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July 11, 2012

Toby Douglas, Director
Department of Health Care Services

Via Electronic Mail to LIHPTransitionProject@dhcs.ca.gov

RE: Comments to the Draft Initial Plan Implementing the ACA in California

Dear Mr. Douglas:

On behalf of Asian Pacific American Legal Center, California Partnership, Community Health Councils, L.A. Gay & Lesbian Center, Legal Aid Foundation of Los Angeles, Legal Aid Society of San Mateo County, Maternal and Child Health Access, National Health Law Program, Project Inform, San Francisco AIDS Foundation, Southeast Asia Resource Action Center, and Western Center on Law and Poverty, we submit these comments in response to the Department of Health Care Services' *Draft Initial Plan Implementing the ACA in California: Transitioning the Low Income Health Program to ACA Coverage Options* (Draft Plan).

Our organizations are committed to ensuring that low-income consumers have access to affordable and quality health care. Among our organizations, we have worked in nearly all aspects of the implementation of the Low Income Health Programs, from collaborating with state and county officials on developing LIHP policies, to working directly with consumers applying to and accessing services in LIHPs across the state. We are pleased that by submitting a Draft Plan to CMS describing how LIHP enrollees will be transitioned to Medi-Cal or the California Health Benefit Exchange in 2014, DHCS is taking the necessary steps for California to implement the Medicaid expansion under the ACA.

But we are disheartened by several aspects of the proposed Draft Plan and believe there is much room for improvement. Our comments focus on the following issues:

1. DHCS's decision to default LIHP enrollees into managed care plans, rather than providing enrollees with the option to choose their own plans;
2. The lack of discussion regarding how the State intends to gain the consent of LIHP enrollees to transfer their information to Medi-Cal and the Exchange in order to assess their eligibility;
3. A recommendation to provide targeted transition information to persons with income above 133% of the Federal Poverty Level so that persons who may be ineligible for Medi-Cal in 2014 can begin learning about their options in the Exchange or a Basic Health Program, if California implements one, as soon as possible;
4. The general lack of detail in the Draft Plan regarding the policies and procedures for how the State and the counties will move an estimated 500,000 people by 2014 from county

LIHPs to Medi-Cal or to the Exchange, and with nine counties that have yet to implement a LIHP, the lack of a provision in the Draft Plan for the transition of individuals in those counties in 2014; and finally

5. The need for regular stakeholder input to begin as soon as possible as DHCS continues to work toward refining the details of the Draft Plan.

Our comments are detailed below. We would be happy to discuss any of our suggestions with your staff as they work to finalize the Draft Plan. To coordinate a discussion, please contact Shirley Sanematsu of the Western Center on law and Poverty via email at ssanematsu@wclp.org or at (213) 235-2638. Shirley will, however, be out of the office from July 16 to July 23; during that time, please contact Vanessa Cajina at Western Center via vcajina@wclp.org or at (916) 282-5117.

1. **We strongly urge DHCS to make consumer choice a priority in transitioning LIHP enrollees to Medi-Cal managed care plans and reiterate our recommendation that LIHP enrollees have the opportunity to select their own managed care plan before being defaulted into a plan.**

We are very disappointed that our key recommendation for the transition – that LIHP enrollees deemed eligible for Medi-Cal be given the opportunity to "opt-in" to a managed care plan by choosing their own health plan – is not part of the proposed Draft Plan. The Draft Plan instead proposes that DHCS will "assign" persons to a managed care plan and only then will assignees be given the option to "opt-out." *See* Draft Plan at p.3, "Medi-Cal Managed Care Plan Assignment." Our recommendation for an opt-in process was offered during the breakout session on the LIHP transition process at DHCS's Stakeholder Advisory Committee Meeting on April 23, 2012 and was strenuously repeated in a follow-up call held specifically to solicit our input on issues regarding the transition. Despite this input, the Draft Plan suggests that the only stakeholder input about plan selection was that the process "should focus on retaining a LIHP enrollee's medical home whenever possible." Draft Plan at p. 3. This does not reflect advocates' views and we ask that that the plan be revised to reflect both perspectives. Failure to do so would be misleading.

As advocates for low-income consumers, we see firsthand the importance of allowing persons to have the choice in selecting the providers that best fit their medical needs and circumstances. This is especially true given the particular challenges that face poor people when accessing health services. Persons living in poverty are commonly limited by logistical challenges such as lack of access to a car or the inability to afford gas to travel longer distances to see providers, who are often few and far between. Under such circumstances, it is critical that people be given

the opportunity to choose their own plan based on their specific needs and the providers that are accessible to them under that plan.

We are unaware of any other instance where there was plan choice (meaning more than one managed care plan is available to a beneficiary) in which DHCS defaulted beneficiaries into a plan without first giving them the option of choosing. New beneficiaries in GMC and Two-Plan Counties are given the opportunity to choose a plan and are only defaulted if they do not make a choice. Similarly, in the recent SPD transition, the State first gave beneficiaries a choice. Only **after** beneficiaries were given the opportunity to **first** choose a plan, then, as a fallback for those who did not choose a plan, could DHCS select a plan that contained the beneficiary's doctor.

Auto-assigning LIHP enrollees to managed care plans based on whether their LIHP medical home provider is part of the Medi-Cal plan, as contemplated by the proposed Draft Plan, fails to take into account that for some consumers it may be more important to see another provider who is not part of the plan rather than seeing their primary care provider at their medical home.[1] If a consumer is defaulted into Managed Care Plan A because her medical home is a provider under in Plan A but the specialist she sees every week to manage her chronic condition is a provider in Managed Care Plan B, she risks a disruption to her care that could be avoided had she been given the opportunity to choose Plan B.

The Draft Plan, in elevating continuity of care above consumer choice, seems to assume that LIHP enrollees have long established relationships with their LIHP providers. While that may be true for some consumers and we expect many will choose a plan that enables them to stay with their LIHP provider or clinic, other LIHP enrollees may not have established a relationship with their LIHP provider and would rather choose a different plan or provider based on their needs. After all, the LIHPs only began enrollment in 2011, and enrollment in some counties will not begin until late 2012 or even early 2013.

In order to fulfill the goal of the Draft Plan to create a transition where LIHP enrollee are moved to Medi-Cal or the Exchange "without interruption in coverage to the maximum extent possible," (STC ¶ 23), we recommend that the selection of a Medi-Cal managed care plan be revised in the Draft Plan with the following principles and timeline:

a. Make consumer choice a priority and provide that the first step in the process where LIHP enrollees who are deemed eligible for Medi-Cal and are in counties with more

[1] We also note that while we disagree with the auto-assignment opt-out process as a whole for failing to respect the right of consumers to choose their health delivery system, we are particularly puzzled by the Draft Plan's provision that even though enrollees may be notified of their assigned health plan as early as October 2013 (enrollees "will receive a notice no sooner than 90 days prior to January 1, 2014"), they must wait until January 1, 2014 if they want to change plans. If DHCS maintains the opt-out process rather than implementing an opt-in process as we recommend, we exhort DHCS to at least allow enrollees who want to change from their assigned plan to do so at any time after they have been notified of the assignment.

than one managed care plan are given the opportunity, after sufficient notification and information sharing about the benefits available in the plans, to select the plan of their choice;

b. Use all possible touch points the LIHP has with its enrollees – *i.e.*, during the annual redetermination process, when an enrollee receives services – to begin outreach, education, and notification efforts about the transition to 2014, with all such general notifications occurring by June 30, 2013 at the latest;
c. Provide specific notification to enrollees by July 1, 2013 of their opportunity to select a health plan, with enrollees receiving enrollment packets and instructions that they have at least 90 days, until October 1, 2013, which is when the Exchange is scheduled to begin enrollment, to select a health plan. Notification and enrollment packets must include information about the delivery system choices, how to make a list of their current and needed providers and types of care, how to assess the plan choices in relation to the list of their needs, and what the enrollee needs to do to select a plan, as well as information for local application assisters, navigators and other community based organizations that can aid enrollees with the process;
d. The proposed Draft Plan states that "telephone assistance for plan assignment will be available in at least the 14 threshold languages" (Draft Plan at p. 5) but does not state when these telephone operators will be available. Under our proposed schedule, we recommend that telephone assistance be made available no later than July 1. Moreover, telephone assistance must be provided in any language that a limited-English proficient (LEP) enrollee speaks. The threshold language requirement refers to those languages for which vital materials must be translated, and does not apply to interpreter or oral language assistance services.[2] See also Issue #4 below regarding language access issues.
e. If an enrollee has not selected a plan by October 1, 2013, their information should be forwarded to certified local assisters and navigators in order for them to contact the enrollees and help facilitate the selection process;
f. And if an enrollee has not selected a plan by November 1, 2013, they may be defaulted into a managed care plan based on claims data to assess the person's health conditions, services needed, and providers. The beneficiary can at that point be enrolled into a plan that includes the majority of the beneficiary's providers with a focus on making sure the beneficiary has access to the providers most critical to her or his medical support system;
g. As we have learned from the transition of SPDs to managed care, it takes several months for health plans to integrate the information of new enrollees in order for them to access care. We therefore recommend that there be at least a 60 day overlap

[2] *See* MMCD, Boilerplate Agreement Between Dept. of Health Care Services and Contractor, Exhibit A, Attachment 9, *Access & Availability*, at §13 (June 2003).

after the transition for enrollees to continue to see their LIHP providers in the event that the managed care plan they are enrolled in is not ready to provide services, even if the LIHP provider is not a plan provider.

In addition to the recommended procedure and timelines outlined above, we also note that there are currently 28 counties that do not have Medi-Cal managed care plans and are fee for service Medi-Cal. The proposed Draft Plan assumes all counties will have Medi-Cal managed care plans by 2014 under the state's current budget proposal and merely states that for any county that has not transitioned to managed care by 2014, "DHCS will provide information in accordance with standard practices to assist these beneficiaries in accessing care."

We ask that DHCS further elaborate on what notifications and outreach will be conducted for enrollees in these rural counties should the roll out of managed care in these counties fall behind schedule. We would note that past planned geographic expansions of Medi-Cal managed care plans have frequently been delayed, making it all the more important that DHCS have a clear plan for transitioning LIHP enrollees to Medi-Cal fee for service.

2. **The proposed Draft Plan does not address how DHCS and the counties intend to gain the consent of LIHP enrollees to transfer their information to Medi-Cal and the Exchange in order to assess their eligibility.**

During the April 23, 2012 Stakeholder Advisory Committee meeting, one of the primary issues raised by DHCS regarding the LIHP transition was how best to gain the consent of LIHP enrollees to transfer their information to Medi-Cal and/or the Exchange. We do not see the Draft Plan addressing this concern. If DHCS has developed a procedure for securing enrollee consent, we ask that it be shared with stakeholders and added to the Draft Plan. Please clarify the status of this issue. We have expressed our view that LIHP is a Medcaid program and that the transition from LIHP to Medicaid/Exchange can be characterized as moving to a more comprehensive but similar coverage program. However, the Draft Plan should spell out DHCS's approach to notifying consumers about the transition and gaining any additional needed information. With so much detail on continuity of care it is disheartening that the Draft Plan does not include more detail on the transition and consumer notification/engagement.

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3. **We suggest that for LIHPs with eligibility up to 200% of the Federal Poverty Level that they provide enrollees who are at least over 133% FPL with targeted information about their potential eligibility for the Exchange rather than Medi-Cal.**

The Exchange is scheduled to begin enrollment on October 1, 2013, with the California Healthcare Enrollment, Eligibility and Retention System (Cal-HEERS) as the gateway in the Exchange for people to select a health care plan. Due to the novelty of the Exchange and the possible attendant confusion that may accompany the inaugural year of Cal-HEERS, we suggest that persons who have a higher likelihood of qualifying for the Exchange rather than Medi-Cal receive targeted outreach and education information about the Exchange as soon as possible.[3]

We therefore propose that the Draft Plan include a policy whereby LIHP enrollees who are above 133% of the Federal Poverty Level receive information regarding the Exchange so that they may have time to become familiar with the concept of shopping for private coverage and the possibility of qualifying for advance payments of the premium tax credit (APTC) or cost-sharing subsidies.

We recognize that the Exchange and DHCS have hired a marketing firm to assist with the branding of the Exchange and Medi-Cal and that there may be an "umbrella" brand for both programs. Nonetheless, given the complexity of the APTCs, the Draft Plan should spell out plans for educating LIHP enrollees about these concepts.

4. **We urge DHCS to work as expeditiously as possible to "fill in the blanks" regarding the specific notices, outreach and education to be sent to LIHP enrollees on the transition.**

We applaud DHCS for its commitment over the last two years to the nearly Herculean task of creating the LIHPs in such a short timeframe and working through the myriad policy issues that come with creating a new health program that currently covers over 423,000 previously uninsured people.

But in light of the fact that we are a little less than a year and a half away from transitioning these enrollees to Medi-Cal and the Exchange, we are generally disheartened by the lack of detail in the proposed Draft Plan on the "nuts and bolts" for how these people will transition from the LIHPs to the next program. The "Schedule of Implementation Activities" on page 7 of the Draft

[3] We particularly support a targeted and early outreach and education effort to persons above 133% of the Federal Poverty Level if California moves forward with the creation of a Basic Health Program. Under the ACA, a Basic Health Program would be available for persons between 133% and 200% of the Federal Poverty Level, and therefore may be a third source of coverage available to LIHP enrollees in 2014. The creation of a Basic Health Program would further underscore the importance of providing targeted substantive information to this LIHP population as early as possible.

Plan, for example, raises more questions than answers. What "general transition notification" will be sent to LIHP enrollees and when during the six-month timeframe of January to June will enrollees receive it? Will there be telephone assistance available at that time to begin answering consumer questions? The Draft Plan also does not account for persons who are not in LIHPs but will be eligible for health coverage under the ACA. Nine counties currently do not have a LIHP. For residents of those counties, how will they be informed of the coverage that will be available to them in 2014? The state should provide more detailed information about how LIHP enrollees, as well as residents in non-LIHP counties, will be notified of the transition and what information will be provided.

We are also concerned about the Draft Plan's lack of information regarding language access. The Draft Plan's only reference to language access is in relation to transition assistance; it is not addressed at all with respect to general communications and notices about the transition. Furthermore, the Draft Plan seems to apply the phrase "threshold languages" to both the translation of documents as well as the use of interpreters, when threshold languages should only apply to translated documents. As noted earlier in these comments, oral interpretation should be provided in all languages.

We suggest that the following language be added to the Draft Plan:

> *All written notices to LIHP enrollees regarding the transition, including eligibility for Medi-Cal or the Exchange, identification of Primary Care Provider (PCP) or Medical Home, plan assignment, and transition assistance will be provided in Medi-Cal Managed Care threshold languages as required by state law. The notices will also include a tagline in at least 16 different languages with a telephone number they can call for assistance, as well as informing individuals that oral interpretation at all points during the transition, including assistance with health plan choice, will be provided in any language at no cost to the individual as required by state and federal law.*
>
> *DHCS will provide oral interpretation assistance at all points during the transition, including assistance with health plan choice to LIHP enrollees in any language at no cost to the enrollee.*

5. **We encourage DHCS to convene a regular workgroup of stakeholders to develop these materials and to further develop the policies and procedures to effectuate the transition to be as consumer friendly as possible.**

We suggest that as part of DHCS's continuing work to develop the essential framework to move almost half a million people to a different health care delivery system by 2014, that DHCS convene a monthly stakeholder workgroup to focus on developing policies and procedures so

that the transition is as consumer friendly as possible. In that way, the transition plan can meet the promise of continuing the care LIHP enrollees have been receiving without interruption in their coverage as they move to new coverage under the ACA.

We specifically request that consumer advocates be given the opportunity to comment on draft notices to consumers. It will be critical to a successful transition that these notices are clearly and simply written as well as explaining to consumers their rights and the steps of the process.

We urge DHCS to take our comments into account as you revise the proposed Draft Plan. Principally, we urge DHCS to make consumer choice a top priority in the transition. By doing so, DHCS will signal to CMS that California continues to be a role model for other states in the implementation of the ACA.

Very truly yours,

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