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February 15, 2019

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Submitted via email: Sarah.Brooks@dhcs.ca.gov; info@calduals.org

CC: Tim Engelhardt, Director
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Centers for Medicare and Medicaid Services
Baltimore, Maryland 21244
Via email: Tim.Engelhardt@cms.hhs.gov

Re: Comments on the 2019 Cal MediConnect Stakeholder Process

Ms. Brooks,

Thank you for the opportunity to comment on ways to strengthen and improve the Cal MediConnect Program. We submit our comments via this letter, and also, as requested, have submitted our suggestions in the Survey Monkey form online. We begin with introductory remarks. Then our substantive comments focus on two key areas: improve access to quality care and address ongoing and emerging challenges to improving the beneficiary experience. We conclude with a recommendation that DHCS reinstate a formal stakeholder workgroup to

improve the program. As a threshold matter, we believe all of our recommendations are cost-neutral and do not require changes to current Cal MediConnect rates.

Introduction

The Cal MediConnect (CMC) program is at a critical juncture. As the largest Medicare-Medicaid Plan demonstration in the country, the program experienced a confusing and difficult enrollment process after its launch in in 2014, membership has finally stabilized. Dual eligibles enrolled in Cal MediConnect report similar if not higher satisfaction rates as those enrolled in Original Medicare or in non-Coordinated Care Initiative (CCI) counties.[1] Over the course of implementation, plans have been able to use care coordination tools to increase access to care for their members, and the Department of Health Care Services (DHCS or the Department) has strengthened key consumer protections, like extending continuity of care protections from six to twelve months and creating a period of deemed eligibility to help members address Medi-Cal eligibility issues.

At the same time, the Cal MediConnect program faces significant challenges both internally and externally. Enrollees report unmet need with respect to accessing long-term services and supports (LTSS), and there remain significant gaps in the provision of care coordination. Improvements to the Medi-Cal benefit package have or will largely envelope additional benefits that were once unique to the CMC benefit package including, for example, transportation and dental benefits. Greater flexibility for Medicare Advantage plans to offer supplemental benefits also encroaches on Cal MediConnect benefits, like Care Plan Options. Furthermore, CMC plans face significant competition from Dual Special Needs Plan (D-SNP) look-alike plans; these products – sometimes operated by insurance companies with CMC plans – offer many of the same benefits but without integration or care coordination. The stakeholder process, once vibrant and robust, has largely stagnated, and major policy changes, like allowing brokers to market CMC, have been announced with very little or no formal stakeholder process. With its eye on enrollment, DHCS has curtailed important consumer protections and neglected consumer experience.

DHCS and CMC plans have all the tools necessary to implement Cal MediConnect in a way that maximizes the program's true potential. It requires DHCS to focus on consumer experience, engage stakeholders, and review data and revise policies and guidance to ensure that the program meets the needs of dual eligible enrollees. We believe this can be accomplished through a reinstatement of a formalized stakeholder workgroup that could consider our recommendations and more. The renewal of the three-way contract between the state, the Centers for Medicare and Medicaid Services (CMS), and the health plans combined with the extension of the Cal MediConnect demonstration for three additional years presents a meaningful opportunity for DHCS to reinvigorate Cal MediConnect as a truly integrated, person-centered, ideal health plan that best coordinates the care of California's dual eligibles.

[1] Graham, C. et al., "Accessing the Experiences of Dually Eligible Beneficiaries in Cal MediConnect: Results of a Longitudinal Study," (Sep. 2018), available at www.thescanfoundation.org/sites/default/files/assessing_the_experiences_of_dually_eligible_beneficiaries_in_cal_mediconnect_final_091018.pdf.

I. Improve Access to Quality Care

a. Better Connect Beneficiaries to Long Term Services and Supports and Care Coordination

Integral to the success of Cal MediConnect is the extent to which enrollees are connected to long-term services and supports (LTSS). The program was created on the theory that integrating Medicare and Medi-Cal benefits under one health plan would allow the plan to better evaluate for and link members to LTSS and prevent institutionalization and hospitalization. Evaluation data, however, indicate – as well as anecdotal evidence on the ground – that beneficiaries have significant unmet need. Two out of five enrollees report they need additional help with personal or routine care.[2] These statistics align with data that Justice in Aging obtained from DHCS via California Public Records Act Request on LTSS assessments and referrals. The data reveal exceedingly low LTSS referrals and assessments.[3]

Relatedly, fewer than one-third of Cal MediConnect enrollees report having a care coordinator.[4] While one might believe that individuals with LTSS or other complex care needs would be more likely to have a care coordinator, data show this is not the case. Despite the assignment of a care coordinator being a contractual requirement, whether a CMC enrollee has a care coordinator seems entirely random, and the ratios of care coordinators to members varies significantly from plan to plan – one care coordinator to 15 members versus one care coordinator to 353 members.[5]

The lack of care coordination and connection to LTSS has consequences. Members report that as a result of unmet LTSS need, they experience adverse outcomes including not being able to get out of bed during the day, taking medication improperly, and discomfort or soiling of their clothing because they could not use the bathroom.[6]

We note that some plans have made strides in connecting their members to LTSS. Health Plan of San Mateo, for example, has had great success in using Care Plan Options services to transition its members out of nursing homes and care coordination tools to increase the number of IHSS hours for their members. However, most plans provide few to no CPO services to their members. Based on data Justice in Aging obtained, several have not provided any CPO services over the course of the demonstration, and policy changes like no longer requiring the counties' IHSS social workers to attend care plan meetings have stymied plan efforts to increase IHSS hours for their members.

Recommendations

Form an LTSS and Care Coordination Workgroup. We recommend that the Department form a workgroup composed of the plans, the Department, and key stakeholders to review plan-reported data on LTSS referrals, assessments, CPO services, and care coordination as well as the data reported on the Cal MediConnect performance dashboard. This workgroup would

[2] Id.
[3] Justice in Aging to release a report summarizing the data obtained in late February 2019.
[4] Supra note 1.
[5] Cal MediConnect Performance Dashboard (p. 16) (Dec. 2018), available at https://www.dhcs.ca.gov/Documents/CMCDashboard12.18.pdf.
[6] Supra note 1.

investigate what difficulties plans are experiencing, and in light of those findings, the workgroup would formulate recommendations and put forth best practices that the Department would incorporate into revised policy guidance.[7]

One example is to explore different pilot models where plans can continue using ICT meetings with IHSS social workers/liaisons. Another example is to examine why the inclusion of standardized HRA questions to probe for LTSS needs across all CMC plans has not resulted in an increase in referrals and assessments for LTSS. The workgroup could also look at care coordination standards required via statute in the Program of All Inclusive Care for the Elderly (PACE) and seek to formalize similar requirements in CMC.

Include Referral Data on Performance Dashboard. In addition, with an aim toward transparency, we urge the Department include on its quarterly performance dashboard LTSS referral and assessment metrics. Currently, LTSS metrics on the dashboard include only utilization. The lack of transparent data impedes efforts of stakeholders and advocates to ask questions and hold DHCS and the health plans accountable.

Implement Policies to Incentivize Provision of Care Plan Option Services. With so few CPO services being offered to members, it is critical that the Department commit to investing in and implementing policies that facilitate the goal of providing services in the least restrictive setting. While we note that the Department has indicated that it is considering the "in lieu of" policy proposal on a separate track, we emphasize here the importance of implementing this policy to ensure health plans are appropriately incentivized and not penalized for providing their members with services that help them transition to or remain living in the community.[8] Furthermore, here we echo comments from our partner Alzheimer's Los Angeles regarding the importance of CPO services and LTSS coordination for people with dementia and underscore that by creating systems of care with clear pathways for enrollees with dementia, plans will better serve all of its members.

b. Better Coordination Across the Spectrum of Care is Needed: Behavioral Health, Dental Services, and Palliative Care

i. Behavioral Health

Another key component that ultimately determines the success of the Cal MediConnect program is integrating services that are carved out of the plan's benefit package, like specialty mental health services and dental care. Behavioral health services have historically been difficult for dual

[7] We acknowledge that concurrent with this process is the MSSP transition to Home and Community Based Care Planning Management benefit and reiterate comments submitted with respect to that transition on the model of care and purchased services. We also recognize that the plans are currently holding best practices sessions. Those sessions, however, are disconnected from a review of the data, and the sessions are not inclusive of the public and key stakeholders.

[8] See, Medicaid Managed Care Rates and In Lieu of Services in Coordinated Care Initiative Counties (Mar. 2018), available at http://www.dualsdemoadvocacy.org/wp-content/uploads/2019/02/CCI-Rates-Recommendation_Consumer-Organizations.pdf.

eligibles to navigate because certain services are Medicare-reimbursable, while specialty mental health (SMH) is covered under Medi-Cal. Adding to the complexity is that SMH remains within the province of the county and not the managed care plan. With the hopes of better coordinating behavioral healthcare, the launch of CMC spawned data sharing agreements between local counties and Cal MediConnect plans.

Like LTSS, evaluation data suggest there is much room for improvement. Beneficiaries report that Cal MediConnect providers are less informed about their behavioral healthcare compared to opt outs and non-CCI counties, and enrollees report similar levels of unmet behavioral health need. A vast majority – almost 90 percent – of Cal MediConnect members indicated that their plan did not assist them in getting much needed behavioral health services.[9]

The data further reveal that individuals who interacted with a care coordinator were more likely to get help from the plan to access needed behavioral health services. Findings like these underscore how important the Cal MediConnect care coordination benefit is in eliminating barriers to accessing services like behavioral health for dual eligibles.

Recommendations

Review existing policies and issue new guidance to better coordinate behavioral health. We encourage the Department to use the data sharing agreements between counties and health plans as a starting point to analyze why CMC medical providers are less knowledgeable about their Cal MediConnect members' behavioral healthcare. From there, DHCS should consider issuing new guidance to plans that better meets a CMC enrollee's behavioral health needs. For example, CMC care coordinators should be explicitly required to work with CMC providers and help beneficiaries navigate their behavioral health coverage.

Include improved metrics for behavioral health on the CMC performance dashboard. Outside of evaluation data, the availability of public-facing data on behavioral health in the program is limited. The quarterly performance dashboard has two metrics on behavioral health, but both of them are about access in the context of emergency room utilization. We encourage DHCS to consider adding more metrics to the dashboard.

ii. Dental

Another carved out service that has proven difficult is dental benefits. Although we appreciate some CMC plans offering supplemental dental benefits, the supplemental benefit is difficult to coordinate with the restoration of adult dental benefits under Medi-Cal. Some plans with supplemental dental benefits overlap with services covered under Medi-Cal's Denti-Cal program, and there is no guarantee that a plan's providers also contract with Denti-Cal. If the providers are not Denti-Cal contracted, CMC enrollees run the risk of being billed for services, or the member may be forced to go two different dental providers for treatment to avoid billing. Regardless, the result is beneficiary confusion and frustration. On-the-ground reports from advocates confirm this experience.

[9] Supra note 1, p. 21-23.

The restoration of Medi-Cal dental benefits and the provision of supplemental dental benefits are independently wise decisions that improve dental access for older adults, but Cal MediConnect is supposed to be an integrated plan across the spectrum of Medicare and Medi-Cal services. The lack of coordination has made the terrain difficult to navigate for CMC enrollees. Further, there is little evidence that Cal MediConnect plans are assessing their members for unmet oral health needs as required by statute.[10]

Recommendations

Coordinate supplemental dental benefits with Denti-Cal and enforce existing Denti-Cal rules. We recommend that DHCS release guidance encouraging plans offering supplemental dental to contract with Denti-Cal providers, and at the very least, be explicit about which supplemental dental providers are contracted with Denti-Cal. Furthermore, pursuant to state regulations, DHCS must advise plans that they are required to assess members for oral health needs and require care coordinators to work with Denti-Cal providers and help beneficiaries navigate dental benefits.

Include dental metrics on the CMC performance dashboard. We encourage DHCS to include metrics pertaining to oral health on the performance dashboard. Currently, there are no metrics on dental services so it is nearly impossible for advocates to hold the Department and health plans accountable to better coordinate this carved out benefit.

iii. Palliative Care

Medicare covers some elements of palliative care while Medi-Cal includes a comprehensive palliative care benefit that was recently implemented pursuant to SB 1004. Unfortunately, to date, DHCS has only issued policy guidance to plans on the delivery for palliative care for non dual eligibles.[11]

Recommendation

Extend APL 17-015 to dual eligibles and issue Duals Plan Letter on Palliative Care. Currently All Plan Letter (APL) 17-015 excludes dual eligibles enrolled in Medi-Cal managed care. We encourage DHCS to extend the guidance to include dual eligibles. At the same time, DHCS should release a duals plan letter providing Cal MediConnect plans with guidance on how to deliver palliative care to dual eligibles. From there, DHCS should work with plans to ensure members are being connected to this benefit. Cal MediConnect with its integrated delivery model presents an opportunity to connect dual eligibles to the palliative care benefit – a benefit which has proven to reduce hospitalizations and unnecessary institutionalization for individuals with serious illness.

c. Improve Access to Transportation and Durable Medical Equipment

i. Transportation

Transportation to service providers was seen as such a critical lifeline for beneficiaries that since the inception of the program, the CMC three-way contract has required health plans to provide

[10] AB 2207; WIC § 14198.8

[11] See, "Palliative Care and Managed Care," All Plan Letter (APL) 17-015, (Oct. 2017), available at https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-015.pdf.

non-medical transportation (NMT) in addition to the Medi-Cal non-emergency medical transportation (NEMT) benefit. The value of NMT was recognized again when California clarified that unlimited NMT is part of the Medi-Cal plan's benefit package. Despite these developments, Cal MediConnect members report ongoing issues accessing transportation to needed services.

In fact, CMC evaluations report that more than one out of ten CMC enrollees indicate needing more help with transportation to medical or other health-related appointments. Unfortunately, the numbers are similar compared to opt out and non-CCI dual eligibles. That unmet need has real consequences. Almost 60% of CMC beneficiaries with unmet transportation need reported missing a doctor's appointment or other medical appointment because they were not able to get there.[12] Furthermore, reports from on-the-ground advocates reveal that some health plans are requiring members to prove they cannot take public transportation before authorizing NMT. In addition, some transportation vendors contracted with the plans are particularly problematic and have major quality of care issues, like failing to secure beneficiaries during rides, arriving late to pick up, and more.

DHCS has failed in fully implementing the transportation benefit.[13] When California clarified that unlimited NMT is part of the Medi-Cal benefit package, the Department failed to issue guidance requiring health plans to inform their members of this clarification. Furthermore, the Department's own guidance allows plans to use a prior authorization process for NMT, which was not used with respect to the CMC one-way trips, and the example of a plan requiring a member to exhaust public transportation before approving NMT shows how problematic a prior authorization in this context can be. Finally, related to accessing carved out services, Department guidance does not require NEMT to carved out services, merely that the plan make its best efforts to refer for and coordinate NEMT.[14] Access to transportation should not depend on what type of transportation one needs and whether the destination is within the plan's benefit package. These types of arbitrary distinctions unnecessarily complicate and exacerbate the transportation access issues dual eligibles face.

Recommendation

Issue revised DPL on transportation. In the revisions, we urge the Department to require health plans to inform members of the NMT benefit in addition to the changes already made to the member handbook. Burying the clarification about NMT in the member handbook fails to adequately inform members. We also encourage that the revisions prohibit plans from using a prior authorization process for NMT and require that plans also provide NEMT to carved out services. If the Department decides to retain the prior authorization process, a revised DPL must make clear that health plans cannot require exhaustion of public transportation before authorizing NMT.

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[12] Supra note 1, p. 48.

[13] We reiterate many of Justice in Aging's comments sent in August 2017 to the Department regarding NMT and the gaps that existed after the issuance of All Plan Letter (APL) 17-010.

[14] See, "Non-Emergency Medical and Non-Medical Transportation Services," Duals Plan Letter (DPL) 18-001, (April 2018), available at www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2018/DPL18-001.pdf.

ii. Durable Medical Equipment

As a health plan that integrates Medicare and Medi-Cal coverage, one of the benefits that was supposed to be easier to access as a result of the demonstration was durable medical equipment. The integration would theoretically prevent issues dual eligibles experienced because Medi-Cal authorizes the equipment if it is categorically excluded from Medicare coverage or Medicare denied coverage in a particular instance, but Medicare does not review a claim until after DME is delivered. Dual eligibles would find themselves stuck. Under one health plan, these authorization issues should be mitigated.

Unfortunately, evaluation results indicate that about half of CMC enrollees need DME but are unable to get it from their plan.[15] The percentage is actually lower for dual eligibles who opted out and about the same as those living in non-CCI counties.

Recommendation

Work with plans to release improved guidance on DME. DHCS should work with CMC plans to investigate what barriers enrollees are experiencing with respect to accessing DME and why the integration has not mitigated access issues. From there, it should issue improved guidance to CMC plans.

d. Improve Coordination with Service Providers to Address Social Determinants of Health

One successful component of the Cal MediConnect program to date has been the development of relationships that did not exist prior to the demonstration. These relationships better position plans to more readily address social determinants of health by connecting beneficiaries to service providers. For example, several health plans have partnered with local Long-Term Care Ombudsman programs to visit nursing facilities with whom they are contracted and their members.[16] Now, some plans are using a similar model to visit other providers, like CBAS centers to develop those relationships as well.

Recommendation

Encourage health plans to formalize agreements with service providers. We encourage DHCS to push these types of best practices across health plans and explore ways to formalize these relationships through policy guidance and other agreements.

II. Address Ongoing and Emerging Challenges to Improving the Beneficiary Experience

a. Prioritize Fixing Ongoing Enrollment and Disenrollment Challenges

In the years after the launch of Cal MediConnect, legal aid advocates have encountered a number of enrollment issues triggered by DHCS systems, like erroneous aid codes and inadequate training

[15] Supra note 1, p. 28.

[16] Hollister, Brooke, et al. Aging Today, "Yes, Collaboration Can Happen – and Means Better Quality of Life for LTC Residents," January/February 2016, available at www.asaging.org/blog/yes-collaboration-can-happen-and-means-better-quality-life-ltc-residents.

for Health Care Options (HCO) customer service representatives. These issues are not the fault of the consumer but can jeopardize the care enrollees receive, sometimes even preventing a dual eligible from enrolling into Cal MediConnect. For far too long, DHCS has prioritized granting the health plans increased flexibility with respect to enrollment, streamlined enrollment and brokers for example, over fixing these administrative problems. But no enrollment flexibility will be useful if beneficiaries continue to face systemic challenges that prevent them from enrolling into CMC or are erroneously disenrolled.

For example, on-the-ground legal aid advocates report that particularly vulnerable Cal MediConnect members, like individuals who cannot leave their homes, are missing their Medi-Cal renewal deadlines and triggering the period of deemed eligibility. Although the deeming period is an important consumer protection, health plans can be more involved in working with legal aid programs on eligibility issues. In one case involving a 70-year old CMC enrollee who could not leave her home, the legal services provider made a special trip to the member's home to help with documents and assist with her Medi-Cal reinstatement. Efforts in New York's demonstration program allow the plan to more proactively help members coordinate and submit their annual Medicaid renewal documentation. Formalizing these relationships allows all aging service providers to better identify and resolve problems that could significantly affect an enrollee's care.

Recommendation

Prioritize fixing ongoing enrollment and disenrollment challenges. The CCI ombudsman program has raised a number of systemic enrollment and disenrollment challenges to DHCS based on real case examples, like erroneous aid codes and inadequate HCO CSR training. The Department must prioritize investigating and fixing these challenges so that dual eligibles can freely enroll and stay enrolled in the Cal MediConnect program. In addition, DHCS should consider encouraging plans to formalize agreements with legal services providers to resolve eligibility issues.

b. Limit the Availability of Dual-Special Needs Plan (D-SNP) Lookalikes

Cal MediConnect is designed to be one of the few – if only – truly integrated care options for dual eligibles in California. The state's D-SNP policy, which essentially required those plans operating both CMC and D-SNP products to cross-walk its D-SNP enrollees into its CMC plan and limited new enrollment, aimed at promoting Cal MediConnect as that option.[17]

However, contemporaneous with the launch and implementation of Cal MediConnect, an explosion of "D-SNP lookalikes" has occurred. These products are not governed by traditional D-SNP rules, and they are not integrated care options. Some companies operating CMC plans also have D-SNP lookalikes. A recent study found that the number of dual eligibles in these lookalike products in California numbered over 90,000, only about 20,000 less than the number of CMC enrollees across the state.[18]

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[17] See, "Dual-Eligible Special Needs Plans," APL 14-007 (July 2014), available at www.dhcs.ca.gov/formsandpubs/documents/mmcdaplsandpolicyletters/apl2014/apl14-007.pdf.

[18] MedPAC, "Managed care plans for dual eligible beneficiaries," (pp. 273-274) (Jun. 2018), available at http://www.medpac.gov/docs/default-source/reports/jun18_ch9_medpacreport_sec.pdf?sfvrsn=0.

Lookalikes are problematic for several reasons. They are not integrated, so the Medicare product is not designed to coordinate benefits with the Medi-Cal plan, unlike CMC. Plans have asked for – and DHCS has given – increased flexibility to skirt around consumer enrollment protections with an aim to enroll CMC members, but the real issue is that they have created competing non-integrated products because capitations are higher than CMC, and products are not subject to D-SNP and MMP rules. These lookalikes have engaged in highly aggressive and sometimes improper marketing behavior in attempt to enroll dual eligibles. Finally, given the cost-sharing structure with high co-pays and deductibles, we also see that members who enrolled in these lookalike plans are also more likely to experience improper billing for covered services despite federal and state law.[19] In short, their rise runs counter to the delivery of integrated care for dual eligibles.

For these reasons, we are deeply concerned with the development and success of lookalike products in California and believe that a plan cannot contemporaneously offer both an integrated product and a DSNP lookalike product in good conscience.

Recommendation

Work with CMS to limit availability and require lookalikes serving dual eligibles to submit to D-SNP or CMC requirements. We recommend that the Department take immediate action and work with CMS to limit the availability of these plans to dual eligibles. For example, they could consider requiring plans that serve a certain baseline of dual eligibles to be registered as a D-SNP or CMC product or DHCS could regulate enrollment into lookalike products. D-SNP lookalikes, if unchecked, will decimate the market for Cal MediConnect and other Medicare-Medicaid Plans and destroy much of the progress CMC has made to date on integrating care.

c. Maintain Consumer-Oriented Enrollment Periods

We were, and continue to be, concerned over CMS's decision to change the special enrollment period (SEP) for dual eligibles to a quarterly basis. We therefore welcomed DHCS's decision to seek – and ultimately obtain approval – for a waiver to allow dual eligibles to maintain a continuous SEP with respect to enrollment into and out of CMC. As we explained in our comments to DHCS from June 2018 on the SEP, the continuous SEP is an important consumer protection that allows dual eligibles to choose a plan that best meets their needs in the most timely manner, and it is a longstanding protection dual eligibles are used to and one that is easy to explain and administer.[20]

Therefore, we are troubled by the Department's intention to reverse course and not seek renewal of the waiver for 2020.

Recommendation

Seek a waiver to continue to SEP for CMC. Particularly after DHCS has already invested resources into operationalizing the continuous SEP with respect to CMC enrollments and disenrollments

[19] 42 U.S.C. § 1396a(n)(3)(B); WIC § 14019.4.

[20] See Justice in Aging's comments on the SEP waiver (June 2018), available at http://www.dualsdemoadvocacy.org/wp-content/uploads/2018/06/JIA-SEP-Comments-Final.pdf.

for 2019 and given the nature of this critical consumer protection, we urge DHCS to continue maintaining the waiver of the SEP. Cal MediConnect is supposed to raise the bar as the ideal delivery system for dual eligibles, so its enrollment rules should be designed to give enrollees the most flexibility to make plan choices that best meet their needs.

d. Address Language Access Concerns

As the ideal delivery system for all of California's diverse dual eligibles, Cal MediConnect must be culturally competent and seek to promote access to care for limited English proficient (LEP) members. Given specific cultural and political histories, distrust of government, and the general failure of managed care networks to contract with in-language providers, many smaller LEP communities opted out of Cal MediConnect in high percentages, meaning that enrollees on average are more likely to be English or Spanish speaking.[21] With this sensitive backdrop in mind, it is critically important that DHCS and the plans provide culturally competent care or risk jeopardizing relationships with LEP communities and fueling their distrust of managed care.

Evaluation data indicate that about half of Cal MediConnect beneficiaries who spoke a language other than English were *never* able to get a professional interpreter when they needed help speaking to their doctors.[22] In fact, the percentages of opt out or non-CCI dual eligibles who were always able to access an interpreter were higher than those in CMC.

These results are alarming. Not only is offering free, timely interpretation services a necessary part of making Cal MediConnect an ideal delivery system, it is required under federal and state non-discrimination laws.[23] Developments in technology should make providing remote interpretation over the phone and video even easier. The difficulty health plans have had in connecting LEP dual eligibles with interpreters raises additional questions about how friendly plan systems are to LEP members, like whether care coordinators and care coordination services are provided in-language.

Recommendation

Investigate the availability of interpreter services in Cal MediConnect. We urge DHCS to take immediate action and investigate and scrutinize plan processes for interpreter services and translated materials and consider including additional metrics on the performance dashboard on this topic.

III. Reinstate a Formal and Robust Stakeholder Workgroup

As noted previously, the Cal MediConnect program has benefited tremendously from robust stakeholder engagement. This engagement, particularly vigorous at the inception, has forced the program to be more person-centered and resulted in positive developments, like specific training

[21] See, for example, Cal MediConnect Opt Out Breakdown by Language, Ethnicity, and Age by County (Sept. 2016), available at http://calduals.org/wp-content/uploads/2016/09/August-Detailed-Opt-Out-FINAL_1.pdf.
[22] Supra note 1, p. 64.
[23] 42 U.S.C. § 2000d et. seq.; 42 U.S.C. § 18116; 42 CFR § 92.201; Cal. Gov. Code § 11135.

for care coordinators on Alzheimer's and related dementia, the institution of a period of deemed eligibility, the creation of a performance dashboard, and more.

However, for the past three years, there has been little formal stakeholder engagement or efforts to improve the program, and much of it reactive. For example, one of the most recent proposals to pilot the use of brokers in Cal MediConnect, which marked a significant rollback in consumer protections, was announced, and the Department sought comment not on whether brokers should be allowed, but how such a pilot should work – in other words, a foregone conclusion. Actions like these have damaged the history of trust and stakeholder engagement that advocates have enjoyed with the Department.

Recommendation

Initiate formalized stakeholder workgroup to improve Cal MediConnect. We recommend that DHCS initiate a formalized stakeholder workgroup for Cal MediConnect to provide input and insight on issues in the Cal MediConnect program. It may include existing DHCS measures like the stakeholder webinars, but a formal stakeholder process should be created to explore and analyze the topics we have raised in our comments today and other program challenges. In convening such a group, we advise the Department to consider inviting different voices, including health plans, consumers, advocates, and providers.

Conclusion

Cal MediConnect has the potential to be an ideal and integrated system of care for California's dual eligible population. The potential will only be reached if DHCS prioritizes Cal MediConnect and signals the program's importance through improved policy guidance and appropriate oversight of CMC plans. It also requires a meaningful commitment to greater transparency and stakeholder engagement. We believe in the potential of Cal MediConnect to better serve California's dual eligibles and hope our comments are instructive to DHCS on where we believe the program must address major challenges in order to succeed.

Again, thank you for the opportunity to comment. Please feel free to contact Denny Chan at dchan@justiceinaging.org to discuss our comments in more detail.

Sincerely,

Justice in Aging
California Health Advocates
Center for Health Care Rights
Disability Rights California
Disability Rights Education & Defense Fund
Health Consumer Alliance – CCI/Cal MediConnect Ombudsman

Little Tokyo Service Center
National Health Law Program
Western Center on Law and Poverty