CALIFORNIA HEALTH ADVOCATES
Medicare: Policy, Advocacy and Education

Corporation for Supportive Housing

MATERNAL AND CHILD HEALTH ACCESS

May 22, 2011

To: The Honorable Holly Mitchell, Chair
Assembly Budget Subcommittee No. 1

The Honorable Mark DeSaulnier,
Senate Budget Subcommittee No. 3

Re: May Revision Proposed One-Year Lock-in for Medi-Cal Managed Care Enrollees - OPPOSE

Our organizations oppose the May Revision proposal to "lock-in" Medi-Cal beneficiaries to their Medi-Cal managed care plan for one year and only allow them to change plans during an annual open enrollment period.

Under the Governor's proposal, Medi-Cal beneficiaries who must enroll into a Medi-Cal managed care plan would be given an initial 60 day period to change plans. After that period, they would have to stay in their plan for the remainder of the year. They would only be able to change plans once per year during an annual open enrollment process.

Medi-Cal beneficiaries have long had the ability to change from one Medi-Cal managed care plan to another. This is a critical option for consumers if they are not getting their needs met by one plan or if their doctor no longer contracts with the plan they are in. Some plans offer additional benefits beyond what Medi-Cal covers, e.g. podiatry services, some adult dental services and vision services and a person who has a new and serious dental or vision condition within one year may want to switch to one of the plans which covers these services. In many areas, there is a shortage of specialists and a particular specialist may only accept certain plans within the county – again creating a need to change plans if a consumer needs to see a particular specialist. Furthermore, sometimes people with mental health disabilities are dismissed from certain medical groups or providers which may require them to change plans. In these situations and others, Medi-Cal beneficiaries need the option to change plans. Though the proposal to create an open enrollment period has been characterized as aligning Medi-Cal with private coverage, Medi-Cal beneficiaries are a vulnerable population, many of whom have unpredictable and changing needs which may require them to change plans more than once per year. Because of this, a "lock-in" does not serve them well nor improve their health but more likely complicates their conditions which may lead then to need more services down the road.

In addition to being insufficient to meet consumers' needs, the initial 60-day period to change plans does not comply with the federal regulations on disenrollment. The federal regulations require that beneficiaries be given 90 days from date of initial enrollment or the date the state sends notice of enrollment, whichever is later. 42 C.F.R. §438.56(c)(2). The proposed TBL only provides 60 days to disenroll. It is also unclear whether the "open enrollment period" is 60 days each year, and if so, from what date or event. Will this period be different for everyone, depending on their eligibility and enrollment date?

Sometimes new Medi-Cal beneficiaries are defaulted into plans and do not know it until after 60 days. If, in a beneficiary's third month of enrollment, she attempts to see her doctor and finds out at that point that she has been enrolled into Plan A but that her doctor only contracts with Plan B, she will not be able to change plans for ten months. While a beneficiary could file for a Medical Exemption Request, given there is a 90-day time limit to exercise that option once enrolled in a plan and given it is an onerous process, the MER is not a viable option for many beneficiaries. Beneficiaries should not have to go through the MER if they could keep their doctor by changing plans. And the state should not rely on the more costly and administratively burdensome MER process.

We are particularly disturbed that the Administration makes this proposal to block beneficiaries from changing plans right as California begins to mandatorily enroll 380,000 Seniors and Persons with Disabilities (SPDs) into Medi-Cal managed care plans. Repeatedly, during the waiver stakeholder process, one of the points made by the Department in response to our concerns about the mandatory enrollment was that people could change plans any time they wanted. With enrollment beginning on June 1, it is a "bait and switch" to now block beneficiaries from changing plans. The SPD population is extremely vulnerable by definition and often faces complex health conditions requiring more than one type of specialty care. Understanding, engaging and navigating new managed care plans will be a challenge for this population. Locking these seniors and people with disabilities into an inappropriate plan will cause negative health outcomes and increase health care costs.

There are other problems with this proposal with respect to the SPD population. These plans have little track record to date to demonstrate their ability to effectively serve this population. There has been no completed audit or review by the state using the Facility Site Review tool. The continuity of care requirements placed on plans will expire after twelve months, creating even more confusion for beneficiaries about which plan will meet their needs and what plans their providers will be enrolled it. Finally, beneficiaries have already been told by HCO that they can change plans at any time and this would serve to create more chaos and confusion.

The federal government rightly recognized the needs of low-income SPDs by establishing the right of Low-Income Subsidy (LIS) Medicare Part D beneficiaries to switch plans every month because of the reduced options that come with being a low-income SPD. As with Medi-Cal beneficiaries, dual-eligibles receiving a LIS are autoassigned to Part D plans and there was a recognition of their need to change plans.

We would like additional information on what the assumed savings is based on and what research the Administration bases this proposal on. If the Administration wants to introduce locking people into one managed care plan, then they should bear the onus of collecting data over at least three years (e.g., how often are people switching plans, consumer satisfaction, complaint data, use of MERs and ongoing use of care continuity, etc.) that establishes the case for this population not being adversely affected by a lock-in period.

We urge you to reject this proposal and continue to allow Medi-Cal beneficiaries to change plans.

cc: The Honorable Bob Blumenfield, Chair, Assembly Budget Committee
The Honorable Mark Leno, Chair, Senate Budget Committee
Members, Assembly Budget Subcommittee on Health and Human Services
Members, Senate Budget Subcommittee on Health and Human Services
Agnes Lee, Office of Speaker of the Assembly John Pérez
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