enrolling 8,000 more beneficiaries in the first month than the health plans in the other seven CCI counties combined.[1] The recent enrollment of 20,000 dually-eligible recipients of Community-Based Adult Services (CBAS) into Medi-Cal managed care resulted in significant problems involving real or perceived access to Medicare doctors, hospitals, and needed services. The proposed strategy envisions enrolling more than this number in the first month

[1] See, "Medi-Cal's Coordinated Care Initiative Population: Definitions and Estimated Counts," available at http://www.dhcs.ca.gov/dataandstats/statistics/Documents/CCI%20Population%20Brief.pdf

alone. Expecting the plans to meet this demand is unrealistic and will result in major disruptions and confusion for thousands of the most needy and medically frail beneficiaries in LA County.

We propose that the timeline or phasing method for enrollment be amended to avoid surges in enrollment in April, July, and October. DHCS could accomplish this in two ways. One, DHCS could increase the passive enrollment period from nine months to twelve months as initially outlined in the Memorandum of Understanding (MOU) with CMS. This would not only avoid enrollment surges in certain months, but it would also decrease the overall number of enrollees subject to passive enrollment in any given month.

Two, DHCS could change the method of phasing beneficiaries into Cal MediConnect. Rather than phasing by birth month, DHCS could phase individuals into Cal MediConnect by last name. This would allow DHCS to set a more manageable enrollment timeline. DHCS has the ability to determine how many beneficiaries have a last name starting with each letter of the alphabet and to create a timeline for enrollment that more evenly distributes enrollees over the nine month enrollment period. Furthermore, this would allow DHCS the flexibility to amend the timeline in the event that that the voluntary enrollment period significantly impacts the number of beneficiaries subject to passive enrollment. For example, DHCS may anticipate enrolling all beneficiaries with last names A-D in April. However, in March, when the voluntary enrollment period ends, DHCS may discover that a large number of beneficiaries with last name starting with the letter C enrolled. To distribute enrollees evenly over the nine months, DHCS could change enrollment in April from A-D to A-F, for example. If DHCS maintains phasing by birth month, we encourage a flexible birth month phasing that spreads enrollment more evenly over the enrollment period and is adjusted to reflect how many beneficiaries enrolled during the voluntary enrollment period.

Enrollment Strategy for Part D Low Income Subsidy (LIS) Re-assignees

Under the current strategy, Part D LIS re-assignees in 2014 will be enrolled all at once in January 2015. We recognize that this strategy is in place to ensure that an individual who has been reassigned to a Part D plan in 2014 does not experience a second disruption in the same calendar year. However, this policy objective is undermined by requiring Part D re-assignees to nevertheless enroll in a Medi-Cal managed care plan in 2014. A few examples will illustrate how disruptive this policy will be in practice for Part D re-assignees:
First, it is important to note that an individual who is reassigned to a Part D plan currently already receives **eight** notices or packets of enrollment materials between October and December.

- Beneficiary A is a Part D re-assignee for 2014. She received eight notices between October and December 2013. Her birthday is in January. Per the enrollment strategy, she will start receiving notices in January 2014 for enrollment in mandatory Medi-Cal managed care in April. She will also receive a choice packet, provider directory, and health plan guidebook in February. She will then be mandatorily enrolled in Medi-Cal managed care in April. In October, Beneficiary A will start getting notices regarding Cal MediConnect. In total, Beneficiary A will receive over 14 notices and other enrollment material between October 2013 and December 2014. This does not include the amount of information she will receive from other health care sources vying for her participation in their plan.

To minimize confusion, it is imperative that DHCS delay mandatory enrollment in Medi-Cal managed care for 2014 Part D re-assignees until January 2015 to coincide with the timeline for passive enrollment into Cal MediConnect for this population. Maintaining passive enrollment into Cal MediConnect and mandatory enrollment in Medi-Cal managed care on the same timeline will also prevent a Part D re-assignee from being placed into one Medi-Cal managed care plan in 2014 and then subsequently reassigned to a different Cal MediConnect plan in 2015. For example, a beneficiary may be placed in LA Care for her Medi-Cal benefit at random because at the time of assignment into Medi-Cal managed care, the beneficiary did not have any providers that were providing Medi-Cal benefits. When enrollment into Cal MediConnect occurs, the beneficiary may be assigned to Health Net because Health Net has the majority of the beneficiary's Medicare providers. If enrollment into Medi-Cal managed care and Cal MediConnect are simultaneous, there will be no risk of a beneficiary being moved from one plan to another just months apart. The benefit of enrolling Part D re-assignees into Medi-Cal managed care separate from passive enrollment in Cal MediConnect is negligible compared to the confusion and disruption it will cause for these beneficiaries.

- Beneficiary B is not a 2014 Part D re-assignee. He has a birthday in December. Accordingly, he will be subject to passive enrollment in Cal MediConnect in December 2014. However, Beneficiary B is also a Part D re-assignee for 2015. Beneficiary B will begin receiving notices for enrollment in Cal MediConnect in September 2014. He also will start receiving notices for being re-assigned for his Part D plan in October. This alone will be very confusing. It will be even more confusing when he decides to opt out of Cal MediConnect, continues to receive Part D notices and will also still receive notices telling him he still must choose a

Medi-Cal managed care plan. Like Beneficiary A, Beneficiary B will also receive many other health care related mailings during this period.

This example illustrates that individuals who will be passively enrolled into Cal MediConnect in the fall of 2014 will likely receive many notices from multiple entities regarding changes in the delivery of their healthcare benefits. DHCS must be cognizant of these issues and coordinate with CMS to decrease the amount of confusion these beneficiaries will experience under the proposed strategy.

Voluntary Enrollment Notices

Notices for voluntary enrollment in Cal MediConnect will be sent to over 200,000 beneficiaries. These notices must make it clear that beneficiaries will have the choice to enroll in Cal MediConnect while simultaneously making it clear that they will still be subject to passive enrollment in the program at a future date and will, regardless of whether they opt-out of Cal MediConnect, be mandatorily enrolled in Medi-Cal managed care. This is a challenging undertaking. To date, advocates have not received drafts of the voluntary enrollment notices to review. These notices should be beneficiary tested and made available to advocates for review and comment.

Under the proposed enrollment strategy, voluntary enrollment notices will be sent on November 1, falling in the middle of Medicare open enrollment, which runs from October 15 through December 7. During this period, dual eligible beneficiaries are heavily marketed to and are flooded with healthcare messaging. Voluntary enrollment notices are likely to be lost among the other Medicare Advantage and Part D marketing materials beneficiaries will receive, diminishing the value of a voluntary enrollment period. We suggest that DHCS consider sending a minimum of two notices to beneficiaries - one on November 1 and one on December 9 to increase the likelihood that beneficiaries will recognize that Cal MediConnect is a new program different from the options they typically hear about during this period. Additionally, DHCS should attempt to clearly distinguish Cal MediConnect notices from the other healthcare marketing materials beneficiaries will receive.

Separate Notices

Beneficiaries who are on the MSSP waiting list and on waiting lists for 1915(c) waivers should receive tailored notices explaining their unique situation and options. Specifically, those on the MSSP waiting list should receive a notice stating that they will continue to remain on the MSSP waiting list, and if a slot opens, MSSP will be a benefit offered by the managed care plan.

Beneficiaries on waiver waiting lists should receive notices explaining that they will remain on the waiting list even if they join Cal MediConnect. The notice should state that if a waiver slot becomes available, they will have the option to disenroll from Cal MediConnect and join the waiver but will remain in a managed care plan for their Medi-Cal benefit. DHCS should flag those beneficiaries who are on waiting lists to ensure that the plans identify these beneficiaries as high-risk individuals requiring immediate attention and care coordination.

In addition to the above unique notices, individuals currently receiving MSSP services will receive different notices separately from other dual eligible beneficiaries because they are subject to passive enrollment all at one time on a date not yet determined. Based on the different number of notices going out to different populations, it is imperative that DHCS and the plans utilize a coding method to help beneficiaries, community based organizations, the plans, and DHCS distinguish the notices.

Enrollment Counseling

With all the challenges outlined above, it is critical that beneficiaries receive enrollment counseling. DHCS must commit to extensive outreach and education to community-based organizations, providers, and other advocates that can assist beneficiaries with understanding the large number of notices they will receive and choices they will have to make. DHCS must also increase efforts to expand HICAP capacity to serve the large number of beneficiaries impacted by the CCI.

Plan Enrollment

Although it is not included in the proposed enrollment strategy, we are concerned about recent statements made by DHCS that Cal MediConnect plans will be permitted to handle some enrollments. This proposal was never discussed with stakeholders and is contrary to what we had understood to be established policy across the CCI counties: Namely, all enrollments would be processed through an enrollment broker except in COHS counties. We ask for clarification of the details of what is proposed and an opportunity to review and comment.

Outreach

While notices are an important component of an effective outreach effort, we have learned from past healthcare transitions that many beneficiaries, for a myriad of reasons, do not

receive the notices or cannot read or understand the notices.[2] Here, the efficacy of notices is further diminished by the demographics of the population impacted by the CCI: More than fifty percent of dual eligibles speak a language other than English primarily. Furthermore, CCI beneficiaries are the most medically frail and more likely to suffer from cognitive disorders, including dementia, which will impact their ability to understand the changes occurring under the CCI. DHCS should commit to a robust outreach effort that targets health care providers, LTSS providers, and caregivers. DHCS should also supplement notices with telephone calls to encourage choice and prompt the beneficiary and/or their caregiver(s) to action.[3]

Thank you again for the opportunity to comment.

Sincerely,

Craig E. Thompson, Executive Director
AIDS Project Los Angeles

Barbara McLendon, Public Policy Director
Alzheimer's Association, California Southland Chapter

Kim Williams, Paralegal, Family Caregiver Unit
Bet Tzedek

Jen Flory, Director
Cancer Legal Resource Center, Disability Rights Legal Center

Melinda Bird, Director of Litigation
Disability Rights California

Silvia Yee, Senior Staff Attorney
Disability Rights Education Defense Fund

Paul S. Castro, Chief Executive Officer
Jewish Family Service of Los Angeles

---

[2] See, California Healthcare Foundation "Briefing, - Transitioning the SPD Population to Medi-Cal managed Care (March 28, 2013)," available at http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20Sacto03282013SPDsTransitionMediCalManagedCare.pdf.

[3] In its amendment to the Special Terms and Conditions of the 1115 waiver "California Bridge to Reform Demonstration," DHCS has committed to making repeated efforts to encourage choice before placing a beneficiary in a default plan including notices, followed by at least 2 phone calls. DHCS should include this language in its outreach plan.

Executive Committee
MSSP Site Association

Kimberly Lewis, Managing Attorney
National Health Law Program

Amber Cutler, Staff Attorney
National Senior Citizens Law Center

Toni Vargas, Staff Attorney
Neighborhood Legal Services of Los Angeles County

Greg Thompson, Executive Director
Personal Assistance Services Council, Los Angeles

Mona Tawatao, Senior Litigator
Western Center on Law & Poverty