California Collaborative Feedback

Updated 10/6/2016

#	Recommendation		Response
1	Re-Message and Create New Materials – Create Consistent Basic Messages	1.1 Materials and new messaging should discuss how the program addresses the person's needs - how it is personalized, cuts red tape, adds transportation, includes vision, provides additional services, helps caregivers, and provides care coordination all in plain language, stories, and visuals that beneficiaries and caregivers can easily understand.	*Revised materials focus on these issues, as additional materials are developed, DHCS/Harbage will use this recommendation.*
		1.2 Develop generic plan-neutral materials that have program highlights and a value proposition that can be used as a leave-behind for those doing program outreach.	*The revised CMC beneficiary toolkit and materials such as conversation guides, fact sheets, and unique toolkits should help serve this purpose, and will be available in hard copy for plans and other partners.*
		1.3 Tailor marketing materials to special population needs (e.g. people with dementia, diabetes, cardiovascular, etc.).	*DHCS/Harbage has already developed some materials targeted at the dementia population and can explore additional tailored materials.*
		1.4 Emulate PACE materials (here and here) and the 1:1 personalized approach to beneficiary outreach to establish and develop a high-touch servicing model.	*DHCS/Harbage will review and use as a model should additional beneficiary materials be developed as well in the CalDuals revamp. PACE materials are similar to revised beneficiary tool kit. DHCS/Harbage will continue to use high-touch outreach, such as telephone town calls, direct outreach and mailings.*
		1.5 Leverage and repurpose what has been created and develop improved dissemination plan (e.g. will I have to change doctors and how does continuity of care work; repurpose Cal MediConnecToons).	*DHCS/Harbage looks forward to continuing to work with the Collaborative to come up with an improved dissemination plan for revised beneficiary materials.*
		1.6 Create and supply template messaging to trusted sources to use on their materials and websites (e.g. county DPSS web sites, county/city Department of Aging web sites, HICAPs, AAAs, Public Authorities, Long-Term Care Ombudsman, APS, etc.).	*DHCS/Harbage can develop these messages.*
		1.7 Request that the Centers for Medicare and Medicaid Services clarify and provide guidance to plans on what is considered educational versus marketing	*DHCS and CMS hosted a CMC plan best practices meeting on clarifying marketing rules, building on the extensive technical assistance already provided by CMS*

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		materials.	*to the CMC plans.*
2	Re-Train and Resource Outreach Staff (Health Care Options, HICAPs, DPSS, CDA, Medi-Cal Ombudsman)	2.1 Renew and extend funding for HICAP counseling.	*DHCS has been working with CDA and CMS to identify additional HICAP funding.*
		2.2 Retrain DPSS staff, HCO CSRs, Medi-Cal Ombudsman, APS, and CDA staff on program, voluntary enrollment, deeming, etc.	*While these organizations have their own internal trainings, DHCS/Harbage will continue to make additional training available.*
		2.3 Provide ongoing and repeated training for local community-based organizations and other trusted community sources partnering with Harbage/DHCS and trusted community sources.	*DHCS will continue to make training available to local community organizations through Harbage.*
3	Coordinate Timing of CMC Notifications so as Not to Conflict with Other Health Care Announcements (Medicare or Medi-Cal) or Enrollment Periods and to Leverage Communications Already Slated for Beneficiaries to Receive	3.1 Annual enrollment period (AEP) for Medicare is October 15, through December 7. Although duals have an ongoing enrollment period, marketing activities are heightened during this period, so DHCS and the plans should avoid intense outreach campaigns during this period.	*DHCS/Harbage will continue to be cognizant of AEP and Medicare marketing in designing outreach and enrollment strategies.*
		3.2 CMC information should accompany annual redeterminations for dual eligibles not enrolled in the program.	*This is not consistent with other Medicare programs.*
4	Create A Next Generation Website for CMC as a Central Repository for Clear and Easy-to-Understand Information	4.1 The CMC website should be repurposed and modeled after the Covered California website.	*Harbage is planning to revamp CalDuals.org, and will explore feasibility of modeling after the CC website.*
		4.2 Feature video success stories, including beneficiary and caregiver perspectives.	*To date, DHCS has not been able to highlight beneficiary success stories due to restrictions around PHI. DHCS will continue to explore the issue.*
		4.3 Include physician champions discussing benefits of program.	*DHCS/Harbage has requested plans help identifying physician champions, and if they can be identified, will feature their stories online.*
		4.4 Feature care coordinators explaining what they do.	*See response to 4.3*

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		4.5 Make resources for choice counseling and assistance with appeals from the Ombudsman easy-to-find.	*Harbage will incorporate this suggestion into our revamp of CalDuals.org*
		4.6 Make plan links and their provider directories more accessible on the website and through the HCO website so that the beneficiary can see if his or her doctor is in the network.	*Harbage will incorporate this suggestion into our revamp of CalDuals.org* *The Health Care Options website provides a searchable provider directory today, however DHCS will continue to keep this suggestion in mind as they make future modifications.*
		4.7 Ensure that the state's resources on the DHCS website (including the HCO website, Medi-Cal Ombudsman site, and any other DHCS-hosted site) include easy-to-find links to CalDuals.	*DHCS will consider this suggestion.*
5	Improve Accessibility: We Recommend These Best Practices for Ensuring Compliance with the Americans with Disabilities Act Regulations and the Effective Communication of Written Notices and Documents	5.1 Wide notice of the availability of auxiliary aids and services for effective communication. Auxiliary aids and services include alternate formats such as Braille, large font print and CD, a qualified reader or translator, or documents translated into American Sign Language captured visually, that will be delivered in a timely manner to individuals who identify themselves to DHCS or a health plan as people with disabilities who require auxiliary aids and services for effective communication. The notice itself needs to be accessible (i.e., placed on an accessible website, posted in physical locations in large font, a tagline in 18 pt. font bold should be placed in all notices sent out just like a LEP tagline).	*Harbage will also look into ways to strengthen education about this in our outreach.*

		5.2 DHCS/CMC needs to have a database where an individual's preferred accommodation need is documented and placed in the individual's record so that the person does not bear the default burden of contacting DHCS/CMC for every single new notice, letter or piece of mail to formally request it in the person's preferred alternative format. This was a very significant breakdown point for CMC last time, when DHCS acknowledged that it keeps no records of accommodation needs and can't promise to not send a patchwork of alternative formats land typical print letters, with an individual having no idea of whether they are receiving everything they need to read in their needed alternate format.	*DHCS updated procedures for providing beneficiaries with accessible materials during the previous round of passive enrollment. Beneficiaries were only required to request an accessible format once, and all following passive enrollment notices would be provided in that format. Unfortunately, data systems do not allow a permanent election of alternative formats.*
		5.3 Designate a place to call or contact if there are accessibility problems, and there must be a place to make complaints about inaccessibility.	*DHCS will be working towards this process.*
		5.4 The person's preferred choice of format should be considered and granted unless it is an undue burden to do so, in which case the entity and the individual need to work out an alternative solution that actually provides effective communication. The entity can offer a set of pre-existing approved auxiliary aids or services, but can't automatically refuse to consider something that isn't on the list (e.g., 18 pt. font is automatically offered, but X needs 24 pt. font, or X needs 18 pt. font Chinese).	*DHCS fullfils and honors all requests made for information mailed by HCO or DHCS. Additionally we full those requests in future mailings for CCI without additional burden on the member.*
		5.5 There must be monitoring to keep track of the number of requests made for each auxiliary aid or service and how many of the requests were met, keep track of the number of complaints made, and so forth.	*DHCS tracks the number of alternative format materials requested from HCO.*
		5.6 Monitored information should be transparently made available to the public.	*The number of requests are too small to present publicly, due to privacy restraints.*

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		5.7 Appeal timelines in notices should follow the delivery of the auxiliary aid or service requested by the person, not the date of delivery of the print letter that the individual could not read.	*DHCS will continue to review this, as this would be a health plan requirement.*
		5.8 A beneficiary should be able to request both an auxiliary aid or service AND a print letter (which is useful to advocates or attorneys that the person might hire in future), if desired, and ideally both should be delivered together.	*Currently DHCS mails both a letter and provides an alternative or auxiliary aid based on the members standing request.*
6	Improve Outreach to Ethnic Communities	6.1 All outreach for CMC should address fundamental distrust of large institutions, including government programs, and build trust by clearly and transparently explaining the value of the program.	*DHCS/Harbage will continue to address these issues through outreach and will take this into account in developing new materials.*
		6.2 Utilize community-defined best practices for outreach strategies. Examples of these types of strategies can be found here and here.	*DHCS/Harbage will review these suggestions and identify strategies that can be incorporated into ongoing CCI outreach activities. For example, Harbage is continuing to explore ways to work with ethnic media outlets.*
7	Build Bridges to Primary Care and Specialist Physicians with a Focus on Ethnic Physician Organizations	7.1 When conducting outreach to physician organizations to provide informational seminars on CMC, send plan representatives who are familiar with billing practices/eligibility requirements and the coordinated care system to be the presenters. This may involve a combination of Harbage and CMC plan staff.	*DHCS/Harbage will continue to partner with CMC plans on collaborative outreach to physicians and physician organizations.*
		7.2 Convene and work with focus groups of physicians who have contracted with CMC plans and inquire about their experience (with the intent to make a good faith effort to make changes).	*DHCS/Harbage will continue to do this with the CMC plans.*

		7.2.a Focus groups can be created through ethnic medical organizations like the Armenian Medical Society and/or county medical associations like the Los Angeles County Medical Association.	*DHCS/Harbage will continue to partner with organizations that serve physicians from diverse backgrounds to get feedback from their members.*
		7.2.b Establish in-depth relationships between the health plan and the local Medical Association. Inland Empire Health Plan has a long-standing successful relationship with the Riverside Medical Association at both the CEO and the Chief Medical Officer level.	*CMC plans do this currently and DHCS supports this collaboration.*
		7.3 Find physician champions of the program. These are likely to be found during focus grouping. Physician champions will be able to participate in peer-to-peer education of the program. Physicians trust other physicians.	*DHCS/Harbage has requested plans help identify physician champions and, if they can be identified, will feature their stories online.*
		7.4 The goal of connecting with physicians should not be to "sell" the program, but to hear their concerns about it and be prepared with responses.	*DHCS/Harbage will continue to use this approach as we engage with physicians and physician organizations.*
		7.4.a Tip: when advertising the meeting make it clear providers are invited to bring questions and concerns. The first 20 min should be devoted to an overview of the program, with the remaining time largely a back and forth between physicians and plan representatives.	*DHCS/Harbage will continue to use this approach as we engage with physicians and physician organizations.*
		7.5 Provide concrete evidence that the CMC program improves on past service delivery models. Assertions that the CMC program is "the best program" without evidence will breed further mistrust and belief that the state is out of touch with beneficiaries and providers.	*DHCS/Harbage will incorporate more concrete evidence as future provider materials are developed and will incorporate it in current messaging.*
		7.6 Be open to and act on concerns raised by beneficiaries and providers and solicit their assessment regarding whether the program is working.	*DHCS/Harbage will continue to use this approach as we engage with physicians and physician organizations.*

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		7.7 OUTREACH CHECKLIST: These are questions that DHCS can provide plans as best practices be asked to improve outreach: A. Questions for Plans: 1. Are we using culturally competent methods to communicate the changes with patients and their physicians? 2. Have we worked with Harbage to connect with medical associations and ethnic serving medical groups to request meetings and offer trainings? 3. Have we addressed the concerns we have heard from physicians during our presentations? 4. Do we have a relationship with the county medical association? 5. Will the county medical association alert us to any consistent concerns about the program by their members? B. Questions for the State: 1. Are representatives doing outreach on the CMC program able to answer specific billing/eligibility/ continuity of care concerns when presenting on CMC? Harbage should consider hiring additional outreach coordinators for languages with the highest opt-outs (e.g. Russian, Armenian, Vietnamese).	*A. DHCS appreciates the feedback and will continue to work with the plans on best practices.* *B. DHCS/Harbage outreach staff are already addressing specific billing/eligibility/CoC concerns in our outreach, and connecting beneficiaries and others to resources when required (eg. When a plan or an HCO representative can best answer the question.) Harbage is actively recruiting additional language speakers for the outreach team.*
8	Build Strong Program Relationships with Other Key Providers	8.1 Pharmacies are often the first point of contact, and first point of disruption, in the program. Build relationships with pharmacy providers who can provide ongoing support and communication to beneficiaries about the program.	*DHCS/Harbage will continue to use this approach as we engage pharmacy providers and their staff.*
		8.2 Educate and partner with other specialty providers, including DME, dentists, optometrists, podiatry, etc. so they will be well-informed about the program and be	*DHCS/Harbage will continue to identify and work with these types of providers and provide them with materials and training as needed.*

		able to assist beneficiaries to access services.	
9	Develop Community Partners	9.1 Develop co-branded materials for statewide and local organizations to distribute.	*DHCS/Harbage has already done so with the* Alzheimer's Association and *California Hospital Association DHCS/Harbage will look to identify other appropriate partners.*
		9.2 Develop Initiatives with a built-in role for community partners, similar to Medicare enrollment processes, where CBOs are actively part of communicating, educating and promoting the value of the program (e.g., the Alzheimer's Association is a partner, is included in the enrollment campaign, participates in developing messages appropriate for their population (in this case, how the program is particularly valuable for addressing beneficiary and caregiver needs around dementia), has ready access to co-branded materials that they can distribute, gives feedback on what is working and what is not, etc.	*DHCS/Harbage will continue to work closely with CBOs and other partners on collaborative events and to engage the beneficiaries they serve.*
		9.3 Develop and maintain relationships with county and community partners (attend their events, conferences and staff trainings).	*DHCS/Harbage will continue to identify new partners and continue to work with and support current, local partners.*
		9.4 Provide program brochures to community partners for distribution.	*DHCS/Harbage will continue to provide materials to community partners for distribution to the populations they serve.*
		9.5 Train community partners in the program and how to enroll consumers through calling HCO and the hours of operation for HCO.	*DHCS/Harbage will continue to work closely with local partners to identify and fulfill training needs, including around enrollment.*

		9.6 DHCS should encourage plans to develop a close working relationship with Adult Protective Services and Community Care Transition Programs, Long-Term Care Ombudsman including training and refresher information about the program, participating in monthly APS Multidisciplinary Care Team meetings, presenting at APS conferences and MDT meetings, and including APS social workers on plan interdisciplinary care team meetings. Plans and DHCS should also reach out to low-income senior housing coordinators.	*DHCS will continue to encourage plans to share best practices to work with local services available to them and the beneficiaries.*
		9.7 Develop a meaningful CCI Stakeholder Advisory Committee and work closely with them, including Independent Living Centers, county legal centers, department of Public Social Services (APS, IHSS), the Public Authority, partner health plans, providers, consumers, IHSS provider unions, housing authority, mental health, senior comparisons and Social Security Administration representatives.	*DHCS will continue to utilize its existing stakeholder forums to collect feedback and suggestions for the program. We encourage all to attend these existing forums where appropriate.*
10	Utilize Best Practices for Enrollment: These Recommendations are Based on Inland Empire Health Plan's Enrollment Strategies, Which Started with a Conversion Rate of 30% That is Now 85-90%	10.1 Identify potential member's needs (market research): A. Ability to keep my doctor. B. No disruption in services (Specialist, DME, RX). C. No hard sell - it turns members off. Use more of an educational approach.	*DHCS/Harbage will work with the CMC plans to incorporate these strategies into their member engagement work. A recent Cal MediConnect Best Practices Meeting centered on Inland Empire Health Plan (IEHP) sharing their enrollment strategies.*
		10.2 Network strategy: A. Build a large network of doctors who are traditionally seeing the fee-for-service Medi-Medi population. B. Provider outreach - educate them on the CCI program and how it impacts them to build doctor buy-in.	

		10.3 Sales Team: A. Inland Empire uses an in-house team. B. Skill – look for social empathy with one-on-one educational as a skill set. C. Be a partner with Member Services, Care Management, Pharmacy, Provider Services Reps, etc.	*DHCS will continue to encourage plans to share best practices.*
		10.4 Lead: A. Pre-screening - Data from the State's eligibility file, CMC eligible aid codes (list on DHCS website), excluding CMC ineligible criteria (<21, DD, ESRD, etc.) from State's file, verifying eligibility through State file PLUS AVES and MarX. B. Marketing and Outreach – Direct mail program info and conduct 1:1 educational sessions from outbound and inbound calls from members. If member is interested, warm transfer to HCO to complete the enrollment.	*DHCS currently provides the health plans and HCO will all the necessary information to identify an eligible beneficiary for CMC. DHCS encourages plans to continue to utilize the data provided by DHCS.* *DHCS will continue to encourage plans to share best practices such as this, and recently hosted a Best Practices meeting on outreach strategies*
		10.5 Partner with DHCS and CMS on actual enrollment assistance experience via bi-weekly calls with contract managers - sharing what is working as well as areas for improvement or questions or clarification.	*DHCS will continue to encourage plans to share best practices. DHCS and CMS will continue to meet frequently to share discussions.*
11	Target LTSS Users Including IHSS, MSSP, CBAS Centers, and Nursing Facilities	11.1 Develop tailored materials discussing how care coordination can be used effectively for the person who self-directs care (see perspectives on this topic from the Personal Assistance Services Council of LA County, here.)	*DHCS/Harbage is already working to develop materials tailored to the IHSS population.*
		11.2 Work with local unions to disseminate information about the value of the program.	*DHCS/Harbage will continue to work closely with IHSS provider unions to increase education and understanding of CCI.*
		11.3 Work with LTSS providers to disseminate information about the value of the program.	*DHCS/Harbage will continue to work closely with IHSS provider unions to increase education and understanding of CCI.*

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