Date: February 3, 2015

To: DHCS and Covered California

From: Consumer Advocates

Re: Concerns regarding transition of consumers between Covered California and Medi-Cal at renewal or due to a change in circumstances

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The following is a list of consumer concerns that have been raised by the following advocacy organizations: The Health Consumer Alliance (HCA), Consumers Union, California Pan Ethnic Health Network (CPEHN), and Project Inform. The concerns are grouped in the order of the transition process the problem would arise in, not necessarily in priority:

A. When Covered California enrollee is terminated from their QHP:

- Could we see the final revised version of the Covered CA letter terminating coverage and informing consumer they are eligible for Medi-Cal?
- We understand this notice was sent late to enrollees who lost coverage at the end of January and were moved to Medi-Cal as of Feb. 1 due a change in circumstances. Will the notice be sent on time for those losing coverage at the end of February and moving forward? What will the target date be?
- Are there different notices for when the updated information was provided by the consumer and when eligibility changes due to the routine data check from electronic sources?
- Are the notices from Covered CA translated into the legally required threshold languages?
- If a consumer's eligibility changes as a result of a routine data check from electronic sources, when is that consumer informed of the eligibility change?
    - Is there an opportunity to provide additional information before the eligibility is changed?
    - Who does the consumer contact if the electronic data is incorrect?
- What notice is sent by the Qualified Health Plan (QHP) to the consumer when terminated due to change in eligibility?
- When does the notice from the QHP get sent to the consumer? Per federal and state regulations, QHP's are required to provide at least 5 days notice before termination.
- Are the notices from the QHP translated and available in the legally required threshold languages?
- How often does CalHEERS re-verify an enrollee's data from electronic databases during the year?
- What federal and state databases does CalHEERS "ping" against as part of this automatic verification? How often do those databases get updated with new information?
- When did the consumer provide consent for these periodic verifications and was it clear which databases he was consenting to be checked?

- Can the consumer provide updated information to Covered California by phone or by uploading recent documents to contest the termination without filing an appeal?
    - If so, how quickly can the system be updated and the consumer reinstated to his/her QHP?
    - Who should the consumer contact?
- Is prior consent required from the consumer in order for Covered California to be able to automatically terminate QHP coverage when an enrollee's eligibility for APTC changes and he/she needs to be transitioned to Medi-Cal?
    - If so, when should the consumer provide this consent?
    - If the consumer fails to provide consent for automatic termination due to an eligibility change, can he/she remain enrolled in the QHP without APTC?
    - What notice will be sent to a consumer who does not give prior consent to automatically terminate QHP coverage when eligibility changes?
- Incorrect eligibility determinations by CalHEERS

  Below are some examples of incorrect notices and eligibility determinations generated by CalHEERS during this transition.

  <u>Examples of incorrect eligibility changes from CalHEERS:</u>
  - Consumer received multiple copies of the same notice even though there was no change in eligibility.
  - Similar to the "last date paid" system error, consumer had his/her monthly income being calculated as their annual income, thus causing the decrease in income eligibility.
  - Covered California enrollee, who was found lawfully present under Covered California's eligibility rules, was given restricted Medi-Cal. This does not make sense as Medi-Cal has a broader definition of lawfully present than Covered California.
  - Existing Covered California enrollee reports an increase in income but the eligibility determination for Medi-Cal is based on incorrect or prior income.
  - Existing Covered California enrollee reports an increase in income (below 400% FPL), remains eligible for Covered California, but is billed the full cost of the premium, seemingly losing all eligibility for APTC.

  Q: How should advocates flag these system problems going forward and are there fixes in place for any of these problems?

B. When the Covered California enrollee becomes eligible for Medi-Cal

- What notice does the newly eligible Medi-Cal enrollee receive from DHCS and when is it sent? Is it generated from CalHEERS or SAWS?
- Stakeholders were not able to review ACWDL 15-01 regarding the transition prior to its release.
    - Is DHCS planning to release additional guidance regarding the transition? If so, could stakeholders be given the opportunity to review before finalizing?
    - We also have some questions about ACWDL 15-01 we'd like to raise.
- Will the statewide notice that was included in ACWDL 15-01 be the same notice that will be sent to former Covered California enrollees who are newly eligible during the year due to change of circumstances?
- Are these notices translated into the legally required threshold languages?
- How will the counties be able to prioritize making final eligibility determinations for individuals moving from Covered California to Medi-Cal due to a change in income?
- Will these eligibility determinations be put in the same "processing line" as new applicants?
- For those who are determined as "conditionally eligible" per ACWDL 15-01, how would someone's SSN or immigration/citizenship status be different than when they first applied and got verified by CalHEERS for Covered California enrollment? Please give us an example of why this would occur. Any enrollee that reported a change in immigration status or SSN should not have had their eligibility changed from Covered California to Medi-Cal solely based on a change in either of these criteria.
- For those who are determined as "pending eligible" per ACWDL 15-01, if CalHEERS electronically checked the databases and found the consumer eligible for Medi-Cal, what additional income information is the county seeking?
- For those who are determined as "pending eligible" based on incarceration or deceased status, how does the consumer refute this finding?
    - If this change in status was not reported by the consumer, what sources of ex-parte, electronic information is CalHEERS using to determine that someone is recently deceased or incarcerated?
    - If the consumer was already found eligible for Covered California having met these two specific criteria, why would the information be different at renewal?
- Why would state residency need to be re-verified if the consumer did not report a change and residency was checked at application?
- Does the transition from Covered California to Medi-Cal affect a consumer's eligibility for ADAP?

C. When the enrollee appeals the termination of Covered California coverage

- How does the enrollee request an appeal of the re-determination of eligibility? Can this be done over the phone?
- Do Covered California call center service representatives (CSRs) currently advise consumers of their appeal rights when they call regarding their coverage termination? If not, could this be added to their script? Could advocates provide feedback to the current CSR script?
- Are Covered California CSRs able to access the consumer's account once the consumer is found eligible for Medi-Cal?
- Who has primary responsibility to resolve the appeal – DHCS or Covered California?
- Are there liaisons between Covered California and each county to facilitate communication in transition cases?
- Advocates have experienced challenges contacting Covered California to informally resolve consumers problems, including not being able to find out who is handling the appeal, not receiving Covered California's position statement in the legally required time period (at least 2 days before the hearing date), and not having the appropriate representatives from Covered California and the counties. These problems are not specific to transition issues, but due to these problems, we would like to request much clearer protocols for how both DHCS and Covered California will handle appeals related to transition issues. Specifically:
    - Who should the consumer and Authorized Representative (AR) contact once the appeal is filed to try to resolve the appeal informally?
    - How and when will the consumer and AR be notified who to contact?
    - Will both DHCS and Covered California be available at an administrative hearing if the appeal is not resolved informally? Who does the advocate contact at either agency if the relevant representative does not appear at the hearing?
    - If the enrollee wins his appeal, whose responsibility is it to disenroll the consumer from the Medi-Cal managed care plan?

D. When the CC enrollee appeals the termination and requests continued enrollment

- When the consumer requests "continued enrollment" through Covered California with APTCs, who has access to the consumer's account to make changes – Covered California or the counties?
- Can both agencies have access to the consumer's account at the same time? If not, could this be changed?
- If the consumer calls his QHP about re-enrolling during the appeal, what will the QHP tell the consumer?
- How does Covered California notify the QHP to re-enroll the consumer once continued enrollment is requested by the consumer?
- How long after requesting continued enrollment will the consumer be able to access services in his/her previous QHP?

- If a former Covered California enrollee loses the appeal but received APTC during the appeal, will Covered California send a notice? Will this notice make clear he will have to pay back the PTC received since January 1 when he was found eligible for Medi-Cal (for reconciliation purposes)?

E. <u>Plan enrollment into Medi-Cal</u>

- What is DHCS' legal authority to automatically enroll these transitioning consumers into a health plan without giving them choice first?
- What data does DHCS have from Covered California to do the plan cross walk?
    - Just plan level data or also PCP / medical group level data?
- Has DHCS analyzed the provider network overlap between the Medi-Cal and Covered California plans?
- When will the consumer receive a welcome packet from the new Medi-Cal plan?
- Will any outreach be done to help these consumers change plans if needed?
- Have Health Care Options (HCO) representatives been provided any specific instructions on how to assist consumers affected by the transition who contact HCO requesting to change plans?

F. <u>Plan re-enrollment to Covered CA QHP, if required</u>

- If a consumer was incorrectly found eligible for Medi-Cal – either by appeal or final determination by the county – who has primary responsibility to re-enroll the consumer into a QHP?
- If an enrollee was incorrectly found eligible for Medi-Cal, can a county worker re-enroll the consumer into his/her previous QHP?
- How quickly will the consumer be re-enrolled?
- How and when does the QHP get notified that the consumer needs to be re-enrolled?
- Once re-enrolled, how long will the consumer have to wait to be able to access care from the QHP?
- Will retroactive coverage for January be automatically provided or will the consumer need to request it? How and to which agency should this request be made?

We appreciate the opportunity to discuss these questions at the upcoming meeting on transition issues.