California Collaborative for Long Term Services and Supports

Recommendations for a Voluntary Enrollment Strategy for the Cal MediConnect Program

Submitted to California Department of Health Care Services
7/31/16

Background

The California Collaborative for Long Term Services and Supports is comprised of 30 statewide aging and disability organizations that promote dignity and independence in long-term living.

In response to an invitation from the California Department of Health Care Services to submit recommendations for a new voluntary enrollment strategy for the Cal MediConnect program, the Collaborative convened a task force to develop a proposal with as much depth and specificity as possible. The task force was co-chaired by Amber Cutler of Justice in Aging and Athena Chapman of the California Association of Health Plans. Laurel Mildred provided staffing.

The chairs nominated and recruited members and guests of the Collaborative with expertise and interest in this area. The task force met four times, on 6-15-16, 6-22-16, 6-29-16 and 7-13-16 to formulate recommendations. We are grateful to all task force members who served:

- Amber Cutler, Justice in Aging, Co-Chair
- Athena Chapman, California Association of Health Plans, Co-Chair
- Susan Arcidiacono, Inland Empire Health Plan
- Gretchen Brickson and Regina Lightner, LA Care
- Denny Chan, Justice in Aging
- Susan DeMarois, California Council of the Alzheimer's Association
- Elizabeth Evanson, California Association of Health Plans
- Lishaun Francis, California Medical Association
- Diane Sargent, Health Net
- Sarah Steenhausen, The SCAN Foundation
- Silvia Yee, Disability Rights Education and Defense Fund

Introduction

The Collaborative appreciates the opportunity to provide recommendations for a CMC voluntary enrollment strategy. Since we began this process, DHCS has released its initial draft of a strategy. The task force has noted a number of strengths in the state's proposal, including plans to implement beneficiary mailings on behalf of the program, and to analyze opt-out data and develop tailored strategies for physician outreach based on the opt-out data. We applaud these developments.

We are aware of the challenges involved in revising the enrollment approach to the program, the difficulty of the timeline and pressure to revise and renew the program's approach. The California Medical Association explains: *The hardest question we received when presenting on CMC came from an African American physician who asked, 'Why does the state keep implementing these pilot programs on poor people and people of color?' The state needs to understand that this is how the program is viewed by many beneficiaries and providers. Through their actions, the state can change this perception by being responsive to concerns and open to suggestions for improvement.*

To aid in this endeavor, the California Collaborative offers the following specific recommendations. We suggest that as the state refines their plan, they define who is responsible for implementation of each item, and a timeline for completion, be included for every action outlined in the strategy.

We have held preliminary discussion with Harbage Consulting about the Collaborative's recommendations, and members of the task force volunteered to continue to work with DHCS and Harbage on an ad hoc basis, to assist in refining and implementing the strategy.

RECOMMENDATION 1: Re-Message and Create New Materials —Create Consistent Basic Messages

1.1 Materials and new messaging should discuss how the program addresses the person's needs - how it is personalized, cuts red tape, adds transportation, includes vision, provides additional services, helps caregivers, and provides care coordination all in plain language, stories, and visuals that beneficiaries and caregivers can easily understand.

1.2 Develop generic plan-neutral materials that have program highlights and a value proposition that can be used as a leave-behind for those doing program outreach.

1.3 Tailor marketing materials to special population needs (e.g. people with dementia, diabetes, cardiovascular, etc).

1.4 Emulate PACE materials (here and here) and the 1:1 personalized approach to beneficiary outreach to establish and develop a high-touch servicing model.

1.5 Leverage and repurpose what has been created and develop improved dissemination plan (e.g. will I have to change doctors and how does continuity of care work; repurpose Cal MediConnecttoons)

1.6 Create and supply template messaging to trusted sources to use on their materials and websites (e.g. county DPSS websites, county/city Department of Aging websites,, HICAPs, AAAs, Public Authorities, Long-Term Care Ombudsman, APS, etc.).

1.7 Request that the Centers for Medicare and Medicaid Services clarify and provide guidance to plans on what is considered educational versus marketing materials.

RECOMMENDATION 2: Re-Train and Resource Outreach Staff (Health Care Options, HICAPs, DPSS, CDA, Medi-Cal Ombudsman)

2.1 Renew and extend funding for HICAP counseling.

2.2 Retrain DPSS staff, HCO CSRs, Medi-Cal Ombudsman, APS, and CDA staff on program, voluntary enrollment, deeming, etc.

2.3 Provide ongoing and repeated training for local community-based organizations and other trusted community sources partnering with Harbage/DHCS and trusted community sources.

RECOMMENDATION 3: Coordinate Timing of CMC Notifications So As Not to Conflict with Other Health Care Announcements (Medicare or Medi-Cal) or Enrollment Periods and to Leverage Communications Already Slated for Beneficiaries to Receive

3.1 Annual enrollment period (AEP) for Medicare is October 15 through December 7. Although duals have an ongoing enrollment period, marketing activities are heightened during this period, so DHCS and the plans should avoid intense outreach campaigns during this period.

3.2 CMC information should accompany annual redeterminations for dual eligibles not enrolled in the program.

RECOMMENDATION 4: Create A Next Generation Website for CMC as a Central Repository for Clear and Easy-to-Understand Information

4.1 The CMC website should be repurposed and modeled after the Covered California website.

4.2 Feature video success stories, including beneficiary and caregiver perspectives.

4.3 Include physician champions discussing benefits of program.

4.4 Feature care coordinators explaining what they do.

4.5 Make resources for choice counseling and assistance with appeals from the Ombudsman easy-to-find.

4.6 Make plan links and their provider directories more accessible on the website and through the HCO website so that the beneficiary can see if his or her doctor is in the network.

4.7 Ensure that the state's resources on the DHCS website (including the HCO website, Medi-Cal Ombudsman site, and any other DHCS-hosted site) include easy-to-find links to CalDuals.

RECOMMENDATION 5: Improve Accessibility: We Recommend These Best Practices for Ensuring Compliance with the Americans with Disabilities Act Regulations and the Effective Communication of Written Notices and Documents

5.1 Wide notice of the availability of availability of auxiliary aids and services for effective communication. Auxiliary aids and services include alternate formats such as Braille, large font print and CD, a qualified reader or translator, or documents translated into American Sign Language captured visually, that will be delivered in a timely manner to individuals who identify themselves to DHCS or a health plan as people with disabilities who require auxiliary aids and services for effective communication. The notice itself needs to be accessible (i.e., placed on an accessible website, posted in physical locations in large font, a tagline in 18 font bold should be placed in all notices sent out just like a LEP tagline).

5.2 DHCS/CMC needs to have a database where an individual's preferred accommodation need is **documented and placed in the individual's record** so that the person does not bear the default burden

of contacting DHCS/CMC for every single new notice, letter or piece of mail to formally request it in the person's preferred alternative format. This was a very significant breakdown point for CMC last time, when DHCS acknowledged that it keeps no records of accommodation needs and can't promise to not send a patchwork of alternative formats land typical print letters, with an individual having no idea of whether they are receiving everything they need to read in their needed alternate format.

5.3 Designate a place to call or contact if there are accessibility problems, and there must be a place to make complaints about inaccessibility.

5.4 The person's preferred choice of format should be considered and granted unless it is an undue burden to do so, in which case the entity and the individual need to work out an alternative solution that actually provides effective communication. The entity can offer a set of pre-existing approved auxiliary aids or services, but can't automatically refuse to consider something that isn't on the list (e.g., 18 font is automatically offered, but X needs 24 font, or X needs 18 font Chinese).

5.5 There must be monitoring to keep track of the number of requests made for each auxiliary aid or service and how many of the requests were met, keep track of the number of complaints made, and so forth.

5.6 Monitored information should be transparently made available to the public.

5.7 Appeal timelines in notices should follow the delivery of the auxiliary aid or service requested by the person, not the date of delivery of the print letter that the individual could not read.

5.8 A beneficiary should be able to request both an auxiliary aid or service AND a print letter (which is useful to advocates or attorneys that the person might hire in future), if desired, and ideally both should be delivered together.

Recommendation 6 - Improve Outreach to Ethnic Communities

6.1 All outreach for CMC should address fundamental distrust of large institutions, including government programs, and build trust by clearly and transparently explaining the value of the program.

6.2 Utilize community-defined best practices for outreach strategies. Examples of these types of strategies can be found here and here.

Recommendation 7 - Build Bridges to Primary Care and Specialist Physicians with a Focus on Ethnic Physician Organizations

7.1. When conducting outreach to physician organizations to provide informational seminars on CMC, send plan representatives who are familiar with billing practices/eligibility requirements and the coordinated care system to be the presenters. This may involve a combination of Harbage and CMC plan staff.

7.2 Convene and work with focus groups of physicians who have contracted with CMC plans and inquire about their experience (with the intent to make a good faith effort to make changes).

7.2.a Focus groups can be created through ethnic medical organizations like the Armenian Medical Society and/or county medical associations like the Los Angeles County Medical Association.

7.2.b Establish in-depth relationships between the health plan and the local Medical Association. Inland Empire Health Plan has a long-standing successful relationship with the Riverside Medical Association at both the CEO and the Chief Medical Officer level.

7.3 Find physician champions of the program. These are likely to be found during focus grouping. Physician champions will be able to participate in peer-to-peer education of the program. Physicians trust other physicians.

7.4 The goal of connecting with physicians should not be to "sell" the program, but to hear their concerns about it and be prepared with responses.

7.4.a Tip: when advertising the meeting make it clear providers are invited to bring questions and concerns. The first 20 min should be devoted to an overview of the program, with the remaining time largely a back and forth between physicians and plan representatives.

7.5 Provide concrete evidence that the CMC program improves on past service delivery models. Assertions that the CMC program is "the best program" without evidence will breed further mistrust and belief that the state is out of touch with beneficiaries and providers.

7.6 Be open to and act on concerns raised by beneficiaries and providers and solicit their assessment regarding whether the program is working.

7.7 OUTREACH CHECKLIST: These are questions that DHCS can provide plans as best practices be asked to improve outreach:

A. Questions for Plans:

1. Are we using culturally competent methods to communicate the changes with patients and their physicians?

2. Have we worked with Harbage to connect with medical associations and ethnic serving medical groups to request meetings and offer trainings?

3. Have we addressed the concerns we have heard from physicians during our presentations?

4. Do we have a relationship with the county medical association?

5. Will the county medical association alert us to any consistent concerns about the program by their members?

B. Questions for the State:

1. Are representatives doing outreach on the CMC program able to answer specific billing/eligibility/ continuity of care concerns when presenting on CMC? Harbage should consider hiring additional outreach coordinators for languages with the highest opt-outs (e.g. Russian, Armenian, Vietnamese).

Recommendation 8 - Build Strong Program Relationships with Other Key Providers

8.1 Pharmacies are often the first point of contact, and first point of disruption, in the program. Build relationships with pharmacy providers who can provide ongoing support and communication to beneficiaries about the program.

8.2 Educate and partner with other specialty providers, including DME, dentists, optometrists, podiatry, etc. so they will be well-informed about the program and be able to assist beneficiaries to access services.

Recommendation 9 - Develop Community Partners

9.1 Develop co-branded materials for statewide and local organizations to distribute.

9.2 Develop Initiatives with a built-in role for community partners, similar to Medicare enrollment processes, where CBOs are actively part of communicating, educating and promoting the value of the program (e.g., the Alzheimer's Association is a partner, is included in the enrollment campaign, participates in developing messages appropriate for their population (in this case, how the program is particularly valuable for addressing beneficiary and caregiver needs around dementia), has ready access to co-branded materials that they can distribute, gives feedback on what is working and what is not, etc.

9.3 Develop and maintain relationships with county and community

partners (attend their events, conferences and staff trainings).

9.4 Provide program brochures to community partners for distribution.

9.5 Train community partners in the program and how to enroll consumers through calling HCO and the hours of operation for HCO.

9.6 DHCS should encourage plans to develop a close working relationship with Adult Protective Services and Community Care Transition Programs, Long-Term Care Ombudsman including training and refresher information about the program, participating in monthly APS Multidisciplinary Care Team meetings, presenting at APS conferences and MDT meetings, and including APS social workers on plan interdisciplinary care team meetings. Plans and DHCS should also reach out to low-income senior housing coordinators.

9.7 Develop a meaningful CCI Stakeholder Advisory Committee and work closely with them, including Independent Living Centers, county legal centers, department of Public Social Services (APS, IHSS), the Public Authority, partner health plans, providers, consumers, IHSS provider unions, housing authority, mental health, senior comparisons and Social Security Administration representatives.

Recommendation 10 - Utilize Best Practices for Enrollment: These Recommendations are Based on Inland Empire Health Plan's Enrollment Strategies, Which Started with a Conversion Rate of 30% That is Now 85-90%

10.1 Identify potential member's needs (market research):

A. Ability to keep my doctor.

B. No disruption in services (Specialist, DME, RX).

C. No hard sell - it turns members off. Use more of an educational approach.

10.2 Network strategy:

A. Build a large network of doctors who are traditionally seeing the fee-for-service Medi-Medi population.

B. Provider outreach - educate them on the CCI program and how it impacts them to build doctor buy-in.

10.3 Sales Team:

A. Inland Empire uses an in-house team.

B. Skill – look for social empathy with one-on-one educational as a skill set.

C. Be a partner with Member Services, Care Management, Pharmacy, Provider Services Reps, etc.

10.4 Lead:

A. Pre-screening - Data from the State's eligibility file, CMC eligible aid codes (list on DHCS website), excluding CMC ineligible criteria (<21, DD, ESRD, etc.) from State's file, verifying eligibility through State file PLUS AVES and MarX.

B. Marketing and Outreach – Direct mail program info and conduct 1:1 educational sessions from outbound and inbound calls from members. If member is interested, warm transfer to HCO to complete the enrollment.

10.5 Partner with DHCS and CMS on actual enrollment assistance experience via bi-weekly calls with contract managers - sharing what is working as well as areas for improvement or questions or clarification.

Recommendation 11 - Target LTSS Users Including IHSS, MSSP, CBAS Centers, and Nursing Facilities

11.1 Develop tailored materials discussing how care coordination can be used effectively for the person who self-directs care (see

perspectives on this topic from the Personal Assistance Services Council of LA County, here.)

11.2 Work with local unions to disseminate information about the value of the program.

11.3 Work with LTSS providers to disseminate information about the value of the program.