JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

April 22, 2016

Sarah Brooks, Deputy Director, Health Care Delivery Systems
Department of Health Care Services
Sacramento, California 95812
Via email: Sarah.Brooks@dhcs.ca.gov

Tim Engelhardt, Director
Medicare-Medicaid Coordination Office
Centers for Medicare and Medicaid Services
Baltimore, Maryland 21244
Via email: Tim.Engelhardt@cms.hss.gov

**SUMMARY**

Thank you for the opportunity to submit recommendations, comment, and questions on the Department of Health Care Services' (DHCS) enrollment strategies and program improvement proposals for California's Coordinated Care Initiative (CCI). As advocates representing organizations who work with dual eligible beneficiaries, we were pleased by the Governor's commitment to the CCI and remain dedicated to its promise on the principle that a coordinated delivery system ultimately results in better care for beneficiaries. We also recognize DHCS's interest in ensuring ongoing enrollment into Cal MediConnect (CMC) and are committed to working with DHCS, CMS, and stakeholders on improving the quality of the program and developing an enrollment strategy that avoids disruption and honors beneficiary choice. We hope DHCS and CMS consider our comments seriously in light of their obligations under the Medicaid Act and the 1115 waiver.

As a number of our organizations raised in a separate, shorter letter, we have several concerns about the new enrollment policies DCHS has proposed. These concerns are laid out in considerable detail in the third section of these longer comments ("Opposition to Proposed Enrollment Changes," p. 8). In summary, we are concerned that the passive enrollment proposal repeats mistakes from the first rounds of passive enrollment and will cause more confusion and disruption for beneficiaries. We are concerned that the "streamlined" or direct enrollment proposal limits important consumer protections and will lead to some beneficiaries being inappropriately enrolled in the demonstration, causing further confusion.

Instead we prefer a different approach to enrollment that is based on an affirmative, voluntary enrollment strategy. This is a strategy that DHCS has full authority to implement, but which it has not yet tried. We believe this strategy – combined with quality improvement efforts –honors beneficiary choice, limits disruption for beneficiaries, providers, and plans, improves program outcomes, and advances the enrollment goals of DHCS. Such a strategy is also more responsive to early evaluation data on beneficiary experience. We provide more details on this idea and other alternative proposals in the first section of these comments ("Alternative Proposals," p. 2).

There are elements of the DHCS proposal that we do support, such as the proposal to extend the deeming period. That and other proposals are covered in the second section of these comments.

WASHINGTON
1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES
3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND
1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

("Proposals We Support," p. 8). Finally, we have several questions about the DHCS proposal that are listed in the final section of our comments ("Questions Regarding DHCS Passive Enrollment Strategy," p. 16).

We recognize that our comments are extensive, but we believe the length reflects the complexity of DHCS's proposals. We appreciate that DHCS and CMS have been consistently willing to consider our views on the demonstration. We take seriously our role as beneficiary advocates in a program that is extremely complicated and complex. We continue to be willing to work with DHCS, CMS, health plans, providers, advocates, beneficiaries, and other stakeholders to ensure that this program provides better care – including more home and community based care, delivered earlier and with an eye to rebalancing – to low-income seniors and people with disabilities throughout California.

## ALTERNATIVE PROPOSALS

In the DHCS document, "Ensuring Sustainable CCI Enrollment," DHCS indicates that the enrollment strategies proposed are designed to increase and promote stable enrollment of beneficiaries eligible for Cal MediConnect. We oppose the majority of the strategies identified (See "Opposition to Proposed Enrollment Changes," p. 8) and offer four alternative steps DHCS should take to meet this important goal.

### Alternative Proposal 1: DHCS Should Implement an Affirmative Voluntary Enrollment Program to Further Its Enrollment Goals for the Program.

The best way to meet DHCS's enrollment goals, protect the rights of beneficiaries, and ensure a more positive transition to the program for beneficiaries, is to implement an affirmative voluntary enrollment strategy.

An affirmative voluntary enrollment strategy would have the following components:

- A mailing or series of mailings to all of the 105,300 dual eligible beneficiaries whom DHCS has identified are eligible for Cal MediConnect but were not subject to passive enrollment because they became eligible for the demonstration in 2014 and 2015 after passive enrollment ended. The mailing should provide simple information about Cal MediConnect, inform beneficiaries that they have the option to enroll, and direct them to Health Care Options and other resources if they would like to learn more about the program. The beneficiary toolkit that DHCS created could be utilized in these mailings. More than one mailing may be necessary to ensure that beneficiaries process the information.
- A mailing or series of mailings to the beneficiaries who were subject to passive enrollment and have opted out of the demonstration. This mailing could be similar to the one above, but should be tailored to reflect that fact that these individuals have received information about the program – and opted out – previously. Virginia did something similar in its demonstration.
- A mailing or series of mailings to individuals who become newly eligible for Cal MediConnect in 2016 and the first half of 2017. Again, this mailing should be similar to the others, but tailored to reflect the fact that these individuals are newly eligible for the program.
- Offer information about Cal MediConnect and an option to enroll in Cal MediConnect when Medicare beneficiaries become eligible for Medi-Cal and are making the Medi-Cal managed care enrollment decision. The beneficiary resource guide and choice book the DHCS has been preparing could also be utilized for this purpose.

- Outbound phone calls from Health Care Options or another independent entity to beneficiaries who recently received voluntary enrollment notices. These calls could flag the mailings for them, respond to any basic questions they might have, and refer them to health plans and HICAP counseling services for additional information. The follow-up calls respond to evaluation data that beneficiaries appreciate one-on-one interactions and education about their enrollment options.[1]
- Continued outreach to beneficiaries from numerous stakeholder organizations that are trusted sources of information in dual eligible beneficiary communities.
- Continued outreach to providers from health plans and stakeholder organizations. This is a proposal also advanced by DHCS, and we welcome more targeted outreach utilizing the excellent provider toolkit DHCS has developed.
- Continued marketing by health plans consistent with the current rules of demonstration as outlined in the Memorandum of Understanding governing the program and related Medicare guidance. It is important to note that plans have been granted significant latitude under current guidance to affirmatively reach out and market the demonstration to beneficiaries.

If DHCS is interested in an affirmative, voluntary process, we have several more specific ideas about timing and content of these mailing and phone calls. We and other advocates would be happy to provide more detailed information and to assist – as we have throughout this process – in drafting and reviewing notices, call scripts, and more.

To be clear, none of these efforts have been attempted to date. All stakeholders have long supported providing unbiased information about Cal MediConnect to eligible individuals. We and other advocates have gone to great lengths to inform dual eligibles about the program and to encourage them to explore whether enrolling in the program makes sense for their individualized needs. We would have fully supported DHCS systematically providing information to newly eligible individuals about the program, and we were surprised to learn that simple steps like the above have not yet happened.

The process outlined above avoids the problems inherent in a passive enrollment process or the "streamlined" enrollment process proposed by DHCS. Instead, it would be responsive to best practices identified in numerous early evaluations of the dual eligible demonstrations. An affirmative voluntary enrollment process would:

- Honor beneficiary choice. Under this process the beneficiary would make an affirmative choice of whether to enroll and into which plan.[2]
- Respect beneficiaries' relationships with providers by avoiding unnecessary disruptions in care. Beneficiaries report greater satisfaction when they are able to preserve these relationships.[3]
- Ensure that enrolled beneficiaries better understand the program and are ready and willing to work with the plan to improve their care experience. A beneficiary who enrolls voluntarily is more likely to understand that they are now in a plan with different rules and more likely to,

---

[1] MACPAC, *Experiences with Financial Alignment Initiative Demonstration Projects in Three States* (May 2015), pg. 16, available at: https://www.macpac.gov/wp-content/uploads/2015/05/Experiences-with-Financial-Alignment-Initiative-demonstrations-in-three-states.pdf.

[2] "[Beneficiaries] did not like that they had no choice in participation, felt forced into a plan, and were uninformed or misinformed about the opt-out process." MAPAC Report, pg. 14.

[3] "They noted that keeping their current provider was a key factor when choosing a plan. These individuals reported that they were generally happy with their choice in health plan because they were able to keep their doctor." *Id.*

when faced with a problem, work with the plan rather than disenroll. They will also be more likely be involved in their own care by completing Health Risk Assessments and participating on interdisciplinary care teams.

- Ensure that plans have good contact information for their enrollees. Plans lack current contact information for large portions of members, making it very difficult to provide them care coordination. Plans are expending incredible amounts of resources finding these enrollees. This is much less likely to occur when the individual provides current contact information through voluntary enrollment.
- Be easy to understand and communicate to beneficiaries and the broader community.
- Be simple and easy to administer, removing layers of complexity and cost for DHCS, plans, and community partners while allowing for the more effective deployment of finite resources.

Most importantly from the DHCS, plan, and beneficiary perspectives, we believe that voluntary enrollments are most likely to lead to longer term, more stable enrollment. Passive enrollment has not proven to be an effective form of enrollment for this program and this population. Opt-out rates are incredibly high.[4] In addition, we know from experience and evaluation data that many people disenroll in the first month or two after passive enrollment because they are surprised to learn that they were enrolled and react negatively.[5] This would be avoided in a voluntary process. Instead, those people who enrolled would have done so under their own volition and, therefore, are more likely to stay enrolled.

In a demonstration program that has already tried passive enrollment with underwhelming results from the perspective of all stakeholders, we think it is certainly worth seeing whether an alternative approach would be more successful at meeting the long term goals of this program.

**Alternative Proposal 2: Ensure that Health Care Options is properly handling referrals from health plans.**

Plans are currently permitted, under special marketing rules created for the demonstration to increase enrollment, to conduct targeted outreach, including outbound calls and mailers to members of their Medi-Cal program to encourage them to enroll in Cal MediConnect. They are not, however, allowed to directly enroll beneficiaries into the program. Instead, they must send them to Health Care Options (HCO) to make the enrollment selection. This is an important consumer protection that advocates pushed for to ensure that the misleading marketing and inappropriate enrollments that occur in the Medicare Advantage program do not occur in this program.

Unfortunately, we have heard reports from plans that the process of handing beneficiaries off to HCO to complete an enrollment may not be working all the time. Plans have reported to us that they often speak with beneficiaries who indicate a willingness to enroll in the program only to find that after transferring these beneficiaries to HCO the enrollment is not actually effectuated. This seems to be part of the rationale for implementing the "streamlined enrollment process."

While plans report this problem and have shared data that shows that many of the people they speak to do not end up enrolling, we have received no reports from beneficiaries or advocates of trouble

[4] Cal MediConnect Monthly Enrollment Dashboard (March 1, 2016), available at: http://www.calduals.org/wp-content/uploads/2016/03/CMC-Enrollment-Dashboard-March-Final-3-28.pdf.
[5] *Supra*, n. 2.

enrolling in the program through HCO by reasons of the enrollment broker. We have not received any calls from a beneficiary or advocate who called or was connected to HCO, tried to enroll, and was unable to do so.[6]

Therefore, we believe that the prudent course of action in this case is to investigate further rather than change the current enrollment process. Since all calls at HCO are recorded, we have asked DHCS to listen to recordings of HCO phone calls that involved transfers from plans to determine whether there was some problem (whether technical or scripting related) or whether the beneficiary simply changed their mind about enrolling after speaking with an independent entity. So far that request has been ignored. We again ask DHCS to investigate this issue further before making changes to the enrollment process that add work, increase program expenses, and decrease consumer protections as outlined in detail below (See "2. DHCS Should Avoid 'Streamlined Enrollment' and Retain the Role of the Independent Enrollment Broker," p. 13).

**Alternative Proposal 3: Investigate difference in opt-out, enrollment and disenrollment patterns across plans to identify issues that may be leading to higher or lower levels of enrollment.**

California has been a leader among states in reporting data on enrollment and opt-outs. The monthly enrollment dashboards have been extremely effective at sharing information about enrollment patterns and trends, and California is the only state thus far to share service delivery metrics through a performance dashboard. We believe, however, that more could be done with this information. DHCS should use this information to make data driven decisions about enrollment policy.

For example, in our analysis of the data we have observed that while some plans have seen very stable or even modest increases in enrollment over the life of the demonstration others have seen a significant loss of enrollment. If DHCS is interested in stabilizing and increasing enrollment in the demonstration, this range of enrollment results among plans is worth further study. Is there some reason that people are disenrolling from one plan, but staying enrolled in another? Is there a strategy the plans that are gaining enrollment are using to increase their numbers? DHCS should aggressively investigate plans with high levels of disenrollment to ensure there are no quality issues in those plans, and DHCS should encourage plans who have stable or growing enrollment to share best practices.

DHCS should also examine where people are enrolling when they opt-out of Cal MediConnect. If they are being enrolled into other Medicare products offered by plans that also run Cal MediConnect plans, CMS and DHCS should stop this practice. If they are enrolling into Medicare Advantage products offered by non-CMC plans, CMS and DHCS should limit MA plan marketing to Cal MediConnect enrollees and Cal MediConnect eligible beneficiaries. CMS has this authority under the section of the Affordable Care Act which authorized this demonstration.

[6] Beneficiaries generally have reported that HCO gave them the information they needed and helped effectuate their enrollment. University of California, *Evaluation of Cal MediConnect: Results of Focus Groups with Beneficiaries* (Mar. 2016), pg. 27, available at: http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_focus_group_report_march_2016.pdf.

DHCS mentions that it is reviewing this information, but this information has now been available for nearly two years. The information should be analyzed, and action should be taken in response before more aggressive and broad changes in enrollment policy are considered.

**Alternative Proposal 4: Focus more on improving the quality of the Cal MediConnect program.**

The best way to ensure increased and stable enrollment in the program is to improve the beneficiary experience in the program. DHCS proposed three steps to improve quality in its proposal entitled "Coordinated Care Initiative Program Improvements," but they do not go far enough, and they leave many issues unaddressed. We strongly believe a renewed and expansive focus on program improvement, paired with a voluntary enrollment period, will have greater long-term effect on enrollment than either of DHCS's enrollment proposals. Instead of expending substantial resources on developing and carrying out complex and confusing enrollment changes, DHCS should concentrate on expansive improvements to the program, which lie at the heart of enrollment, retention, and person-centered care.

**We support the focus on LTSS referrals.** We applaud DHCS's efforts to review and improve CMC plan policies and procedures regarding LTSS referrals and standardizing Health Risk Assessment (HRA) LTSS referral questions to the extent possible. We look forward to commenting on the draft questions when DHCS releases them. We also agree that DHCS must update and strengthen reporting requirements around interdisciplinary care teams, individualized care plans, and referrals to long term services and supports. Many of us welcomed the new performance dashboard and submitted a number of clarifying questions in response, so we hope to see at least some of those questions resolved in the dashboard's next iteration.

The focus around LTSS referrals is particularly important because one of the core promises of integrating Medicare and Medicaid was to better connect beneficiaries to much-needed LTSS services. Unfortunately, anecdotal evidence from local service providers indicates that the program has not resulted in any significant increase in LTSS referrals. Furthermore, research reveals that only 35% of LTSS users enrolled in Cal MediConnect had been contacted by a care coordinator from their plan while only 32% remember receiving individualized care plans.[7]

Numbers like these and other evaluation data suggest that significant numbers of consumers do not know that care coordination services are available and should be a wakeup call to DHCS, CMS, and plans that more work is needed in this area.[8] This quote from a recent evaluation of the program demonstrates this problem.

> Moderator: *[Other participant] mentioned a person named a case manager. Do you know if you have one? Have you ever been told about that?* [CMC Beneficiary A]: *No I have not.*
> [CMC Beneficiary B]: *I want to ask you, uh, how do you get a social worker?*
> [CMC Beneficiary C]: *Uh, I don't have that--I want a person who really would be a coordinator of medical services. Wow! That would be fabulous.*[9]

[7] Community Living Policy Center, Long-Term Services & Supports in the Cal MediConnect Duals Demonstration: Preliminary findings from the consumer survey, slides 9, 12.
[8] MACPAC Report, pg. 26.
[9] UC Evaluation, pg. 36.

It is discouraging, however, that DHCS is only now beginning to look closely at this issue and collect more information. We pushed for specific measurements around LTSS provision and referrals when the program was being designed so that at this point in the program, we would know whether the program was leading to more use of home and community-based services as intended. Unfortunately, we do not have any data to show that access to HCBS has been increased. We encourage DHCS to act quickly on this and to provide clear direction to plans that they must be providing LTSS referrals and utilizing available community-based resources.

**An open, transparent best practices sharing session would advance program goals.** We believe that the DHCS's proposed Best Practices sharing session, while a worthwhile effort, should not be limited to health plan attendees. Many advocates have direct experiences that should be shared as well. For example, Alzheimer's Greater Los Angeles has worked closely with plans on operationalizing dementia care training while the Long-Term Care Ombudsman has been meeting with plans to improve care for residents in skilled nursing facilities. Best practices from all their work, and the efforts of others, should be shared universally. We question whether DHCS's proposed process of inviting select advocates to present on specific topics will be adequate to ensure the kind of dialogue that would be most effective in identifying constructive responses to the challenges that have been identified in the evaluations.

**Expansive continuity of care policies minimize disruption and allow beneficiaries time to transition into plans.** Many of our organizations have long advocated for the elimination of the distinction between specialty and primary care visits with respect to DHCS's continuity of care policy. The distinction has proven to be meaningless and adds an unnecessary wrinkle of confusion on top of a confusion-fraught program. Therefore, we welcome DHCS's investigation of the potential modification. Relatedly, we believe that many health plans are already using a twelve-month continuity of care period on a case-by-case basis with respect to Medicare services. If DHCS is able to finalize these two policy changes, we hope individuals impacted by the proposed second round of passive enrollment are able to benefit from it. The evaluations to date of the Cal MediConnect program have proven that the program would benefit from further expansion of the continuity of care policy. For example, beneficiaries reported severe disruption in access to their medical equipment and supplies, and evaluation data suggest many beneficiaries still do not know about this important protection.[10]

**Unfortunately, the DHCS proposal for quality improvements leaves several important areas unaddressed.** The evaluation data suggest additional areas that DHCS should act on to improve quality. For example, many stakeholders anticipated that managed care would reduce the barriers beneficiaries face when obtaining services. However, evaluations reveal that in obtaining transportation and communicating with doctors, Cal MediConnect beneficiaries report similar levels of problems as their counterparts in FFS Medicare and as those in non-CCI counties.[11] We urge DHCS to investigate why managed care has not been delivering these services at a level that had been anticipated and work with Cal MediConnect plans on these problem areas.

---

[10] *Id.* at 54.

[11] Data from the Field Research Corporation's polling results in October and December 2015 reveal that Cal MediConnect beneficiaries reported similar levels of problems in the areas of pre-authorizations and denials, transportation, disability access, language access, and other issues as their FFS counterparts. October data, pg. 3, available at: http://www.thescanfoundation.org/sites/default/files/field_research_medicare_medi-cal_polling_results_102715.pdf; December data, Table 7, available at: http://www.thescanfoundation.org/sites/default/files/field_research_medicare_medi-cal_polling_results_2_12-7-15.pdf.

Another major barrier to enrollment and services identified in the evaluations has been the practice of "delegation." For example:

> Beneficiary: "*… I have [CMC health plan] and then I have um, uh, the one for the doctor itself cause she's—she's a part of some…I dunno. I don't understand it. Because I have to go through [medical group name] then [CMC health plan] and they have to agree to do, you know, whatever [medical group name] ordered. Or one of them will say no. That's—that's been my problem because I have so many people I have to go through. I don't understand if it's the same insurance company or, you know, whatever. But it's like, real confusing.*"[12]

Delegation, as practiced by some Cal MediConnect plans, means that plan members are limited to using providers that are affiliated with a sub-group within the plan, usually the group to which their primary care provider belongs. This delegation model severely limits beneficiary access to specialists, specialty hospitals, and other providers that, although within the plan network, are not affiliated with the sub-group. We recommend that DHCS thoroughly review the implications of delegation on member-centered care and address the negative impact on beneficiary access to care. Particularly in Southern California where the penetration of delegation seems relatively high, DHCS must commit to releasing policies and guidance that mitigate the potential negative effects of delegation on access to care.

Finally, while Cal MediConnect plans are of no additional cost to beneficiaries, delivery system transitions and provider confusion have exacerbated the problem of balance billing.[13] We applaud DHCS's provider bulletin including a reminder about balance billing rules. To ensure cost is no barrier to service delivery, we encourage DHCS to work with plans on ensuring that CCI beneficiaries are not inappropriately charged for covered services, and to share best practices for provider and beneficiary education regarding balance billing protections.

## PROPOSALS WE SUPPORT

Before discussing our opposition to the enrollment changes DHCS has proposed, we note that we do support some of those changes, and we recommend that DHCS pursue those changes while also pursing the strategies we have identified above. Specifically, we believe that DHCS should extend the deeming period. This would help stabilize enrollment and would address an issue that beneficiary advocates and health plans like the Health Plan of San Mateo have laudably been working to fix.

We also support the effort DHCS is taking on quality improvement and their plans to continue targeted provider outreach as indicated in the section above.

## OPPOSITION TO PROPOSED ENROLLMENT CHANGES

---

[12] UC Evaluation, pp. 53-54.

[13] Evaluations have shown that some Cal MediConnect beneficiaries are subject to unlawful balance billing. For example, one Cal MediConnect beneficiary reported, "*And I ended up having to pay for my own test strips, which is incredibly expensive. I can't afford it. I am disabled. I'm on disability. And, um, I had to wait almost two months for them to fill that prescription to get those sent to me. It was outrageous. And I was—am— you know, my blood sugars were worse because of the stress involved. So they—instead of health care, they were causing me more health problems. Across the board.*" *Id.* at 53.

We offer the Alternative Proposals above because we are strongly opposed to the majority of the enrollment changes DHCS has proposed.

**1. DHCS SHOULD ABANDON ITS PROPOSAL TO CONDUCT MORE PASSIVE ENROLLMENT.**

In "Ensuring Sustainable CCI Enrollment," DHCS proposes to passively enroll newly eligible duals as well as those who moved from a non-CCI county to a CCI county in 2014 and 2015. Beneficiary experience from the first round of passive enrollment demonstrates that the passive enrollment process is deeply flawed and should not be repeated for a number of reasons.

**Passive enrollment causes disruption and confusion for beneficiaries.** Early evaluations of Cal MediConnect clearly indicate that passive enrollment was a disruptive experience for beneficiaries that led to loss of services and providers. For example:

> *"I don't even remember getting the letter. All I remember is that I called to make her an appointment with her usual doctor who she's had for 20 years at [HMO name] and they said, 'Sorry, she's not a member of [HMO name] anymore.'"*
>
> "*Like I said, mine was just disruption in the beginning. Because like I already said I was already set up and then they took me off without me knowing …I was in the middle of getting my medication. I needed my medication. I couldn't get it."*[14]

These quotes indicate how beneficiaries experienced passive enrollment. It was highly disruptive – beneficiaries often did not know that they had been enrolled until they arrived at their provider's office and were told a longstanding appointment would be cancelled because of their enrollment into Cal MediConnect.[15] Because of passive enrollment, many beneficiaries' first experience with Cal MediConnect was negative, damaging public perception of the program both in the short and long term.

The current proposal targets beneficiaries who have newly gained dual eligibility in the past two years. While some of these duals may not have established relationships with their providers, a large percentage will. Due to DHCS's delay in releasing and implementing a proposal for this population, many new dual eligibles already have been receiving services through fee-for-service for up to two years. Some were Medicare eligible first and formed relationships with fee-for-service Medicare providers for even longer. Consequently, the likelihood for disruption in care is as high for this population as it was for the population in the first round of passive enrollment.

**The notices DHCS plans to use do not adequately inform beneficiaries of their options and, for most, ask them to make a decision they have already made.** DHCS proposes using the same noticing process and same notices it did in the first round of passive enrollment. The early evaluations are clear that the notices used in that process did not adequately communicate to consumers their choices in a clear and meaningful way.

---

[14] UC Evaluation, pgs. 24, 51.

[15] RTI International, *Report on Early Implementation of Demonstrates under the Financial Alignment Initiative*, pg. 16, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf.

"Enrollees were confused with the letters they received about the enrollment process and timeline. Some did not understand their choice to opt out of the demonstration. While others mistakenly believed they would lose all their established benefits under their previous Medi-Cal and Medicare coverage if they did not enroll in the demonstration program. As a result, they did not feel they had a choice regarding enrollment."[16]

**The notices DHCS plans to use are not tailored to this population and will result in disruption in Medi-Cal Managed Care plan enrollments.** For this proposed round of passive enrollment, the notices are particularly problematic because they are not tailored to this population and will generate even more confusion and disruption. The current notices present beneficiaries with two options: (1) they can join a Cal MediConnect plan or (2) they can opt-out of Cal-MediConnect, but still must join a Medi-Cal plan for their Medi-Cal benefit. However, based on DHCS's estimates, almost 70 percent of those who will be subject to this round of passive enrollment are already in a Medi-Cal managed care plan.[17] Thus, thousands of individuals will be prompted to choose a Medi-Cal managed care plan, even if they already have one. If they choose a Medi-Cal plan other than the one they are currently enrolled in, this will initiate a switch, which poses potential disruptions in the provision of Medi-Cal covered services. For example, beneficiaries may experience delays and interruptions in transportation and incontinence supplies, since plans may use different vendors for these services. This will be disruptive for beneficiaries, providers, and health plans.

**Determining who is subject to passive enrollment in this proposed approach is difficult.** The current proposal does not consider a fundamental lesson learned from implementation: complex enrollment criteria lead to confusion and noticing mistakes. The proposal makes it extremely difficult to identify who will be subject to passive enrollment into Cal MediConnect in 2016, and who is not. Eligibility for passive enrollment will depend on a number of individualized factors, including eligibility for Cal MediConnect, county of residence, the date of gaining dual eligibility, the date the beneficiary moved to a CCI county, and potentially other factors we do not yet fully understand. This complexity will be difficult for many advocates and service providers to understand and explain to the communities they serve. Many beneficiaries will struggle to determine whether they are properly included in the passive enrollment group. It will be difficult for DHCS and HCO systems to ensure they have sent notices to the right population and nearly impossible for advocates in the field to help identify and elevate noticing problems for DHCS.

**DHCS's expedited timeline does not provide sufficient time to prepare and educate the community.** DHCS's five-month timeline is unrealistic to transition over 100,000 beneficiaries through passive enrollment. DHCS has proposed September and October effective dates for this population. To meet that timeline, the first 90-day notices would need to be mailed in approximately 30 days. However, with only 30 days until the first notices would be mailed, key decisions, like which beneficiaries will be enrolled in September and which in October, have yet to be made.

Furthermore, 30 days is not enough time to adequately educate the community and the over 100,000 beneficiaries the proposal implicates. Prior to the first round of implementation, years of education, training, and outreach and repeated systems testing still resulted in avoidable disruptions in care, confusion, and systemic errors.

---

[16] MAPAC report, pgs. 15-16.

[17] Department of Health Care Services, "Ensuring Sustainable Coordinated Care Initiative Enrollment," (April 2016), pg. 3, available at: http://www.calduals.org/wp-content/uploads/2016/04/4.7.16-Sustainable-Enrollment.pdf.

In addition, despite having experience with the first round of passive enrollment, health plans, HICAP counselors, ombudsman advocates, the enrollment broker, and the broader community – all parties required for a successful transition – would experience an enormous strain on their capacity to meet the needs of this group based on its sheer size. At the height of passive enrollment, the Los Angeles HICAP had a seven-week wait period for individuals seeking a Cal MediConnect counseling appointment. Frustrated consumers had to make enrollment decisions without much-needed assistance from HICAP counselors.

**DHCS systems and capacity may not be ready for the transition.** DHCS's expedited timeline raises serious questions about systems readiness. Justice in Aging's Fix-It List demonstrates that state systems – despite being tested – were not ready for this kind of transition previously. The result was a number of different problems, including notices to excluded populations, untimely notices, a failure to process opt-out requests, erroneous disenrollments from Medi-Cal managed care, and beneficiaries being enrolled into plans not ready for passive enrollment.[18] These systems issues have largely been resolved, but some linger. For example, some beneficiaries report systems issues complicating enrollment because they are erroneously identified as having other health coverage (OHC). Continuing issues like these make us doubt whether the DHCS computer systems are ready for another round of passive enrollment.

Furthermore, DHCS's CCI proposals do not exist in a vacuum. Rather, these dramatic and resource-intensive policy changes to the CCI occur at a time when DHCS is also rolling out other health care initiatives under 1115 waiver authority, like the Whole Person Care Pilot, the Health Homes Program, changes to the Denti-Cal program, and others. DHCS's resources are spread thin and will be even thinner when faced with responding to the inevitable challenges that will arise during implementation of multiple programs and initiatives. We also believe the unidentifiable nature of the population subject to enrollment may present unique implementation challenges that did not arise during the first round of passive enrollment and cannot be forecasted at this time but which undoubtedly will require intensive DHCS resources to resolve.

**Plan capacity to handle this wave of passive enrollees is uncertain.** Plans have been working hard to provide services to current enrollees. They are spending resources finding members without contact information, attempting to complete HRAs and reaching some with care coordination services.[19] We know that this has been a challenge for plans and we are appreciative of the work and learning they have done to serve this population.

However, we question whether they are prepared for a large influx of new enrollees. Evaluation data confirm how much difficulty plans experienced in meeting the demands created by passive enrollment.[20] Evaluations further suggest that very few current enrollees are receiving the kind of person-entered care coordination and increased access to HCBS that was envisioned by the demonstration. Many enrollees,

---

[18] Justice in Aging Coordinated Care Initiative Fix List (last updated March 2015) available at: http://www.justiceinaging.org/wp-content/uploads/2015/02/CCI-Fix-List-20150309.pdf. See, for example, issues 6, 4, 21, 26, and 20 on the List.

[19] "MMPs also indicated that their staff spent an inordinate amount of time trying to locate enrollees in order to complete initial health assessments and introduce enrollees to the benefits of the demonstration." RTI Evaluation, pg. 14.

[20] *Id.* at 18.

including LTSS users, do not even know about the availability of the care coordination benefit and most have not received an interdisciplinary care plan.[21] We are concerned that adding a large number of new enrollees now will make it that much more difficult for plans to provide the services their members need and are entitled to under Cal MediConnect.

**Health Care Options capacity to handle another wave of passive enrollment is also a concern.** In the first wave of passive enrollment numerous problems arose at HCO. Notices were sent to the wrong populations, opt-out forms were not properly processed, beneficiaries were erroneously disenrolled from their Medi-Cal managed care plans, and more. We doubt whether HCO is ready to take on a challenge of this size again.

**DHCS's consumer protections are inadequate to insulate beneficiaries from the disruption and confusion of passive enrollment.** In its proposal DHCS indicates that consumer protections are in place to help beneficiaries avoid disruption. With the exception of an additional toolkit of materials that are available on a website, these protections were all in place during the first round of passive enrollment and proved to be ineffective at preventing confusion and disruption.

**Finally, and perhaps most importantly given the goals DHCS has identified, passive enrollment has not proven to be effective at increasing or stabilizing enrollment in Cal MediConnect.** One clear lesson learned from implementation of the demonstration in California and nationally is that passive enrollment did not generate the level of enrollment that CMS, states and health plans expected. "In aggregate, the six demonstrations enrolled fewer beneficiaries than the States initially anticipated in the first 6 months of operations[.]"[22]

In California, opt-out rates ranged from 37 to 58 percent in most Cal MediConnect counties.[23] In some language and racial minority communities, opt out rates were consistently well above 70 percent.[24]

Even upon being passively enrolled into Cal MediConnect, many beneficiaries disenrolled when they experienced a disruption in care or discovered their providers were not contracted with their new plan.[25] Current disenrollment rates in California range from 8% to 26% depending on the county.[26] Although health plans invest resources in finding and onboarding their members, many members, due to the nature of their enrollment, end up disenrolling shortly after their effective date. This is very disruptive for both beneficiaries and plans.

DHCS's proposal does little to address these enrollment trends and does nothing to examine the high opt out rates within certain communities or the high disenrollment rates among some plans. If the same opt-out (50%) and disenrollment (21%) rates hold true for this proposed round of passive enrollment, the DHCS proposal will only enroll about 31,000 new individuals into the program this year across five CCI counties. A gain of enrollees of this size does not justify the disruption, confusion and negative

---

[21] *Supra*, n. 7.
[22] RTI Evaluation, pg. 10.
[23] *Supra*, n. 4.
[24] For instance, Russian, Armenian, and Korean speakers in Los Angeles opted out at 94, 82, and 78% respectively. Korean and Vietnamese beneficiaries in Orange County opted out at 73 and 70% respectively. Cal MediConnect Opt out Breakdown by Language, Ethnicity and Age by County (March 2016), available at: http://www.calduals.org/wp-content/uploads/2016/03/March-Detailed-Opt-Out-Final.pdf.
[25] *Supra*, n. 22.
[26] *Supra*, n. 4.

reaction from the community that this process will create. We believe similar enrollment numbers could be achieved through the alternative proposals we offer above.

**Should DHCS proceed with passive enrollment, we have several recommendations.** For reasons explained above, we strongly oppose the use of passive enrollment as proposed by DHCS. However, should DHCS insist on using a passive enrollment mechanism in 2016, we encourage DHCS to commit to the following to ease the burdens on beneficiaries, caregivers, and advocates:

- Passive enrollment of beneficiaries already in Medi-Cal managed care should not begin until tailored notices are created that are consistent with their enrollment choices. These notices should be open to robust stakeholder input and also undergo beneficiary testing.
- Passive enrollment of all beneficiaries should not overlap with the Medicare Annual Election Period. During this period, capacity of HICAP offices across all CCI counties will be extremely limited, and beneficiaries should have a meaningful opportunity to engage with a HICAP counselor prior to their effective date in a Cal MediConnect plan.
- Beneficiaries should be separated into more than two effective dates to ensure DHCS, plan, and advocate capacity to handle the influx of enrollees. 105,300 beneficiaries is a large group, so to the extent this group can be spread across multiple effective dates, stakeholders will not be overwhelmed.
- For individuals transitioning to managed care from FFS Medi-Cal, DHCS should work with plans to revise and tailor their Medi-Cal member materials for dual eligibles. These materials currently do not include adequate information about MLTSS or how Medicare coverage impacts network access and service delivery.
- Plan provider directories should include as much information as possible to allow beneficiaries and advocates to make an informed choice. DHCS should subject Cal MediConnect plans to the requirements of California Health and Safety Code Section 1367.27.[27] Effective July 1, 2016, this law requires plans to keep their directories frequently updated and list critical details for providers in their network. Cal MediConnect members, like other Medi-Cal beneficiaries, should receive provider directories that are reflective of the actual network of providers available to them.
- DHCS should hold from passive enrollment all beneficiaries whose notices are returned as undeliverable and are unreachable even after additional measures. Passively enrolling beneficiaries who do not receive notice of these changes violates basic notions of due process. Due to the difficulty of communicating with this population, this policy modification would ultimately preserve more resources, both from DHCS and the plans, that could be used to improve beneficiary experience and quality of services.

## 2. DHCS SHOULD AVOID "STREAMLINED ENROLLMENT" AND RETAIN THE ROLE OF THE INDEPENDENT ENROLLMENT BROKER.

In the proposal called "Streamlining the Cal MediConnect Voluntary Enrollment Experience," DHCS proposes significantly reducing the role of HCO by allowing health plans to submit enrollment transactions directly to the broker. The proposal would permit HCO to process an enrollment transaction into Cal MediConnect without ever speaking to the dual eligible beneficiary, removing a

[27] CA Health and Safety Code, Sec. 1367.27 (October 8, 2015), available at: https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201520160SB137 (Today's law as amended).

longstanding and deliberate consumer protection while increasing confusion among duals regarding their choices.[28]

While DHCS refers to this process as "streamlining" enrollment, we refer to it as direct enrollment because it effectively allows plans to directly enroll beneficiaries into the demonstrations. DHCS distinguishes between the two terms, reasoning that the proposed process is not direct enrollment because the plans send the enrollment form to HCO instead of sending an enrollment transaction directly to Medicare as plans do in the Medicare Advantage program. While this is a valid distinction, from the beneficiary perspective, the two processes are essentially the same. In both cases a beneficiary is enrolled in a plan based on information submitted by the plan.

**An enrollment broker provides an important function in the Cal MediConnect enrollment process.** At the onset of designing Cal MediConnect, DHCS and its federal partners explicitly affirmed the important role of an independent enrollment broker and rejected proposals that would have allowed streamlined or direct enrollment.

The independent enrollment broker was included in California based on experience beneficiaries have had in Medi-Cal and Medicare. In Medi-Cal, the independent enrollment broker is utilized in any county with more than one Medi-Cal plan to choose from.[29] The broker serves as a resource for information on all plans so that a beneficiary can get unbiased information about which plan to choose when making a selection. The broker serves this function for all Medi-Cal managed care enrollees in these counties, not just dual eligibles.

The streamlining or direct enrollment proposal eliminates this important function of HCO for dual eligibles, providing them less protection than is afforded to other Medi-Cal recipients making managed care enrollment choices. Instead or working through an independent enrollment broker, a dually eligible beneficiary would get information about one plan directly from that plan and then make an enrollment decision likely in the presence of a representative of that plan. They would not have the opportunity to learn about other plans and to see if there may be another that includes more of their providers or offers other services that would be a better fit for them.

---

[28] Note that we also believe "streamlined" enrollment violates existing marketing rules, which expressly prohibit marketing calls from becoming enrollment calls. Sec. 80.2, CMS Medicare Marketing Guidelines (July 2, 2015), available at: https://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2016-Medicare-Marketing-Guidelines-Updated.pdf.
In addition, direct enrollment also violates the spirit of the three-way that operationalized Cal MediConnect. The three-way contract language envisions a robust role for HCO, including presenting potential enrollees with unbiased information and education in particular around rights and responsibilities and the care delivery system including health risk assessments, provider networks, and the interdisciplinary care team. Sec. 3.2.2, Three way contract template, pg. 134, available at: https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/financialalignmentinitiative/downloads/cacontractwithoutsub.pdf. By permitting plans to submit transactions to HCO directly and removing HCO from the beneficiary experience, consumers will be less prepared to make informed, objective decisions about their healthcare as set forth in the three-way contracts.

[29] Since COHS counties only have one Medi-Cal plan to choose from, they have never used an independent enrollment broker. The experience in those counties, therefore, is not relevant to counties where there is more than one Medi-Cal plan or Cal MediConnect plan to choose from.

In Medicare, there is no independent enrollment broker. Instead, plans are allowed to directly enroll beneficiaries into their plans. This has led to numerous reports over the last 10 years of illegal and inappropriate marketing and enrollment processes among plans. Advocacy organizations regularly hear stories of seniors being pressured to sign enrollment forms they do not fully understand by plan agents and brokers. Sometimes these stories reflect clearly inappropriate practices by agents such as when English forms are provided to non-English speakers. Other times, the stories are ones of a senior who simply did not want to say no to the nice person who visited their home and was sitting on their couch waiting for a signature before leaving.

The inclusion of the enrollment broker was meant to avoid these situations in the Cal MediConnect program. Plans can still market to dual eligibles, but since plans then have to refer the beneficiary to HCO to make the enrollment choice, the beneficiary is free of pressure – including implicit pressure – from a plan when actually making the enrollment choice. [30] The streamlining or direct enrollment proposal eliminates this important function of HCO and exposes beneficiaries to potential pressure and inappropriate marketing. Evaluation data confirm the risk of inappropriate marketing, and our experience is that it may be especially problematic in limited English proficient communities, where brokers and agents target individuals who already have low health literacy and less access to accurate information.[31]

**DHCS has not explained why limiting HCO's role in the enrollment process is necessary or is likely to lead to higher enrollments.** DHCS explains in its proposal that it "has heard from stakeholders that [the warm hand off to HCO] place[s] an additional and unnecessary burden on these beneficiaries." However, as discussed in Alternative Proposal #2 above, not one of the advocates whom we have spoken to have reported that the beneficiaries they serve encountered difficulty with getting their enrollment processed at Health Care Options due to the enrollment broker. Moreover, evaluation data confirm that HCO has been able to process enrollments and disenrollments for consumers. For instance, beneficiaries reported HCO gave them the information they needed and helped them exercise their choice.[32]

Cal MediConnect plans have indicated that transferred beneficiaries did not ultimately enroll, but that may simply mean that the enrollment broker provided the beneficiary with more information about the program and the beneficiary decided to not enroll or choose a different plan. It is important that beneficiaries have this opportunity to receive unbiased information and make a different selection.

If there is some problem with the hand off process, an investigation will reveal that and then stakeholders can work with DHCS to identify a solution to that problem (See Alternative Proposal #2 above).

**The consumer protections DCHS proposes to shield consumers from harm under this process are inadequate.** First, DHCS proposes requiring Health Care Options to send confirmation notices upon

---

[30] In fact, Cal MediConnect plans are given more opportunity to market to potential enrollees than other Medicare Advantage plans. For example, Cal MediConnect plans are permitted to cold call potential enrollees. Medicare Advantage plans are not allowed to do this. Sec. 70.5, CMS Medicare Marketing Guidelines, p. 46.

[31] UC Evaluation, pg. 25.

[32] "*Moderator: So who else made a phone call like [beneficiary who called Health Care Options]? One, two, three, four, five of you. And, um, eh—that, that—did you feel that that person or that uh, person was able to help you—give you the information that you needed? Beneficiary: Yup. Yeah. Another beneficiary: More or less.*" *Supra*, n. 6.

processing a beneficiary's enrollment into Cal MediConnect. This actually is existing policy per CMS Medicare-Medicaid plan guidance and is not an additional proposed protection.[33] Second, DHCS proposes requiring HCO to call beneficiaries, up to five times in a three-day window, to confirm their choice. However, as the FAQs detail, DHCS still intends to enroll individuals who cannot be reached over the phone during the outbound verification process and whose confirmation notices are returned as undeliverable. The result is a scenario where beneficiaries, based on an unsolicited contact by the health plan, and only speaking with the plan representative one-on-one, could be enrolled without any actual independent verification of their decision.

**If DHCS were to pursue this policy change, stronger consumer protections are necessary.** Most importantly, the presumption behind the outbound calls must be reversed. The enrollment should only be effectuated if HCO is able to reach the beneficiary and confirm that they intended to enroll in the plan that submitted the enrollment form. If they are not able to independently verify the enrollment with the beneficiary, it should not be processed.

DHCS would also need to regularly audit these outbound phone calls – and share the results of those audits with stakeholders – to demonstrate that beneficiaries were in fact confirming these enrollments. In addition, DHCS and CMS would need to commit to strong enrollment and marketing sanction and civil monetary penalties against any plan found to be misrepresenting enrollment decisions of beneficiaries or violating existing marketing rules.

## QUESTIONS REGARDING DHCS PASSIVE ENROLLMENT STRATEGY

The passive enrollment proposal raises a number of questions. This list is not intended to be exhaustive.

- It is unclear whether the 105,300 number includes individuals new to Medicare who were defaulted into Part D plans because they did not pick one. How does DHCS plan on ensuring that those individuals are not improperly noticed and subject to passive enrollment twice in a one-year period, contrary to Medicare rules?

- The proposal does not seem to address new dual eligibles who, since becoming newly dually eligible, joined a Medicare product other than a Cal MediConnect D-SNP plan. Will those individuals still be excluded from Cal MediConnect passive enrollment, and how will DHCS ensure they are not improperly noticed? Given the high penetration of MA products in some CCI counties, this number may be significant. Will they be included in the operationalization of MLTSS?

- DHCS's proposal includes a dramatic departure from existing policy in that it proposes to pair new duals to MLTSS plans in part based on the quality of the Medi-Cal health plan. It is unclear what metrics will be used for quality and the extent to which provider utilization data will continue to be a factor for plan assignment. What will DHCS do to avoid arbitrary plan pairing?

- Footnote 1 of the populations chart indicates that LIS re-assignees will be assessed every year and that *only* [emphasis added] when numbers are sufficient will they be passively enrolled into

[33] Sec. 30.4.2., Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (June 14, 2013), p. 37, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMPFinalEnrollGuidance.pdf.

Cal MediConnect in January. What constitutes a sufficient number? Were LIS re-assignees from 2015 included in passive enrollment for January 2016? If not, will those individuals be subject to passive enrollment if they do not otherwise fall into one of the other populations eligible for enrollment?

- DHCS proposes operationalizing MLTSS enrollment daily by August 2016. What is DHCS's plan to accomplish this, and how will this interact with the proposed Cal MediConnect passive enrollment timeline?

Thank you again for providing the opportunity to submit these recommendations and questions. We reiterate our commitment to working with DHCS, CMS, and stakeholders to improve the CCI program and ensure that dual eligible beneficiaries receive high-quality, coordinated care.

Sincerely,

Justice in Aging
Asian Americans Advancing Justice – Los Angeles
Asian Law Alliance
California Association of Public Authorities
California Health Advocates
California In-Home Supportive Services Consumer Alliance
Californians for Disability Rights
California Senior Leaders Alliance
Center for Health Care Rights
Coordinated Care Initiative Ombudsman
Disability Rights California
Disability Rights Education and Defense Fund
Jewish Family Service of Los Angeles
Legal Aid Society of San Diego
Little Tokyo Service Center
Los Angeles Aging Advocacy Coalition
LifeSTEPS (Life Skills Training & Educational Programs)
National Health Law Program
Neighborhood Legal Services of Los Angeles County
Personal Assistance Services Council of Los Angeles County
St. Barnabas Senior Services
Western Center on Law and Poverty