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Greetings:

Thank you for the opportunity to comment on the Health Care Options (HCO) call script that DHCS plans on utilizing in the proposed streamlined enrollment process. Likewise, thank you for the opportunity to comment on the Health Risk Assessment (HRA) standardized questions. We have provided detailed comments below and have attached specific redlined edits to the call script.

Health Risk Assessment

We strongly support DHCS's commitment to improve Cal MediConnect plan polices and procedures regarding the delivery of and referral to long-term services and supports (LTSS). This is particularly important in light of the most recent evaluation data that demonstrates that very few enrollees are offered LTSS referrals and are receiving care coordination. The standardization of HRA questions for LTSS referrals is an opportunity to ensure that all health plans are consistently identifying LTSS need and making referrals to services where appropriate. We, however, believe that the proposed questions as drafted will not meet this goal.

We urge DHCS to form a working group comprised of LTSS providers, the health plans, and relevant stakeholders to develop a set of questions that guarantee beneficiaries receive the appropriate referrals to the range of LTSS available, including CBAS, MSSP, IHSS, care plan option services, behavioral health, and dental. LTSS providers have decades of experience in developing and administering assessments to the dual eligible population. Their expertise must be leveraged to the greatest extent possible in the development of the standardized questions. We also endorse the comments submitted separately by the California Association of Adult Day Services (CAADS) and the Multi-purpose Senior Services Program Site Association.

Streamlined Enrollment

We begin by noting that the streamlined enrollment proposal is something entirely new and is part of an ongoing demonstration. The proposal changes the means in which Cal MediConnect plans can enroll beneficiaries into their Medicare product implicating Medicare Marketing Guidelines, Medicare Medicaid Plan Enrollment Guidance, and the Cal MediConnect Memorandum of Understanding. DHCS and CMS must commit to providing Cal MediConnect plans with clear written guidance on the streamlined enrollment process that comports with existing guidance (see our additional comments below).

Additionally, the design of the streamlined enrollment process must be guided by two paramount goals: first, establishing procedures that honor consumer choice and incorporate consumer protections from marketing that is abusive or confusing; and second, developing data to evaluate this new system and measure its success. The current proposal and call script do not adequately protect beneficiary interests or adhere to Medicare rules. There also is a need to add robust oversight and data collection.

Pursuant to Medicare marketing guidelines, health plans and brokers are prohibited from contacting a beneficiary through unsolicited contact or "cold calls." Enrollment into a Medicare product can only occur upon the beneficiary's consent to be contacted or engage with the plan or broker. If a member ultimately decides to enroll in a Medicare product, the health plan must conduct an Outbound Enrollment Verification (OEV) to confirm the enrollment and ensure the beneficiary understands his or her choice. [1]

Unlike other Medicare products, Cal MediConnect plans are currently able to contact beneficiaries through unsolicited contact and cold calls. Cal MediConnect plans are afforded this opportunity under a special exception in the Medicare rules that permit a Medicare plan to contact beneficiaries enrolled in one plan product to discuss other Medicare products.[2] Accordingly, Cal MediConnect plans have been conducting calls to beneficiaries who opted out of Cal MediConnect but who were mandatorily enrolled in their Medi-Cal plans to discuss enrollment in Cal MediConnect. Currently, if a beneficiary indicates that he or she wishes to enroll in the Cal MediConnect plan, the Cal MediConnect plan transfers the beneficiary to Health Care Options (HCO), the independent enrollment broker, to process the enrollment transaction. While Cal MediConnect plans are not permitted to employ brokers, the Cal MediConnect plan

[1] Medicare Marketing Guidelines, Rule 70.7.
[2] Medicare Marketing Guidelines, Rule 70.6; Marketing Guidance for California Medicare-Medicaid Plans, Rule 70.6

employees reaching out to members do receive increased compensation for securing an enrollment in the Cal MediConnect plan.

Under the streamlined enrollment proposal, the Cal MediConnect plan will no longer have to transfer the beneficiary to an independent enrollment broker to process the enrollment. Instead, the health plan will accept the enrollment and directly submit the enrollment transaction to HCO. HCO will then be responsible for contacting the beneficiary to confirm enrollment. Under this new process, Cal MediConnect plans are now afforded both the ability to reach out to a beneficiary unsolicited and also directly enroll the beneficiary into the health plan. The HCO outbound calls are the only safeguard in place to independently verify the enrollment decision. Accordingly, in addition to increased oversight from regulators, the verification process should be as robust as possible.

Safeguards and Oversight

To ensure beneficiaries are protected, the following measures must be taken in the streamlined enrollment process:

1. **HCO must make direct contact with the beneficiary before processing the enrollment transaction.**

   The current process contains fewer safeguards than Medicare rules. Medicare rules require Medicare plans processing enrollments to ***directly speak*** with the beneficiary to confirm enrollment through the OEV process. If the plan is unable to speak with the beneficiary or his or her appointed representative directly, the plan must continue to call the beneficiary or follow up with a written communication.[3] DHCS has proposed that HCO need only attempt to contact the beneficiary to confirm enrollment in the Cal MediConnect plan, but does not require HCO to obtain ***actual confirmation*** prior to processing the enrollment. Medicare's longstanding protections are a safeguard against overzealous marketing activities. Medicare beneficiaries should not experience less protection when enrolling into Cal MediConnect than any other Medicare product.

   Under Cal MediConnect streamlined enrollment, it is even more imperative to directly speak with the enrollee to verify enrollment since Cal MediConnect plans can reach out to beneficiaries unsolicited. Unsolicited contact and cold calls are generally prohibited under Medicare rules because CMS recognizes that such contact can lead to unduly influencing a beneficiary to enroll in a plan. When the plan has both the ability to reach out to and enroll a beneficiary, the plan is afforded an unparalleled opportunity to influence a beneficiary's choice – particularly when the population in question has chronic multiple conditions, low health literacy, and

[3] Medicare Marketing Guidelines, Rule 70.7.

includes many individuals who have limited proficiency in English. Accordingly, the Cal MediConnect outbound verification should afford beneficiaries every opportunity to confirm that they have made an informed choice, and like the OEV process, require the plans to directly speak to the beneficiary. If HCO is not able to speak directly to a beneficiary within ten days of receiving the enrollment transaction, the enrollment should be voided.

Additionally, the call script should be amended to reflect the call script used in the OEV process. We have provided suggested edits to the HCO call script (attached). Furthermore, DHCS should test the call script with beneficiaries. Recognizing that there is no one-size-fits-all approach, HCO CSRs should also be required to contact the beneficiary at different times and different days of the week and retain the usual practice of recording all calls. In a similar vein, HCO should also be required to document all call attempts, including time and date of each attempt, and other methods of contacting the beneficiary to verify the enrollment.

2. DHCS must provide a written policy outlining the operationalization of streamlined enrollment.

The streamlined enrollment policy is both a departure from Medi-Cal's policy of ensuring all Medi-Cal beneficiaries, other than those in COHS counties, make managed care enrollment decisions through HCO, and Medicare's requirement that plans adopt an OEV procedure. As such, prior to implementing streamlined enrollment, DHCS must provide clear written guidance to the plans to ensure consistent and proper implementation of the new process. This written policy must address a number of specific areas that remain unclear with regard to operationalization of the proposal. Specifically, the written policy should provide clear guidance to the plans on the following:

- **The beneficiary population the plans can enroll through streamlined enrollment**. The streamlined enrollment written policy must contain a description of who the plans can reach out to and enroll through the streamlined process, and it must include a prohibition against selectively reaching out to potential enrollees. Plans should not be allowed to use protocols that exclude high-cost utilizers or otherwise discriminate against certain dual eligible populations.
- **The circumstances where a plan can conduct outreach to a beneficiary through unsolicited contact**. There should be a limitation on the amount of outreach the plans conduct to individual beneficiaries. The written policy should include standards regarding how often a plan can contact a beneficiary to ensure that beneficiaries are not subjected to endless and overwhelming marketing calls. We recommend that Cal MediConnect plans be permitted to reach out to beneficiaries a maximum of two times a year to discuss enrollment in Cal MediConnect, and the period of time between

contact should at a minimum be three months. In addition, the guidance should prohibit the plans from initiating contact with a beneficiary who has opted out of passive enrollment for the first three months following the date of opt out.

- **A map or outline of the streamlined enrollment process.** The written policy should provide a step-by-step explanation of the streamlined enrollment process. For example, what will the plans have to submit to HCO to process the enrollment? How will the plans submit the enrollment? What will the enrollment process look like for the beneficiary? If a beneficiary attempts to cancel the enrollment through 1-800 MEDICARE, what process is in place to ensure the transaction is cancelled? How enrollments will be cancelled or handled in cases where the beneficiary did not have the capacity to make an enrollment decision?
- **Training and quality control for the enrollment broker and health plans.** As stated elsewhere, outbound verification calls are a new responsibility of HCO. This written policy should provide details on how DHCS intends to train the enrollment broker and health plans on these changes and ensure quality control, a critical element given the addition of new actors to the enrollment process.
- **Explicit prohibition against turning an outreach/education outbound call into an enrollment call.** Medicare marketing rules prohibit health plans from turning an outbound call, used for educational purposes, to a beneficiary into an enrollment call.[4] Plans may accept enrollment requests via an incoming (in-bound) telephone call only. The written policy must incorporate this prohibition and provide plans clear guidance on when the plan can utilize streamlined enrollment, which in light of the Medicare Marketing Guidelines, should only apply to incoming calls from a beneficiary to the plan.

3. DHCS must commit to increased oversight of the streamlined enrollment process.

In order to both assess whether streamlined enrollment is effective and to ensure that the streamlined enrollment process is not harming beneficiaries, DHCS must commit to increased oversight of this new policy. To this end, DHCS should review the HCO outbound calls and collect data on how often beneficiaries indicated they did not want to enroll in Cal MediConnect and their reasons. DHCS also must collect data on enrollment and disenrollment. The current enrollment dashboard includes the number of beneficiaries who are opting out. Since streamlined enrollment will be implemented when passive enrollment has completed in all counties, the data reported on the enrollment dashboard should reflect the current enrollment and

[4] Medicare Marketing Guidelines, Rule 80.3. See also Marketing Guidance for California Medicare-Medicaid Plans, Rule 70.9.2 , that prohibits Cal MediConnect plans from participating in unsolicited individual appointments or offering appointments unsolicited.

disenrollment trends. Specifically, the dashboard should be updated to include the following enrollment and disenrollment data:

- **Voluntary Enrollment**: the number of individuals who enroll via affirmative voluntary enrollment reported both in the aggregate and by plan (including a breakdown by age, ethnicity, and LTSS use)
- **Streamlined Enrollment**: the number of individuals who are enrolled via streamlined enrollment both in the aggregate and by plan (including a breakdown by age, ethnicity, and LTSS use)
- **Disenrollment data**: the number of individuals who disenroll both in the aggregate and by plan (including a breakdown by age, ethnicity, and LTSS use) and a breakdown of how many individuals disenroll voluntarily (both in the aggregate and by plan) and how many individuals disenroll involuntarily through loss of eligibility (both in the aggregate and by plan).

It is also imperative that DHCS track what Medicare products beneficiaries are switching to. We know that the majority of individuals who disenroll from Cal MediConnect do so voluntarily by enrolling in another Medicare product. Streamlined enrollment will not act to resolve this shuffling of duals from Medicare product to Medicare product. In order to address this issue, DHCS, CMS and stakeholders must review the data to determine what is the best policy to address this issue.

4. DHCS must commit to a robust voluntary enrollment strategy.

Streamlined enrollment targets a population that has already made a choice not to participate in the Cal MediConnect program. While some of these individuals may change their minds after receiving additional information about the program from the plan, many will not – particularly when it is the health plan engaging in the outreach, and this population is known to be distrustful of managed care. DHCS must commit to a written policy on how it will conduct an affirmative voluntary enrollment process with robust steps to engage beneficiaries, stakeholders, and providers. This written policy should also address the type of notices beneficiaries will receive and how to better coordinate mandatory enrollment notices with Cal MediConnect information. Other than a written policy, we believe a voluntary enrollment effort is made most effective if DHCS creates and leverages expertise and input from a small working group to concretize and implement the policy.

In addition, because a voluntary enrollment process will be timed with the Department operationalizing MLTSS, we recommend combining Cal MediConnect information with MLTSS notices to beneficiaries in fee-for-service Medi-Cal. This information should be provided 90, 60, and 30 days prior to the Medi-Cal enrollment date. Such a timeline provides beneficiaries transitioning into managed care from Medi-Cal fee-for-service more time to pick a Medi-Cal plan and complies with state

law and the 1115 waiver authorizing the CCI.[5] More importantly, the 90/60/30 timeline provides a beneficiary more time to consider whether he or she wants to voluntarily enroll in a Cal MediConnect plan.

Thank you again for providing the opportunity to submit these comments on the streamlined enrollment process and HRA questions. We are committed to working with DHCS, CMS, and stakeholders to develop enrollment strategies that honor beneficiary choice and improving the CCI program. We look forward to hearing from you with regard to the establishment of a working group to develop a comprehensive voluntary enrollment strategy.

Sincerely,

Justice in Aging
California Health Advocates
Center for Health Care Rights
CCI Ombudsman
Disability Rights California
Disability Rights Education & Defense Fund
Legal Aid Society of San Diego
National Health Law Program
Western Center on Law & Poverty

[5] See WIC § 14182. Beneficiaries transitioning from fee-for-service Medi-Cal into managed care must be informed at least three months prior to enrollment by notice at no more than a sixth grade reading level, how their system of care will change, when, and who they can contact to receive assistance with making a choice. See also 1115 Waiver STC, p. 98, "CCI Eligibles transitioning from Fee-For-Service will be notified at least 90-days in advance of the effective date of enrollment of upcoming changes in delivery systems."