California Advancing & Innovating Medi-Cal (CalAIM)

Annual Managed Care Plan Open Enrollment

1/7/2020

Agenda

- 10:00 – 10:15 Welcome, Introductions and Agenda Overview
- 10:15 – 11:00 Annual Enrollment Presentation
- 11:00 – 12:00 Discussion on Workgroup Deliverables
- 12:00 – 12:45 Lunch
- 12:45 – 1:15 Discussion on workgroup deliverables (cont.)
- 1:15 – 2:15 Each workgroup member speaks for 2-3 minutes on key aspects of the Annual Enrollment proposal they are excited and or concerned about
- 2:15 – 2:45 Open Time for Workgroup Member Questions, Comments and Future Agenda Suggestions
- 2:45 – 2:55 Public Comment
- 2:55 – 3:00 Closing

CalAIM Key Goals

To achieve such principles, CalAIM has three primary goals:

1. Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
2. Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
3. Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

Annual Enrollment Overview

- Currently, in counties with more than one Medi-Cal managed care plan, enrollees may change their Medi-Cal managed care plan every month. This activity limits the plans' ability to provide adequate and appropriate care coordination to their members.

- An annual Medi-Cal managed care plan open enrollment process would allow enrollees to change their Medi-Cal managed care plan only during a specified open enrollment period, however, exceptions will be allowed based on a consumer-friendly process that recognizes true needs for a change in plan.

Annual Enrollment Overview cont.

- Annual Enrollment:
  - Reduces variation and creates standardization for beneficiaries
  - Reduces member risk by enhancing patient care management and supports the population health management strategies
  - Improves quality outcomes by allowing the beneficiary to develop long-lasting, positive relationships with their Medi-Cal MCPs and providers
  - Increases continuity of care, higher quality of care and better health outcomes
  - Aligns Medi-Cal enrollment with other line of business processes

Exception Process

- Consumer-friendly exception process will at a minimum include the following:
  - During the first year of enrollment for a beneficiary newly enrolled in Medi-Cal managed care and whose plan was assigned through the default enrollment process
  - During the first year of enrollment for a newborn that is automatically assigned to their mother's Medi-Cal managed care plan
  - During the first year of enrollment for a beneficiary moving from one county to another, whose plan in the new county was assigned through the default enrollment process

Exception Process cont.

- An enrollee for whom their primary care provider (includes physician extenders) and/or specialists, has terminated his/her contract with the Medi-Cal managed care plan that they are enrolled in, but that provider is available in the other Medi-Cal managed care plan in the county or another provider that is preferred by the beneficiary is available in a different network than their existing plan for whom their current provider has terminated his/her participation
- Aging into PACE eligibility
- In Lieu of Services availability in another Plan in county

Exception Process cont.

The exception process will also include the following allowances for choosing a Plan outside of the Annual Open Enrollment period for “good cause” as defined in Title 42 C.F.R 438.56(d)(2) defining “cause.”

Examples include, but are not limited to:

- Transgender services not available in network;
- HIV/AIDS services not available in network;
- Lack of access to services covered under the contract; and
- Conditions whose management requires coordination of multiple specialties.

DHCS Proposed Process to Operationalize Annual Enrollment

- Annual beneficiary notification of open enrollment period:
  - DHCS will notify enrollees 90 days prior to the end of the calendar year of their option to change Medi-Cal managed care plans during the annual open enrollment period. If enrollees do not elect to change their Medi-Cal managed care plan, they would be required to remain in their existing plan for one calendar year until the next annual Medi-Cal managed plan open enrollment period.

- Beneficiary request to change plan outside of open enrollment period:
  - If a beneficiary requests a plan change based on one of the proposed exceptions, the customer service representatives will allow change, effective the following month.

Annual Enrollment Key Points

- Project Implementation Date: *January 1, 2022 (enrollment effective date)*
  - First annual Medi-Cal health plan open enrollment period from November 1, 2021 to December 15, 2021 for enrollment effective January 1, 2022.
  - Each year thereafter, the annual health plan open enrollment period would occur from November 1 through December 15.
  - Medi-Cal managed care plan enrollment would be effective on January 1 of each year.
- Separate from Medi-Cal Eligibility. Medi-Cal Eligibility determinations continue to be year round
- Enrollees can keep existing MCP if no selection is made during the Open Annual Enrollment period
- Medical Exemption Request (MER) Process remains the same
- Consumer-friendly Exception Process will be available

Plan Change Data

- Yearly % of people who switch to Fee for Service

Year	2012	2013	2014	2015	2016	2017	2018	2019	Average
Transfer %	Not Available	0.09	0.08	0.08	0.07	0.07	0.06	0.07	0.07

- Yearly % of people who change Plans

Year	2012	2013	2014	2015	2016	2017	2018	2019	Average
Transfer %	17.27%	18.36%	16.39%	19.17%	16.74%	18.10%	17.88%	18.76%	17.68%

Plan Change Request Reasons

Top 3 reasons Medi-Cal Beneficiaries switch plans each month:

	July 2019 (%)	August 2019 (%)	September 2019 (%)	Quarter Average(%)
Health Plan did not cover Beneficiary needs	16.71	15.64	15.20	**15.85**
No reason checked	13.83	12.90	12.63	**13.12**
Could not choose doctor I wanted	9.71	7.98	7.82	**8.50**

Annual Open Enrollment Federal Requirements

- Under Federal Law as defined in Title 42 C.F.R 438.56(d)(2), beneficiaries must be permitted to change plans during the allowed change period for the following reasons:
  - The enrollee moves out of the [plan's] service area
  - The [plan] does not, because of moral or religious objections, cover the service the enrollee seeks
  - The enrollee needs related services to be performed at the same time; not all related services are available within the provider network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;
  - For enrollees that use [managed long-term services and supports], the enrollee would have to change their residential, institutional, or employment supports provider based on that providers' change in status from an in-network to an out-of-network provider with the [plan] and, as a result, would experience a disruption in their residence or employment; and
  - Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's care needs.

Annual Enrollment in Other States

Key Findings on Annual Enrollment in Other States

- In five of the six states that use an annual open enrollment period, beneficiaries have 90 days following enrollment during which they may change plans for any reason (the “without cause change period”).
  - 90 days is the minimum without cause change period permitted under federal law.
  - Florida offers beneficiaries 120 days to change plans without cause following initial plan enrollment.

- The surveyed states vary in how permissive their rules are with respect to plan switching during the period between the without cause change period and annual open enrollment period. Many of the rules governing plan switching during the time outside of the open enrollment period are vague and broadly written, giving states substantial discretion to determine whether or not good cause exists for a plan change.

Annual Enrollment in Other States cont.

State	Without Cause Change Period	Rules on Plan Changes During the Change Period
Florida	120 days	• Tracks federal requirements • For certain exceptions, enrollees must seek resolution through the plan grievance process before seeking disenrollment from the plan • For other reasons enrollee may bypass the grievance process

New York	90 days	• More permissive than required under federal law
		• Permits plan changes:
		  • For failure of the plan to arrange for covered services;
		  • Where member, plan, and social service district agree plan change is in the best interest of the member
		  • When children enter or are discharged from foster care; foster placement
		• No requirement to seek resolution through the plan grievance procedure
		• Individuals in long-term placement in nursing homes may change plans at any time.

Annual Enrollment in Other States cont.

State	Without Cause Change Period	Rules on Plan Changes During the Change Period
Arizona	90 days	• State regulations appear less permissive than federal law requires
Ohio	90 days	• More permissive than federal requirements in some respects • Allows plan change if agency determines that continued enrollment in plan would be harmful to enrollee • Before seeking a determination of just cause to switch plans a beneficiary must "identify providers of services" • Agency must make a decision on a plan change request within 45 days; if agency fails to decide, request is considered approved • The change period does not apply if the member is a child receiving Title IV-E federal foster care maintenance or is in foster care or other out of home placement.

Annual Enrollment in Other States cont.

State	Without Cause Change Period	Rules on Plan Changes During the Change Period
Virginia	90 days	• Slightly more permissive than federal requirements • Authorizes agency to find good cause to switch plans if it determines, in its sole discretion, that member with complex needs would be better served by another plan • If agency does not respond to disenrollment request within a month, request is automatically granted • If agency requests information from plan to assess disenrollment request, plan must respond within two working days
Illinois	90 days	• Regulations only provide that beneficiaries are entitled to disenroll at any time for cause. • Enrollees in the Medicare-Medicaid Alignment Initiative (i.e., serving dual-eligible beneficiaries) can change plans at any time

Workgroup Deliverables

1. Provide Pros and Cons of an Annual Health Plan Enrollment process for Medi-Cal beneficiaries.
2. Define the consumer-friendly exceptions and provide ways on how they will be operationalized.
3. Determine what member health plan open enrollment materials are needed as well as timing and content of the materials.

Deliverable 1: Pros & Cons

Workgroup Feedback

Pros

- Increased continuity of care to assess risk & manage the member and improve their health outcomes
- Reduce plan and potentially state administrative cost and burden
- Greater motivation for members and plans to work through issues
- Parity with private insurance and Medicare
- Opportunity for beneficiaries to be informed and make educated choices on their health care options due to the open enrollment process
- Increased opportunities for member engagement
- Ability to track health outcomes/reduce costs and fragmentation around the clinical care delivery system

Deliverable 1: Pros & Cons cont.

Workgroup Feedback

Pros (cont.)

- Aligns the enrollment with other healthcare lines of business, easing the experience for consumers and providers
- Increase timely recertification, reducing the number of pending status members and gaps in coverage
- Improved HEDIS results, increased completion rates of HRAs and engagement/participation in care management programs
- Transactional elements such as authorizations and referrals could be easier for the provider to manage
- Investments in technology also require time to engage members and encourage utilization
- Better coordination of care because members won't be able to change plans frequently
- Helps providers with billing because they can rely on members staying with a plan for a year (unless exceptions apply). Less confusion for providers when checking eligibility in the portal

Deliverable 1: Pros & Cons cont.

Workgroup Feedback

Cons

- Beneficiary abrasion/dissatisfaction (perception of choice being taken away) leading to increased call volume and grievances
- Administrative burden and complexity of managing the proposed exception process, particularly if not clearly defined
- Placing access and resource challenges (e.g. travel times, travel expenses, unpaid time from work, etc.) on beneficiaries
- Creates variation, policy inconsistencies and inability to manage members

Deliverable 1: Pros & Cons cont.

Workgroup Feedback

Cons

- Could discourage MCPs from entering expansion areas, limiting the ability for MCPs to grow sufficient membership to adequately operate and meet state requirements, including contracting with new providers and meeting HEDIS Minimum Performance Levels (MPLs).

- Reduced interactions with members for enrollment could make it more difficult for counties to maintain accurate member demographic information and result in increased issues with accuracy of demographic information on state files

Deliverable 2:
Define Exceptions *and* Ways to Operationalize
Workgroup Feedback

Exceptions:

- Grace period – during the first three months of enrollment for beneficiaries who are defaulted into a health plan
- B1 babies who are auto assigned to their mother's plan
- Beneficiaries whose PCP is no longer with the plan but is contracted with another Medi-Cal managed care plan in the county
- Members whose specialist under which they are receiving active care as defined by an open authorization, is no longer with the plan, but is contracted with another Medi-Cal managed care plan in the county
- Allow any child beneficiary to change plans if they were auto-assigned into a plan

Deliverable 2: Define Exceptions *and* Ways to Operationalize Workgroup Feedback (cont.)

Exceptions:

- Individuals who experience the following major life events:
  - Homelessness, Institutionalization, Marriage, Pregnancy
- Individuals who change aid codes (e.g., TANF to SPD) and may require access to a different network of providers
- Hepatitis C and STD services
- Beneficiaries have the option to switch plans outside of the annual enrollment period, in order to access ECM or In Lieu of services that are not covered by their current health plan

Deliverable 2: Define Exceptions and Ways to Operationalize Workgroup Feedback

Ways to Operationalize the exceptions:

- Create multiple entry/intake points for exception requests by beneficiaries to be considered (e.g., local county social services agencies, health plans, HCO, DHCS)
- Create a process where all inquiries, which have been initially vetted at intake, are then routed to a single source (DHCS or HCO) for validation and processing.
- Phone in option for member or the provider if the member gives approval, to call in to change plans after default assignment
- Online option via a portal for a member to request a change in their plan if they were assigned a default plan and didn't want it.
  - However, if the member accesses routine care (not urgent or emergent care) prior to requesting disenrollment from their assigned plan, the reassignment cannot occur as they have now accessed care through the current assignment

Deliverable 3:
Health Enrollment Materials:
Workgroup Feedback

- Notices sent to beneficiaries by DHCS informing them of the open enrollment process at least 60 days in advance
- Updated language in the EOC/member handbook and/or an errata
- One page informational handout about their plan (similar to the health plan comparison chart on the HCO website)
- FAQ document clearly explaining the process for beneficiaries and other relevant stakeholders
- Plan and DHCS communication (via email, mail, website & member portal)

Deliverable 3:
Health Enrollment Materials:
Workgroup Feedback

- Materials will need to be available and updated for any enrollments due to change in eligibility, moving/change of residence, childbirth, or loss of employer-based coverage
- Timing and production of materials will mirror other open enrollment materials many of the Plan's employer-based insurance or Medicare plans
- County Mailings
- Common choice packet with equal representation of plans via enrollment website
- Plan advertisement during open enrollment to general public and our members (via digital campaigns and through transit)

Workgroup Discussion

Each member has 2-3 minutes to share there thoughts on the
Annual Open Enrollment Proposal

Open Time for Workgroup Member Questions, Comments and Future Agenda Suggestions

Annual Enrollment: Next Steps

Submit feedback and questions to:

CalAIM@dhcs.ca.gov.

Next Workgroup Session for *Population Health Management Strategy and Annual Plan Enrollment* is scheduled on February 11, 2020.

Questions?