John Baackes
Chief Executive Officer

April 22, 2016

Ms. Sarah Brooks
Deputy Director
Health Care Delivery Systems
Department of Health Care Services
1500 Capitol Ave.
Sacramento, CA 95814

VIA ELECTRONIC MAIL
Sarah.Brooks@dhcs.ca.gov

RE: Proposed CCI/CMC Program Improvements

Dear Ms. Brooks:

Thank you for the opportunity to provide L.A. Care Health Plan's (L.A. Care) comments on the Coordinated Care Initiative (CCI) and Cal MediConnect (CMC) program improvements presented by the Department of Health Care Services (the Department) on April 7, 2016.

L.A. Care is highly committed to the success of the CCI and CMC programs. We firmly believe that the integration of Medicare and Medi-Cal acute and long term services and supports under a single plan offers dual eligible beneficiaries the opportunity to obtain care coordination and assistance with managing the full range of benefits to stay healthy and remain living in their homes and communities.

The participating plans have learned so much since CCI and CMC were implemented in 2014. Huge strides have been made in the last 18 months in capturing critical information integral to caring for this complex population by mining data in the claims histories of enrolling beneficiaries, updating questions in the health risk assessments, refining the individualized care plans and improving participation in the interdisciplinary care teams. We also strengthened our liaisons with members and providers by enhancing our new member onboarding process, collaborating with managed long term services and support providers, such as skilled nursing facilities and community-based adult services that aid the dual eligible.

In furtherance of our shared objectives to meet the needs of this complex population, we would also like to take this opportunity to offer the following comments:

Passive Enrollment

L.A. Care supports the State's proposal to implement an improved passive enrollment process for beneficiaries who have become newly eligible for CMC. However, the improved process must incorporate strengthened consumer protections and lessons learned from California's recent experience with the initial waves of passive enrollment.

A public entity serving Los Angeles County • 1055 West 7th Street, 10th floor • Los Angeles, California 90017
Telephone 213.694.1250 • Fax 213.623.8606 • www.lacare.org
Accreditation of Medi-Cal and L.A. Care Covered

For a Healthy Life

In order to achieve optimal communication with our prospective members, L.A. Care requests the Department to consider providing CMC plans with information about the beneficiaries that will be part of the passive enrollment process at least 120 days before the effective date of the passive enrollment. Beneficiaries, health plans and the Department are able to preempt avoidable challenges when plans have the ability and sufficient time to review, compare and test enrollment files prior to implementation. The additional 30 days would also contribute to increased beneficiary satisfaction because there will be more time to locate and contact the beneficiary, develop a relationship and establish continuity of care, all of which are key to a smooth transition.

Further, the passive enrollment process must be informed and supported when at all possible by available utilization data to ensure the ease of beneficiary transition, support continuity of care and arrange for services needed. Preempting needed services will mitigate disruption in care and more importantly fosters a partnership between the beneficiary and the CMC plan.

Streamlined Enrollment

L.A. Care supports the proposed streamlined enrollment process. We have invested a great amount of effort to educate and inform our current Medi-Cal members who are duals about the benefits of integrating both Medi-Cal and Medicare benefits under one plan. Leveraging the existing Medicare enrollment protections for beneficiaries and enhancing the ability to provide prospective beneficiaries with personalized education, CMC Plans will be able to efficiently enroll interested beneficiaries and prevent any losses associated with duals who do not successfully complete the existing process on their own.

In order to accomplish these activities, L.A. Care would ask the Department to consider the timing of the streamlined process implementation and how it will coincide with the proposed passive enrollment phases. If both enrollment proposals are implemented simultaneously, will the Department's enrollment broker, Health Care Options (HCO), be equipped to handle the influx of enrollment? In addition, please confirm that HCO will be responsible for all enrollment verification activities and member communications. Any additional member communications that will be required by the CMC plans will require at least 90 days to be reviewed by the plan and translated to comply with Medicare and State marketing guidelines.

Further, we request additional guidance on the role of the CMC plan in enrolling the beneficiaries such as application forms to be utilized, enrollment data sharing between DHCS/CMS and the CMC plans as well as effectuation timelines. In our most recent experience with educating beneficiaries who will become eligible for CMC (i.e. beneficiaries who are reaching their 65th birthday), L.A. Care has encountered challenges with ensuring a seamless transition into CMC for Medi-Cal members who elect to participate in CMC. HCO has been unable to verify Medicare eligibility for beneficiaries who have not reached age 65. We request that the Department consider leveraging CMC Plans access to CMS data, such as MARx, to ensure the enrollment verification process is seamless to the beneficiary.

Program and Consumer Protection Improvements
L.A. Care is aligned with the Department's proposals to strengthen CMC for its beneficiaries through targeted provider outreach as well as enhancing continuity of care and extending deeming provisions. In an effort to support the Department's provider outreach plan, L.A. Care requests a better understanding of how the Department will identify providers for this targeted outreach as well as the proposed activities and literature to educate these providers.

L.A. Care has implemented a series of outreach efforts to educate members on their rights and responsibilities when placed into deeming for CMC. Extending deeming would afford members additional time to contact their county eligibility worker to reestablish their eligibility status. Accompanied by hold harmless financial protections, as the vast majority of members during the one-month deeming initiative have not remained dual eligible, we support moving to a two-month deeming period but would like to better understand the implications of this proposal to the plans.

Attached is a detailed list of comments and requests for clarification that L.A. Care would like the Department to consider. We welcome the opportunity to further discuss these proposals and our questions.

We thank you for this opportunity to comment on the proposed improvements to the program and look forward to collaborating with advocates, our providers and regulators to continuously improve the ability of CMC to meet the diverse needs of duals. With consideration of the issues outlined above, we believe the proposed improvements are important next steps in realizing the goals of the CCI/CMC programs.

Sincerely,

John Baackes

Cc: Kerry Branick
Javier Portella
Hillary Haycock

Encl.

Comments to DHCS Re: Sustainable CCI Proposals
L.A. Care Health Plan

Heading	Category	Comment or Question
2016 Annual Passive Enrollment into CMC	Enrollment Systems	1. Will the Department provide health plans the file layout prior to initiating passive enrollment? If so, when can plans anticipate receiving these files? Recalling lessons learned from California's previous passive enrollment experience, beneficiaries, CMC plans, and the State are able to preempt avoidable challenges when plans have the ability to test files prior to implementation. 2. Will the Department be able to identify who has opted out of the CCI/CMC program in the first wave of passive enrollment? A test/comparison file that would allow CMC plans to compare their eligible membership with the DHCS eligible membership prior to passive enrollment would ensure any discrepancies in the data can be flushed out prior to the effective date? 3. How will DHCS distinguish between who is passively enrolled in September and then in October? 4. Will CMC plans receive historical claims data to ensure continuity of care? If so, by when should we anticipate those files? 5. Will there be any supporting documents that CMC plans need to keep on file? If so, please elaborate on which documents are needed. 6. Will data be provided to CMC plans regarding the beneficiaries that "opt out" of this wave of passive enrollment and the type of plan in which they elect to enroll (i.e. MAPD, PACE, FFS Medicare)? 7. An increase in enrollment volume can contribute to a delay in the plan's 4Rx submission should State enrollment data (i.e. member demographics) not be received timely. It has been timely, but if CMC Plans were to receive a large volume of enrollment data, it would be crucial to have timely receipt of the data to process member enrollment (i.e. 4Rx data). 8. During previous passive enrollment phases, CMC plans have struggled with reconciling eligibility information when CMC plans are expected to adjust members' eligibility to a retroactive date. Can CMS limit or eliminate their practice of changing members' coverage start date to an earlier effective date after the new enrollment has been sent to the health plan? 9. Currently the health plans are expected to initiate reconciliation of discrepancies to DHCS and CMS. Does CMS and DHCS have plans to create a combined eligibility reconciliation report and/or a month-end file to address eligibility discrepancies? 10. Currently, the Transaction Reply Report (TRR) enrollment file does not contain demographic data needed to complete a member enrollment (i.e. no address on where to send the ID card, welcome kit, etc). Under our current structure we must wait until the state data is received (either the HCO or DHCS 834) to complete the enrollment. Can CMS add members address to the TRR file layout?

Comments to DHCS Re: Sustainable CCI Proposals
L.A. Care Health Plan

Heading	Category	Comment or Question
2016 Annual Passive Enrollment into CMC	Enrollment Projections	1. Will DHCS share the auto assignment methodology for the CMC participating plans in L.A. County? 2. Will the State provide enrollment estimates associated with each of the populations outlined in the *Coordinated Care Initiative Enrollment Strategies Table April 2016* issued on April 7, 2016? Can you please add the population estimates to this table?
2016 Streamlined Enrollment into CMC	Enrollment Timelines & Processes	1. When does the State propose the streamlined enrollment approach will begin? 2. Will paper enrollment forms or an electronic submission process be utilized to document and communicate enrollment data to DHCS/CMS? Will CMC plans be required to maintain any records (paper or electronic) to verify the enrollment request? 3. What is the cutoff date to effectuate an enrollment for the 1st of the following month? 4. Will beneficiaries maintain their right to actively enroll in a CMC plan of their choice during the passive enrollment period?
2016 Streamlined Enrollment into CMC	Beneficiary Verification Processes	1. Will an enrollment confirmation code or tracking number be provided to the beneficiary and/or health plan to monitor the progress of the application? 2. When will the State share with health plans and stakeholders the HCO outbound enrollment verification (OEV) script? 3. How will DHCS verify the beneficiary is eligible for the program (i.e. age-ins who can enroll 30 days in advance)? Please explain how the State has reviewed the alignment of State enrollment with Medicare enrollment processes for people who are turning age 65. 4. Would the Department consider leveraging CMC plans' access to MARx and allow them to verify enrollment in MARx and notify HCO that the MARx verification has been completed? This would be most beneficial when assisting beneficiaries who are aging into Medicare. 5. Will the CMC Plan have any required member notification mailings related to the streamlined enrollment process (i.e. request for additional information if an application or enrollment form is received by the Plan incomplete or the Resident Verification Form)? 6. Will CMC Plans continue to receive the Daily Transaction Reply Report (DTRR) from CMS for the streamlined enrollment process? 7. Will there be any newly classified beneficiaries (aid codes) who will be eligible to enroll as part of the streamlined enrollment process (i.e. M1, L1, RU)? 8. Will the Department notify the beneficiary when the contact information provided within the enrollment file is different from the contact information listed in the Medi-Cal Eligibility Determination System (MEDS)? How will the beneficiary know to contact their County Eligibility Worker or Social

Comments to DHCS Re: Sustainable CCI Proposals
L.A. Care Health Plan

Heading	Category	Comment or Question
		Security eligibility worker to update their contact information? 9. Will the Department notify the CMC Plan when the contact information provided within the eligibility file is different from the contact information provided in the enrollment file? 10. Currently the health plans are expected to initiate reconciliation of discrepancies to DHCS and CMS. Does CMS and DHCS have plans to create a combined eligibility reconciliation report and/or a month-end file to address eligibility discrepancies?
Member Protections Integral to the Coordinated Care Initiative and Cal MediConnect	Exploring Extending the Deeming Period for Beneficiaries in Cal MediConnect	1. During the one month period, plans are not responsible for financial risk associated with in-home supportive services (IHSS) (cost is built in for first month). Who would assume the financial risk for IHSS if the deeming is extended to 60 days? 2. Will the health care plan (HCP) status codes change or will there be additional HCP status codes to identify deemed members? 3. Would CMC plans be required to send out additional notifications for the second month of deeming (i.e. a 60-day notice and then a 30-day notice)?
Member Protections Integral to the Coordinated Care Initiative and Cal MediConnect	Providers who have influenced enrollment decisions for Cal MediConnect Beneficiaries	1. What methodology is being used by the Cal MediConnect Ombudsman to identify providers in need of outreach? 2. What is the timing of the Department's planned provider outreach? 3. How will the Department engage providers and achieve their buy-in for CMC? 4. Does the Department intend to update the Provider Toolkit currently available on CalDuals.org, last revised November 3, 2015? 5. Will any newly developed or revised beneficiary or provider materials be available for comment by CMC Plans and/or stakeholders?