Transitioning from share of cost Medi-Cal/CHPS (Kaiser) to full scope Medi-Cal (Kaiser). How difficult can it be?

In the fall of 2016, a letter from Kaiser made the situation pretty clear:

“After December 31, 2016, if you or a family member qualifies for Medi-Cal, they’ll no longer qualify for the Child Health Program (CHP)… Therefore, it’s important to apply for Medi-Cal immediately if you think you and/or your family member may qualify.”

Below is a “case study” of the attempt to transition twin siblings from Kaiser CHP (and share of cost Med-Cal) to full scope Medi-Cal (with Kaiser). Hopefully, the problems described can serve as a reminder that much work needs to be done to improve better assessment and improve Medi-Cal enrollment processes.

What exactly was the enrollment challenge?

Of question was, how to arrange a seamless transition so that the children did not have a gap in their Kaiser coverage. They both have ongoing health issues and loss of Kaiser for a month or two would be disruptive to their care.

While the twins were covered under share-of-cost Medi-Cal, they were also covered by Kaiser Child Health Program.

A change in family income meant that they would lose Kaiser CHP coverage as of December 31, 2016.

For most, Medi-Cal enrollment is a tedious and uninteresting topic. However, an attempt must be made to draw focus on what feels like a disfunctional enrollment system. Hopefully by highlighting some issues, positive changes can be made.

Who does a parent call to find out how to transition from one Medi-Cal program to another?

That was unclear.

At the beginning of October, 2016, an initial phone call to Kaiser member services suggested that no steps could be taken until coverage ended. Reportedly, Medi-Cal would not do take any steps to sign up twins for a health plan until the letter describing termination of coverage was in hand, and Kaiser would not send out a HIPPA required letter until 12/31/16. This answer suggested an unavoidable loss of Kaiser coverage for at least a couple of months.

(BTW: much of this information was inaccurate; HIPPA letter was not required to remove additional insurance info and the process could be started well before the end of coverage).

Next attempt at contact was with county social services over a series of days. Calling county requires extra patience. The first two calls resulted in being on hold for over an hour and having

to give up because of time constraints. Other calls were cut off fairly quickly, with no opportunity to leave message or wait on hold, because of "high call volume."

County office hours are M-F 8:30am-5pm - difficult hours for a working person to be making phone calls and waiting on hold.

The instruction manual.

A call to Kaiser CHPs member assistance at 1-800-620-4685 resulted in some of the best information. Once the twins had switched to full scope Medi-Cal the following steps were specified:

1) Assign health care plan to Alameda Alliance for Health.

2) Select plan partner KA. Call 1-800-430-4263 Health Care Options to ask them to send a Medi-Cal choice form.

3) Mail choice form back to Health Care Options and wait 2 weeks.

4) Call Alameda Alliance 877-932-2738 two weeks after mailing form to confirm that active in the system and to request Kaiser as provider. Apparently no change will be made without the phone call (even though a form has been submitted).

5) Get permission from Kaiser to enroll by calling Cal Medi-Cal State Sponsored program department (CMSSP) at 1-844-250-6906, as well as to find out the day Kaiser will be effective.

6) At each step call Kaiser Medi-Cal 1800-436-3717 because the above steps may have changed.

It seemed vaguely straightforward, and possibly doable, but strange how many phone calls were required.

Kaiser indicated that the above steps were not written down for parents because the steps changed too frequently to be set down in written instructions. Indeed, more recent contact with other agencies have suggested that there are a couple more additional steps required to truly complete the transition process.

Step required before starting the first step. Notify county of pending loss of CHP Kaiser coverage so that county could switch children to full scope Medi-Cal.

Through most of October and into November, the primary challenge became the basic step of getting the twins back on full scope Medi-Cal. Of surprise was that when finally able to get through to the county, their coverage was reportedly due to end because re-enrollment information was overdue.

Of note:

No request for re-enrollment information had been sent out by county, even though it was apparently months overdue.

No notice of action regarding overdue re-enrollment application or pending loss of coverage was sent out by county. The phone call, initiated because of question about the transition, was what led to awareness of missing re-enrollment application.

Fortunately, the county was able to take the application information over the phone; though failed to mention that additional paperwork was also needed.

From October through mid-November, 2016 multiple phone calls and visits to county substation were required to re-enroll the twins and to document pending loss of Kaiser coverage.

Of question, is how does county and in turn DHCS assess the reliability of the county systems that send out re-enrollment packages to families. How would county or state know if there was a pattern of re-enrollment packages not being sent out? How would that issue be addressed? In the recent past, county sent out re-enrollment packages with autofill information blank, so there was no information on things like where to submit completed package and deadline date for return. What is the system for seeking out and correcting these sorts of problems (some system-wide) when the families may be the only ones aware of the issue?

How can one twin be deemed eligible for full scope Medi-Cal and the other twin not?

In November, 2016, Twin B (the one with an identified disability) was found eligible for fee for service Medi-Cal with an almost $2000 share of cost, while Twin A was deemed eligible for full scope Medi-Cal, no share of cost.

Needless to say, a few phone calls were required for this issue. The county caseworker determined that because of the family income and disability Twin B was being screened for different coverage. She indicated there was nothing she could do. A request for supervisor review was made by parent.

In a later phone call, the caseworker indicated that she had checked with her supervisor who did not know what to do, but that another caseworker took the disability code out of the computer and that within two days, both twins should be showing up as “no share of cost.”

Of note is that a few years ago, twin B’s Medi-Cal coverage was wrongfully discontinued while twin A remained eligible. Coverage was eventually reinstated after the local state legislator’s office and others pushed hard for remedy.

What is going on that creates this type of enrollment error? Clearly it is a system problem, in which one fix for one person does not translate to later re-enrollment, let alone others in parallel situations.

The Notice of Actions (NOAs) from County Social Services do not help clarify the situation.

Here are summaries of the NOAs received during a one month period during fall 2016. Each one is a separate, very formal document.

All qualifying information is the same for the two children in the household, except twin B has been identified at some point in the Medi-Cal system as a disabled child. Note that some of the NOAs refer to coverage in 2013 and others refer to denied applications to various Medi-Cal programs. No explanation was offered of why information on previous years or about the various programs was forwarded in the NOAs.

County NOA 10/06/2016
"This notice applies to: Twin A
You have been:
Approved for the Medically Needy Program for a family with a child whose…. You are entitled to full benefits **beginning 07/01/2013**….. Your share of cost is $……."

County NOA 10/06/2016
"This notice applies to: Twin B
Twin B is/are eligible for initial **TMC for the period 07/01/2013 through 12/31/2013**.
You are entitled to **full benefits**."

County NOA 10/06/2016
"This notice applies to: Twin B
Beginning 09/01/2016, you are eligible to receive Medi-Cal benefits **without a share-of-cost** under the Aged and Disabled Federal Poverty Level Program."

County NOA 10/06/2016
"**Beginning 09/01/2016**, your child(ren) listed on this notice:
Twin B, Twin A
has full scope Medi-Cal benefits……
TLICP Approval"

County NOA 10/07/2016
"Twin B, Twin A
Your eligibility to receive Medi-Cal **will be discontinued on the last day of 10/2016**. The reason for this discontinuance is:
You did not complete the redetermination process…… [they need income information]. …. If we do not get the information by 1/29/2017 you must reapply for Medi-Cal."

(10/13/2017 Parent Tax Returns submitted directly to County, in follow up to information given during phone call earlier in month to county.)

County NOA 11/03/2016
"This notice applies to: Twin B
We have reviewed all information available to us about your circumstances, and we find your application for Medi-Cal, **dated 12/01/2016**, has been **denied**. The reason for this denial is:

Your family's income is over the allowable limit….
TLCICP Denial"

County NOA 11/03/2016
"This notice applies to: Twin B
Your application **dated 07/01/2013** for the Aged and Disabled Federal Poverty Level Program has been **denied**.
Here's why:
Your countable income exceeds the Aged and Disabled Federal Poverty Level Program income limits."

County NOA 11/03/2016
"This notice applies to: Twin B
The 100 Percent Program provides Medi-Cal benefits at no share-of-cost for children….. A review of your case shows that:
You do not qualify for this program because your family's income is over the allowable limit.
You will receive a separate notice about regular Medi-Cal."

The county Notice of Actions were confusing, so how about trying the phone system?

Below is a log of active/inactive Medi-Cal status based on phone contact with county workers or automated system. The county automated system gave inaccurate and inconsistent information about Medi-Cal eligibility status, which is nerve racking to say the least.

October 4, 2016
Phone call to county worker:
Active. Twin A and B
But due to lose coverage because re-enrollment info missing.

October 12, 2016
County automated system:
NOT Active. Twin A and B
"…not found in our system."

County worker:
Active. Twin A and B
Until end of month - due to be cut off in January, 2017 because paperwork due.

October 26, 2016
County automated system:
NOT Active. Twin A and B
"…not found in our system."

November 2, 2016
County worker:
Unknown status. Twin A and B.
She does not know the status, the "system" has not given an answer yet about their status.

November 7, 2016
County automated 24 hour line:
Unknown status Twin B.

November 9, 2016
County automated system:
Active. Twin A and B
But twins have completely different level of coverage.
Twin A - "Your Medi-Cal is active. You have no share of cost. Your other health coverage is June."
Twin B- "Your Medi-Cal is active. The Medi-Cal share of cost is $1955 for the month of November. Your other health coverage is June."

November 15, 2016
County automated system:
NOT Active. Twin A and B
"I'm sorry. A case was not found in our system."

November 16, 2016
Active. Twin A and B
Voice mail from caseworker saying she was sorry she had not called earlier and that both were active.

November 18, 2016
County automated system:
NOT active. Twin A and B
"I'm sorry. A case was not found in our system."

November 28, 2016
System not accessible.

December 21, 2016
County automated system:
NOT active. Twin A and B
"I'm sorry. A case was not found under (SS#) in our system"

Second call to automated system, later in morning:
Active Twin A and B
"Your Medi-Cal is active. Your share of cost is "**June**."

Now that twins apparently had access to full scope Medi-Cal, time to start working the steps to get them covered by Medi-Cal Kaiser.

In late November, phone calls with some branch of DHCS 1800-436-3717 confirmed general steps required to keep Kaiser active:

1) Mail back Cal Options Form
2) Wait one week

3) Call Alameda Alliance to make sure active in their system 877-932-2738
4) Call CMSSP 844-250-6906
5) Wait to get a welcome letter from Kaiser

Finally! Some progress. First step of transition has been completed.

A November 29, 2106 a phone call to Health Care Options was reassuring, "Both have regular Medi-Cal for now." During the course of the call they put in the request for twins to be signed up with Alameda Alliance and transferred to Kaiser.

Up until this point, all had said that the Health Care Options form had to be completed and mailed in. No one shared (perhaps they don't know) that the change form could be completed by phone, a same day process.

Unfortunately, Health Care Options pointed out a new stumbling block.

During the phone call in late November, the Health Care Options person emphasized that county needed to be contacted by parent right away because the Kaiser coverage was still showing up as active. The county worker had not documented the pending loss of coverage. Apparently the county needed to update the case on the state system, to show that Kaiser was ending 12/31/16.

A phone call to Medi-Cal, 800-541-5555, probably a state level number, but really it is hard to keep track of what numbers go with which organizations. The person on the other end of this call said that Kaiser could not be removed until later in the month of December.

Waiting for county case worker to document the pending loss of Kaiser….

Throughout December phone calls led to a dead end because the twins were still showing up as ineligible for Managed Care Plan because the state system had not been updated by county caseworker. Repeatedly was told that **only** the county case worker could remove insurance information from the state system. Multiple attempts were made to have county worker update the state system.

Good news. Medi-Cal Ombudsman office was helpful, but are they the only ones that knew about a crucial form/website?

At the end of December, a phone call to ombudsman office resulted in another burst of progress. Apparently on the DHCS website there is a Other Health Coverage (OHC) form which can be completed, not just by county caseworkers, but by **parents**. Within 24 hours of submission of the form online, the ombudsman office enrolled the twins in Alameda Alliance - a big step completed.

When told that other agencies had said that county worker had to complete the form to remove other health coverage, and that none apparently knew that parents can complete the form, the ombudsman noted that the county may not know, “It is a big system.”

The form is simple and clearly notes that a parent can complete it. Up until this point, all had said that the county caseworker must complete this step (which turned out to be the OHC form). County never did document the pending loss of health coverage, despite repeated requests. Given that the OHC step was required before anything else could happen, the transition process was stalled unnecessarily for over a month.

Next hurdle, Cal Choice Options. But Ombudsman helps out again.

The phone call on December 28, 2016 to Cal Choice Options was discouraging. They said there would be a 7 to 10 day wait before Alameda Alliance would get the request to switch to Kaiser, meaning a guaranteed break in Kaiser coverage.

Fortunately yet another call to the Ombudsman office reveals that switch can be done in the same day.

By the afternoon of December 29, 2016 Cal Choice Options reported that twins were listed in the system as having Alameda Alliance with Kaiser.

New instructions from Cal Choice Options included:

A letter should arrive in 7-10 days re: enrollment to Alameda Alliance. After getting the letter, call Alameda Alliance to make sure they have been assigned to Kaiser. No need to double check with Kaiser.

Ombudsman steps in again.

The ombudsmans office is like a secret power. They can change information in the system during a phone call, rather than the “fill out a form and wait weeks for information to be processed” timeline that had been described repeatedly by other agencies.

Phone call to ombudsman December 29, 2016 was helpful again. They said to call Alameda Alliance on 1/2/17 to confirm transfer to Kaiser, that there was no need to wait for a letter. She did something while on the phone to get them processed. Both twins would be active with Alameda Alliance on 1/1/17.

Kaiser generously extended the coverage of children in CHP program in order to give families enough time to get children signed up for Medi-Cal.

Descriptions of lots of phone calls have been skipped. Hopefully, the tedium and frustration of this overall experience has been communicated.

Multiple phone calls the first week of January in attempt to complete the preordained last steps almost resulted in transition to Kaiser (though one which would have involved a loss of Kaiser coverage during January).

However, it was discovered during one of the many calls that the twins were still active in Kaiser. Another phone call revealed that Kaiser decided a "couple of weeks ago" to extend CHP coverage for two months past the communicated termination date so that families would have time to get their children coverage from Medi-Cal if eligible.

Kaiser indicated that the extension of coverage and change in date of loss of coverage to 2/28/17 would not matter to the other agencies. One hopes not since all of the above was based on the premise of a 12/31/16 termination date…

As an aside, how many agencies and phone numbers have to be called in order to arrange the transition?

A lot. No one will provide a written guideline of the agencies that must be contacted to ensure a transition happens. These are all numbers that appear to be crucial; all seem to have a role in the process of transitioning the coverage.

Alameda County Social Services 1-510-263-2420
Alameda Alliance 877-932-2738
Cal Health Care Options 1-800-430-4263
Medi-Cal Ombudsman 1-888-452-8609
Kaiser Permanente Medicaid Assistance Center 1-800-620-4685
Medi-Cal Assistance with Kaiser 1-800-423-2571
Kaiser Medi-Cal 1800-436-3717
Kaiser CHPS program 1-800-255-5053
Medi-Cal 1-800-541-5555
Alameda Alliance 1-877-932-2738
Kaiser Member Services 1-800-464-4000
California Medi-Cal State Sponsored Program (CMSSP) 1-844-250-6906

With the current situation, how many phone calls were made regarding transition of kids from Medi-Cal fee for service/Kaiser CHPS to Medi-Cal full scope/Kaiser?

About 25 contacts have been made with workers by phone or in person regarding the enrollment process. In general, the calls are not simple or short.

Multiple other calls have been made in which it was not possible to reach a person. Hours have been spent on hold.

Given how complicated it is, why is the parent in charge of negotiating the all the steps of transition?

No one agency seemed to know the full picture. Multiple steps and phone calls to multiple agencies are required to transition coverage. Agencies give conflicting, incomplete information, suggesting that there is a fair amount of confusion within the agencies about how to make the various steps and overall process happen.

Each step has been complicated and depends on the other agencies.

Hours of health plan, county, and state agency time were been spent on this one family's, still to be completed, transition. Wouldn't it be cheaper for DHCS to transition the case through the system beginning to end, rather than having multiple people and agencies attempt to coach the parent in walking through the unclear steps?

Some questions.

How can DHCS improve the re-enrollment and transition of coverage processes?
How does DHCS assess the "customer experience"?
How can DHCS integrate feedback from subscribers to better their enrollment systems?
How can the various branches of county, state, managed care be better informed?
How does DHCS learn of subscriber problems at county level?

Little, if any, data regarding typical enrollment experience for children's Medi-Cal is available from DHCS.

But there must be shared experiences of frustration, confusion and worry for parents trying negotiate the Medi-Cal enrollment. And more importantly, other experiences of children in active treatment who have an unnecessary break in medical services or temporarily lose access to regular providers, not for any reason other than faulty, unwieldy, and inefficient Medi-Cal enrollment processes.

Hopefully, DHCS will develop a means to better gather and integrate feedback from parents to improve the subscriber experience. If there is little to no awareness of the problems, how can systems improve?