NSCLC
National Senior Citizens Law Center

Center for Health Care Rights
ADVOCACY FOR HEALTH CARE CONSUMERS

February 24, 2014

Department of Health Care Services ("DHCS")
Delivered via email to: info@calduals.org

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

Greetings:

Thank you for re-releasing the enrollment strategy for Los Angeles County ("Los Angeles") into Cal MediConnect. Given the changes that have occurred in Los Angeles since the release of the proposed enrollment strategy late last year, we are pleased that DHCS is actively reevaluating the enrollment strategy and appreciate the opportunity to offer our comments on it.

As DHCS is aware, we have serious global concerns about Coordinated Care Initiative ("CCI") enrollment readiness that have led us to urgently request a significant implementation pause in all counties other than San Mateo. We reiterate that request here with respect to Los Angeles, where the potential for beneficiary confusion and access problems is most acute since the county has by far the largest population affected by the CCI and the most complex enrollment strategy.

We also have a number of Los Angeles-specific concerns.

With so many individuals eligible for Cal MediConnect in Los Angeles, the enrollment strategy must strike a balance of being clear and easy to explain to beneficiaries but also contain sufficient details to account for unforeseen circumstances. Equally as important, with the addition of three new health plans as primary contractors, the enrollment strategy must consider the readiness of these new plans. We believe that the re-released Los Angeles enrollment strategy presents serious issues around voluntary enrollment, the assignment algorithm, enrollment into LA Care, and the manageability of the waitlist. Thus, we strongly request that enrollment into Cal MediConnect should be delayed until these issues are resolved.

As an initial matter, the re-released enrollment strategy is a general strategy subject to, as DHCS enumerates, ten different conditions. It is simply not possible to boil down the strategy as a simple concept that can be easily communicated to the dual eligibles who will be impacted. To add further challenges, the timeline and strategy for enrolling dual eligibles not subject to passive enrollment into Cal MediConnect and other seniors and persons with disabilities into Medi-Cal managed care plans do not correspond to the Cal MediConnect timeline and strategy. Such complexity makes it unreasonable to expect beneficiaries to actually understand how the enrollment strategy applies to their individual circumstances and to make informed and meaningful decisions. Furthermore, the two different timelines and enrollment strategies will result in certain populations receiving multiple sets of notices simultaneously or, at best, months apart. A chart outlining when and what notices the different populations will receive is

attached. Relinking the two timelines and postponing passive enrollment into Cal MediConnect until all plans can accept passive enrollment would eliminate much of the complexity and allow the State, CMS, and the health plans the necessary time to adequately demonstrate they are ready to move forward with enrolling hundreds of thousands of beneficiaries into new plans.

The text describing voluntary enrollment must be clarified.

The strategy appears to imply that all five plans will be available for voluntary enrollment, not simply Health Net and LA Care. It must be clarified that only Health Net and LA Care will accept beneficiaries for voluntary enrollment. In addition, the revised strategy seems to incorrectly imply that beneficiaries can opt out during the voluntary enrollment period, so language must be provided that explains clearly to beneficiaries that they can only opt out after they have received their first 90-day notice. Some beneficiaries may try to opt-out during voluntary enrollment, especially after receipt of the voluntary enrollment notice. The enrollment strategy must make clear that any attempt to opt out will not work during the voluntary enrollment period.

The assignment algorithm lacks important details and the system needs to be reformed.

DHCS intends to assign beneficiaries to plans based on an assignment algorithm that uses a beneficiary's highest utilized and paid prescribing provider from the most recent twelve months of Medicare and Medi-Cal data but does not provide greater detail on how the algorithm works. The strategy does not explain what happens if a beneficiary's usage results in an uneven distribution among participating plans or if a beneficiary's usage results in matches with more than one participating plan. This is especially plausible since considerable overlap with providers exists among some of the participating plans.

The strategy also does not explain how the algorithm gives DHCS confidence that beneficiaries will be enrolled into each participating plan in the numbers that DHCS expects. Furthermore, the strategy does not clearly explain that those already enrolled in a Medi-Cal managed care plan will be passively enrolled into that plan's Cal MediConnect product. As our comments on the previous enrollment strategy explained, DHCS should consider more than just enrollment into a Medi-Cal managed care product as the link to a corresponding Cal MediConnect product because many dual eligibles enrolled into the Medi-Cal product simply in order to continue receiving their Community Based Adult Services ("CBAS") benefits and did not consider medical provider and prescription drug factors. Where so much of the strategy relies on the algorithm, it is imperative that DHCS develop a process for establishing a link that is tested and accurate for meeting a beneficiary's needs.

Relatedly, the strategy states that beneficiaries who are currently enrolled in a Health Net or LA Care managed care product for Medi-Cal benefits will be automatically enrolled into the same plan's Cal MediConnect product on July 1. The enrollment strategy, however, does not address what will happen if a beneficiary is enrolled in either LA Care or Health Net, but is linked to one of their sub-contracted plans. For example, if a beneficiary is actually linked to Care1st, it would make no sense to passively enroll a beneficiary into LA Care's Cal MediConnect plan. Similarly, if a beneficiary is linked to Molina, passively enrolling him into Health Net defeats intelligently assigning beneficiaries to plans. As July is the first month of passive enrollment in Los Angeles, we question whether DHCS, CMS, and the plans will be ready to assist and serve 36,000 beneficiaries in the first month of passive enrollment. On a related point, the timeline chart needs to be changed to reflect the fact that beneficiaries enrolled in a Medi-Cal product through Health Net and LA Care are not enrolling from July through November 2014, but rather at one time on July 1, 2014.

Enrollment into LA Care is confusing and presents potential capacity concerns.

DHCS will work to identify beneficiaries whose primary care provider is only affiliated with LA Care and will passively enroll them into LA Care regardless of birth month beginning in December 2014, assuming that the plan no longer has a low performing icon. This raises several concerns. First, this strategy will be extremely difficult to explain to beneficiaries. It is unclear what DHCS will use to determine who those beneficiaries are, and it is also unclear how DHCS will identify and flag these individuals in its system. Most concerning, there is no way for beneficiaries to know if DHCS has determined that they are part of this population. Second, the enrollment strategy does not elucidate how passive enrollment will be carried out for this population being held until December 2014. As written, the policy implies that the entire population being held from July through December will be passively enrolled in December in one month and at one time. The enrollment strategy does not specify the number of individuals DHCS estimates will be held for enrollment into LA Care. Regardless of the size of this population, concerns exist about LA Care's capacity to accept enrollment of these individuals and then, only one month later, accept and process enrollment of its share of the over 90,000 duals who are scheduled for passive enrollment in January 2015.. Third, the strategy fails to provide alternative arrangements should LA Care's low performing icon continue into 2015. As DHCS's recent experiences with the health plans demonstrate, a project of this size must account for contingencies.

The proposed waitlist system could require extremely detailed recordkeeping.

According to the passive enrollment population numbers provided in the enrollment timeline, we estimate that the earliest the 200,000 person cap would be reached and a waitlist created is in December 2014. It is possible that beneficiaries who will be passively enrolled in December 2014 and afterward, including beneficiaries with December birthdays, Medicare Part D Low-Income Subsidy plan re-assignees, Medicare Advantage Product beneficiaries, and Multipurpose Senior Services Program ("MSSP") beneficiaries, will be placed on this waitlist. These beneficiaries could total almost 90,000 in number. Because of the complicated enrollment timeline and because the waitlist prioritizes those who opt-in over passive enrollees, DHCS must record if and when a beneficiary opts in. It is unclear whether DHCS has structures in place, and what those might look like, to guarantee accurate recordkeeping to effectively manage a waitlist of this potential size.

Given the number and magnitude of concerns the LA enrollment strategy presents, we firmly believe that LA enrollment should not begin as scheduled and should be delayed until these issues are resolved. We thank you again for the opportunity to comment on the enrollment strategy, and we look forward to continue to working with DHCS and CMS to improve LA enrollment strategy and the CCI rollout generally.

Sincerely,

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