June 1, 2007

Vanessa Baird, Chief
Medi-Cal Managed Care Division
California Department of Health Services
1501 Capitol Ave., MS 4411
Sacramento, CA. 95814

Dear Ms. Baird:

We write in response to the e-mail sent last Friday, May 25, with a request for comments on a proposed, "Telephone Enrollment Phase I Call Center Script". While we appreciate being asked to comment on the proposed script, we must take issue with the fact that this issue was not raised at the last Medi-Cal Managed Care Advisory Committee, the forum for which such matters should be addressed in a timely manner. Furthermore, receipt of the email notice constituted the first notice that DHCS was considering adding this telephone outreach protocol to Maximus' HCO responsibilities. We consider this new project a significant change in the enrollment process – one that warrants more than the one week period for committee feedback. The information presented to-date is incomplete and lacks key elements upon which to assess the merits of the program design. Therefore, we ask that: (1) this issue be added to the agenda of the Advisory Committee at our next meeting in June; (2) the department address the issues outlined below; and (3) the project be placed on hold until such time as we have reached agreement on its design, content and implementation.

Since we have no context for the proposed Telephone Enrollment, we ask that you provide the following background information:

1) Is the Telephone Enrollment Process being proposed within Maximus' existing contract or will additional funds be allocated for this work?
2) What is the proposed timeline and what are the steps that must take place prior to implementation?
3) For what time period will this project be funded? How many counties or areas are involved in the pilot?
4) How long are the voice recordings stored, for any dispute about what was said or understanding about what was said?
5) The lack of a signature requirement can be beneficial, as noted. If signature enrollment can be done for enrollment, then we would expect disenrollment and plan changes, especially those of an urgent nature and/or taking place as a necessary follow-up to fraudulent enrollment, to be able to use this technology and benefit as well.
6) We would want to be sure that a follow-up paper copy proof of plan and provider selection is mailed to the beneficiary, or that this information (how the selection was made, "On X day you chose ___ by phone) in the plan's enrollment letter and a process for disagreement if the enrollment is disputed is included in the letter.
7) Is this process currently taking place in any other state? If so, what do we know about that experience, including:

a. Which states?
b. What is the population and how does it compare to California?
c. What has been the success rate?
d. How many call backs are necessary for enrollment?
e. Do enrollees select a provider?
f. What information do the scripts include?
g. What problems have been identified in those states and how does MAXIMUS plan to address any which would be relevant here as well?

8) What if a person's paper plan enrollment arrives in the mail after the phone conversation, either because s/he forgot or did not realize it was sent, or changes his/her mind about the selection – if it arrives the same or next day, which selection is honored if the selections are different? What if you talk to one parent for a child, but the other parent has already sent the form – is it only the case head you will speak with? If so, that information needs to be on the script.
9) There is nothing in this script about choice of a provider in addition to the plan. Everywhere that "plan" is mentioned must be changed to "plan and provider". Choice of provider is much more important than plan, even, especially if people have used the fee-for-service Medi-Cal they might already be receiving care from a particular provider. It appears that Maximus will not have this information, from the "Beneficiary Frequently Asked Questions". Choice of provider is the first consideration for a beneficiary, yet it appears Maximus will not have that critical information and will tell the beneficiary to call to find out about providers.
10) You need to have a special script for pregnant women and their considerations, given their start, often, in fee-for-service Presumptive Eligibility and their possible special need to stay with their existing provider and not upset current treatments and/or visits scheduled. This is especially true for women enrolled in 1931(b) Medi-Cal in their third trimester.
11) There is no information in the scripts about helping people who have received a packet in error, or are receiving the call in error because they are not mandatory enrollees, or who need help with the exemption process. Scripts must be written for all these possibilities.
12) During the *Verification* process, what will Maximus do if the address provided is different than what is in their system?

Script comments and questions:

Greeting and opening

13) We join with Marty Martinez in asking what the plan is for recognizing other languages and getting the caller to a speaker of that language. You need an approved script for questions about language and the phone transfer to a Maximus representative who speaks the appropriate language and/or how the person will be called back. What will Maximus do with non-English, non-Spanish speakers they encounter, since the e-mail indicated they were starting out with only English and Spanish? What is the timeline and plan for additional languages to be called?

14) What if another person or a child answers the phone? You need an approved script – to note that caller should only talk to case head – what if the second parent wants to talk and make decisions? The mother may be a child's case head, but the father may think he should make a decision – or vice versa. You will need a way to address this.
15) What time of day and day(s) of the week do you plan to call consumers? Working families may be more accessible after traditional 9-5 work hours; reaching them during this time period can be problematic.
16) What if the family or right person is not home or does not want to talk – will the Maximus representatives try again or will you leave them a message, in the appropriate language? You need an approved script for these possibilities.
17) What is the time frame prior to default that the calls will be made? The script indicates that the person was called after 30 days and seems to indicate one call with the possibility of a call back the next day if the person wants more time. Wouldn't it be better to call sooner and provide more education and information rather than the day it is due?
18) Contracted outreach entities in Los Angeles have some of these activities in their Scopes of Work. Have you explored how DHCS might utilize these agencies and/or ensure that the beneficiary is not getting conflicting or duplicate information?
19) If the beneficiary says he or she did not get a packet, is DHCS going to ask them to enroll in a health plan anyway, over the phone, instead of pending their default and ensuring s/he receives a packet or gets to an enrollment representative? We do not believe you can expect anyone who genuinely has no idea they needed to have chosen a plan AND a provider to do so over the phone. DHCS must send them a new packet, explain Health Care Options and pend their default for another 30 days.

Plan Choice section:

20) The Plan Choice section only asks, "Do you know which plan you want?" Many of us worked extensively over a long period of time during managed care implementation as well as during the rollout of the Maximus contract with CBOS in Los Angeles on scripts for Maximus to consider, making sure issues were raised such as: their current provider; whether they are currently in a course of treatment; what are their specialty care needs; what language do they prefer; what provider gender do they prefer; and what are their transportation needs, among other such important issues. Maximus should be asking these questions during their presentations or over the phone when beneficiaries choose plans. They should also be educating about the fact that their selection will determine where they get their care, their specialty care, their medications, etc. For children, it is particularly important to know about urgent care provisions.

    Again, it does not appear that Maximus will have current provider information for each plan so that a beneficiary can reproduce his or her provider network, if s/he has more than one provider and/or wants a specific hospital. Beneficiaries often have to call providers because the plan information is not current, even on the computer.

21) Please be sure that the enrollers are well-trained that the only mandatory county for dental care enrollment is Sacramento.

Call Backs

22) It does not appear that Maximus will have a toll-free number where they can be reached if it is easier or better for the beneficiary to call back.

    We would recommend everyone be allowed get a call back because that second call is important to give the family time to consider enrollment issues if they have not understood the need to enroll in the first place, and because Maximus is not helping with actual provider choice and continuity of care issues.

These are just our preliminary comments and questions. We welcome the opportunity to discuss the project, its design, protocol and implementation in more detail at the June meeting. Any information you can provide in response to the above prior to the meeting will be greatly appreciated and assist us in our preparation. We look forward to hearing from you at your earliest convenience in order to know how to proceed at this time. Thank you for your consideration of our recommendation. We look forward to working closely with you on this new effort to assist consumers in the selection of their healthcare provider.

Sincerely,

Lynn Kersey
Maternal and Child Health Access

Lark Galloway Gilliam and Mark Paredes
Community Health Councils, Inc.

Angela Gilliard and Kim Lewis
Western Center on Law and Poverty

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