July 2, 2013

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Re: Comments on All Plan Letter: Continuity of Care: Definition and Practice

Greetings:

Thank you for the opportunity to respond to the All Plan Letter (APL) addressing Continuity of Care (COC), and agreeing to extend the deadline for comment to provide stakeholders with additional time to review and respond to this very significant document. As indicated in a May 2013 letter from over 40 consumer advocacy organizations in California, COC is critical to a successful transition and an area that we are eager to have further discussions about with the Department of Health Care Services and the Medicare Medicaid Coordination Office. We hope our comments on the APL can serve as a starting point to more in-depth conversation about this complicated and important subject. As discussed further in our comments, we believe that some of the areas where the APL is confusing or unclear reflect broader inconsistencies and gaps in policies that should be addressed before a final APL is drafted.

With the transition of seniors and persons with disabilities (SPDs) into managed care in 2011, we learned that COC is arguably the most critical factor in successfully transitioning high need beneficiaries into a new health care setting. The poor performance of COC protections led to significant, and at times catastrophic, disruptions in care, beneficiary and provider dissatisfaction, increased costs for providers, and increased administrative costs for the plans and State.

The problem during the SPD transition was not the COC standard itself as much as the way the protections were operationalized. More than eighty percent of SPDs did not know that they had a right to continue to see their current providers.[1] Many providers serving SPDs had no knowledge of the COC protections, refused to participate in COC, or were uneducated about how the protections applied.[2] Plans improperly denied requests for COC and failed to inform their members of these rights. Arguably, the largest disruptions to COC occurred in situations where Independent Practice Associations (IPAs) contracted by the plans denied COC protections to beneficiaries. In sum, the lack of continuity of care in the SPD transition was distressing and left many in the consumer community distrustful of whether the State can transition additional beneficiaries into new health programs safely.

With the lessons learned from the SPD transition, we believe DHCS has an opportunity with the current APL to strengthen COC protections and develop guidance so that these protections are more available and exercised by beneficiaries. We are discouraged that the draft APL effectively mirrors prior APLs addressing COC that have proven ineffective. We have provided comments below and in track changes that focus on how the APL can be amended to ensure that COC provisions are in place that improve a beneficiary's transition into a different health care setting. As mentioned above, in addition to our comments, we would welcome the opportunity to collaborate with DHCS further in the development of this APL.[3]

APL Format

We have provided comments in track changes following the current structure. However, we suggest that the letter be substantially reorganized and rewritten to provide needed clarity. Advocates would be happy to work with DHCS in this venture. Plans need to know what their obligations are for Medi-Cal enrollees in general, as well as any deviations that apply only to specific populations. Currently, the letter creates separate sections for each subpopulation and then repeats information about general protections (sometimes worded differently, making it unclear whether the protections are in fact the same or slightly different for different populations), along with specific protections and exceptions. We are concerned that this structure will make it difficult for plans to understand what protections apply in which

[1] See, California HealthCare Foundation "Briefing, Transitioning the SPD Population to Medi-Cal Managed Care, (March 28, 2013)" at www.chcf.org/events/2013/briefing-spd-transition-managed-care.

[2] See, The Kaiser Commission on Medicaid and the Uninsured, "Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Insights from California (June 2013)" at http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8453-transitioning-beneficiaries-with-complex-care-needs.pdf

[3] For additional recommendations on drafting robust COC protections, see "Continuity of Care in the Dual Eligible Demonstrations: A Tool for Advocates" available at http://www.nsclc.org/wp-content/uploads/2013/05/Care-Continuity-Final-052913.pdf.

circumstances, and by repeating information, may confuse more than it explains. Instead, we suggest that the letter start out by explaining the relevant laws and regulations -- including the Federal Medicaid law and regulations, the Welfare & Institutions Code and title 22 of the CCR, the Health & Safety Code and title 28 of the CCR , and the Memorandum of Understanding (MOU) between DHCS and CMS -- that govern COC for ***all Medi-Cal managed care enrollees***, including the transitioning Cal MediConnect enrollees, Healthy Families children and LIHP enrollees. The letter could then list any unique protections and unique exemptions to which individual populations are entitled.

Omitted Populations

The APL is only targeted at SPDs, dual eligibles enrolling in Cal MediConnect, and Healthy Families children. The APL fails to address SPDs who were previously excluded from mandatory enrollment in Medi-Cal managed care who will now be enrolled in MCPs under the Coordinated Care Initiative. Likewise, the APL does not address COC rights for those dual eligible beneficiaries who either are excluded from participation in Cal MediConnect or who choose not to participate in Cal MediConnect, but who will be mandatorily enrolled in MCPs for their Medi-Cal benefit. Finally, the APL does not include beneficiaries transitioning from LIHP to Medi-Cal managed care. These populations must be included in the APL.

Continuity of Care Definition

The APL does not clearly state that COC provisions apply both to continuity of services, and continuity of provider relationships. Currently, the beginning of the letter only describes continuity of services, but then the subsections also describe continuity provisions for provider relationships. The APL must clearly explain that these protections apply to both providers and services.

Second, as written, the APL only affords COC protections to beneficiaries moving from fee-for-service (FFS) to managed care. For example, the APL states that "DHCS and its contracted MCPs must ensure that person the State is transitioning into MCPs under the Waiver continue to receive the services they need during their transition from FFS to managed care." (APL p. 3; see also APL pp. 2, 6 & 7). This language seems to have been adopted from the SPD transition where beneficiaries were only moving from FFS to managed care. However, many of the beneficiaries now being transitioned are already in some form of managed care. The APL should be amended to anticipate transitions from one health care network to another.

If a beneficiary decides to change from one Cal MediConnect plan to another or from one CCI plan to another, COC protections should be available. This APL denies COC protections beyond

those initially afforded when a beneficiary first moved into managed care. This limitation fails to recognize that disruptions in care occur with any transition. For example, a beneficiary in one Cal MediConnect plan may switch plans in order to gain access to specialists that are in another Cal MediConnect plan. However, the beneficiary still will need to see her primary care provider, who is a member of her old plan but not her new plan. The new plan should afford COC protections to the beneficiary to continue seeing her primary care provider until she finds a new provider in the new network. The beneficiary should also be guaranteed the right to continue current treatment regimens in the new plan. That right should extend for the same period (6 months for Medicare services and 12 months for MediCal services) starting from the date the individual changes Cal MediConnect plans.

Accessing COC Rights

Accessing COC rights should be simple and streamlined to prevent disruptions in care. As currently described in the APL, the COC system is instead burdensome and will result in delays or denial of care. Currently, the APL states that a plan must begin to process requests for COC within 5 working days after receipt of the request and must complete such request within 30 days of such request, unless a medical condition requires more immediate attention. The process for accessing COC rights should be more automatic, with a presumption that COC be provided. The current process in place, for example, fails to account for circumstances where a beneficiary is passively enrolled in a plan on Tuesday and visits her provider on Friday, not realizing that the provider is out of the plan's network and, perhaps, not really understanding that her coverage has changed. Under this scenario, the beneficiary would not be able to see her provider, even though the appointment may have taken months to schedule. The APL should include a procedure that would allow providers in such circumstances to immediately verify that COC provisions apply. If a question about the right to COC cannot be resolved at the point of service, the default should be to provide COC until a determination can be made.[4]

[4] A good model is the COC provision in Medicare Part D. It provides that if a beneficiary presents a newly written non-formulary prescription at the pharmacy during the COC period, and the pharmacy cannot determine at the point of service whether the prescription is for ongoing drug therapy, the pharmacy must fill the prescription and the plan must cover the fill. See Medicare Prescription Drug Benefit Manual, Ch. 6 at 30.4.3, available at www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Chapter6.pdf.

Another good model within the Medicare context is the "best available evidence" (BAE) policy which gives plans clear guidance of evidence that is sufficient to provide a beneficiary with the Low Income Subsidy, even if federal or state computer systems do not reflect the subsidy at a particular point in time. http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Best_Available_Evidence_Policy.html. The BAE policy provides for immediate provision of the subsidy for beneficiaries who present prima facie evidence of eligibility, as well as swift determinations and problem-solving contacts for beneficiaries who do not meet the initial criteria.

The APL should include as an additional safety net a hold-harmless provision that would allow out-of-network providers to provide urgently needed care and still be reimbursed in the event COC provisions do not apply. During the SPD transition, many out-of-network providers provided unreimbursed care to beneficiaries to prevent disastrous disruptions in care. Many other out-of-network providers discontinued treatment in fear they would not be reimbursed. A hold-harmless provision would ensure beneficiaries do not lose access to critical care during the transition period.

Ongoing Relationship - Cal MediConnect

The APL misstates COC provisions that were outlined in the MOU authorizing Cal MediConnect. The APL states that an enrollee can "continue treatment for up to six months with their out-of-network Medicare providers and 12 months with their out-of-network Medi-Cal providers with whom they had ongoing relationships and ***who served them as their primary care or specialist providers***." (APL p. 5). The italicized language is not in the MOU nor is it in statute and should be deleted from the APL accordingly. (MOU p. 95; WIC §§ 14182.17(d)(5)(G); 14132.275(k)(2)(A)). This severe limitation on categories of covered providers must be removed. Furthermore, the provision in the APL fails to make it clear that beneficiaries can maintain both their current providers and ***service authorizations***. (MOU p. 95). As emphasized previously, the APL must explicitly state that a beneficiary has both the right to continue seeing her provider and the right to continue receiving services. The APL should be amended to clarify that COC protections extend equally to access to current providers and to continuing services and treatments.

In the same vein, the APL fails to explain that in limited circumstances, beneficiaries have the right to keep long-scheduled appointments with a provider whom they have never seen before. For example, a beneficiary who is scheduled for surgery with an out-of-network provider may keep that scheduled appointment even if the beneficiary has not previously seen the provider.[5]

The APL also conflicts with the MOU regarding the evidence plans can rely on to determine the existence of an ongoing relationship with a provider. The APL states the plans can use "data provided by CMS and DHCS, such as FFS utilization data from Medicare and Medicaid." (APL p. 6). The MOU also allows proof of the relationship by documentation from the provider or beneficiary (MOU pp. 95-96). The APL should be amended accordingly.

The MOU and the APL both have a stricter standard for determining when a beneficiary has an "ongoing relationship" with a provider than the COC protections afforded during the SPD

[5] HSC § 1373.96(j); See also, http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_20066.asp.

transition. Under the SPD transition, an ongoing relationship was assumed if a beneficiary had seen the provider once within the previous 12 months. Under the MOU and this APL, an existing relationship is only established if a beneficiary has seen the provider ***twice*** within the previous 12 months. Medicare recipients may often only see a specialist once within a 12 month period, but may have seen that specialist over many years. Further, having two standards is confusing and creates additional complexity for plans in providing these protections. In light of the findings from the SPD transition, we advise DHCS to adopt the SPD standard for establishing an ongoing provider relationship.

Lastly, the APL inaccurately limits which providers the plans are required to work with. The APL states that plans are *not* required to work with providers "who offer carved-out Medi-Cal services." (APL p. 6). Under Cal MediConnect, carved-out benefits include county administered Medi-Cal mental health and substance use benefits. The MOU specifically states that although plans are not responsible for providing these benefits, plans are "responsible for coordinating with local county agency(ies) to provide seamless access to these specialty mental health and substance use services." (MOU p. 74). Plans must enter into MOUs with county agencies to effectuate this requirement. The language in the APL contradicts this requirement and fails to reflect the COC standards outlined in the MOU, which simply state that COC protections do not extend to IHSS providers, durable medical equipment, medical supplies, transportation, or other ancillary services. (MOU p. 96).

<u>Ongoing Relationship – Healthy Families</u>

The APL states that the existence of an ongoing relationship between a transitioning Healthy Families enrollee and an out-of-network provider may be determined by self-attestation. However, then it goes on to state that the plan must verify the relationship by contacting the provider. This language is both confusing and inaccurate. Nothing in the waiver or state statute requires plans to verify the existence of an ongoing relationship. And requiring plans to verify the existence of these relationships is burdensome to plans, providers and enrollees. The language requiring verification should be taken out.

<u>Prescription Drug Coverage</u>

The SPD transition resulted in many beneficiaries losing access to vital prescription drugs. Yet, the APL entirely omits COC protections for prescription drug coverage. SPDs, LIHP enrollees, and children transitioning from Healthy Families are afforded COC protections pursuant to WIC § 14185(b). Dual eligible beneficiaries can continue receiving Part D covered prescription drugs

pursuant to Part D transition rules.[6] Dual eligibles who are prescribed drugs that are not covered by Medicare, but instead by Medi-Cal, also receive the benefit of the COC protections afforded to SPDs. The APL should include these specific COC provisions for prescription drug coverage.

Nursing Facilities

The current APL does not address continuity of care rights for residents of nursing facilities. For Cal MediConnect enrollees, the MOU states that it is unlikely that beneficiaries will have to change nursing facilities for the first 12 months under continuity of care protections. (MOU p. 85). This protection does not go far enough. Individuals residing in a nursing facility, particularly long-time residents, should not be forced to move out of their home because the facility is not part of their plan's network. Beneficiaries should be allowed to continue residing in a nursing facility as long as the nursing facility has a Medi-Cal contract. To accomplish this objective, the APL should require plans to enter into an agreement with the beneficiary's non-network nursing facility for the length of the demonstration period.[7]

Limitations to kinds of services subject to COC protections

The MOU states that dual eligibles in MMPs will have COC rights for Medicare services for six months. Medicare covers a wide range of services including such items as physical and occupational therapy, home health, DME, chemotherapy, and much more. Yet the APL (p. 7) seems to attempt to limit those Medicare rights to primary care physicians and specialists, a limitation that is entirely inconsistent with the guarantees of the MOU. The APL should make it clear to plans that enrollees have the right to COC protections for **ALL** Medicare services.

The explicit exclusion of COC rights for DME is a particular concern. No other state with an MOU has excluded DME from coverage. Moreover, Medicare covers a wide range of DME so it is particularly inappropriate for California to fail to give COC protections to a Medicare service that will get COC protection in all other states.

[6] WIC § 14132.275(j)(1)(A)(iv).

[7] A good model for continuity of care for nursing facility residents is provided for in Virginia's dual eligible demonstration. Under the MOU, beneficiaries who are residing in a nursing facility at the time of the program, may continue residing in the nursing facility for the length of the demonstration unless the beneficiary no longer meets the criteria for nursing home care or if the beneficiary wishes to move out of the facility. See pp. 73-74, www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/VAMOU.pdf.

Also, existing guidance for Medicare Advantage plans requires a 90 day transition period in which plans must continue to supply and, if required, repair non-preferred brands of DME, prosthetics, orthotics and supplies (DMEPOS) furnished in the previous year.[8] Yet the MOU would deny beneficiaries even this basic Medicare protection, making Cal MediConnect participants worse off with respect to DME than if they did not participate in the demonstration.

We recognize that the MOU excluded DME and other "ancillary" providers from the COC protections. However, at the time the MOU was negotiated, DHCS and CMS were not privy to the findings of the studies of the SPD transition that demonstrated that over a quarter of SPDs using DME found access more difficult when transitioning to managed care.[9] With the lessons learned from the SPD transition, we urge DHCS to expand COC protections to these services for all populations.

Outreach, Education, & Notice

The SPD transition demonstrated that in order for COC provisions to be effective, beneficiaries, providers and the plans have to have knowledge of the provisions and understand the provisions. The APL should explicitly outline the responsibilities of DHCS and the plans to provide outreach, education, and notice of COC protections.

DHCS

The APL should include a specific commitment by DHCS to conduct extensive outreach and education to providers. With the CBAS transition, providers conveyed misinformation to consumers leading to major disruptions in care, the effects of which advocates are still resolving today. IPAs also routinely failed to afford COC protections to beneficiaries. The APL should spell out the steps that DHCS will take to educate providers and IPAs about COC protections. These steps should include developing a clear information sheet for providers and IPAs describing COC so all providers are reviewing the same information and can feel assured that the COC provisions will apply.

The APL should state clearly what steps DHCS will take to explain COC rights to consumers. Those steps must include notices to beneficiaries that describe COC rights in a manner beneficiaries can understand. We have learned from the SPD experience

[8] Medicare Managed Care Manual, Ch. 4 at 10.13, available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04. pdf.

[9] See e.g., CHCF study, www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/S/PDF%20Sacto03282013SPDsTransitionMediCalManagedCare.pdf at Slides 29 and 34.

that the concept of COC is not easy to convey. DHCS should strive to explain COC rights in terms that make sense to beneficiaries, like "Can I keep seeing my doctor?", "Will I have to stop my treatment if I join my plan?", etc. In addition to including rights in beneficiary notices, DHCS should create a COC information sheet that can be easily understood and accessed by beneficiaries, caregivers, and members of the community. The APL should include a timetable showing the dates by which DHCS will complete each step of beneficiary and consumer education.

Finally, the APL should also state that DHCS will verify that plans understand their responsibilities for COC compliance and that all plan employees and contract providers understand their responsibilities to beneficiaries regarding COC. DHCS must verify that plans have provided training to their staff on COC provisions as part of their readiness review.

Plans

The APL should require that plans train all staff on COC provisions and outline the plans' responsibilities in conveying these rights to beneficiaries. The APL should require plans to describe COC rights on the plans' materials and notices in a manner that beneficiaries can understand. Likewise, plans should be responsible for explaining COC rights when applicable during beneficiary phone calls and in-person meetings and should have specially trained staff that will be available to assist out-of-network providers with using and negotiating plan policies and procedures for such processes as specialist referrals, prescriptions, and treatment authorizations. The APL should also require plans to have policies in place that ensure that providers in the plans' networks, including IPAs, are complying with COC provisions.

Attachment 1

The Attachment to the APL includes several errors. We also do not feel that the table as constructed provides adequate guidance to the plans on when and to whom COC protections apply. We recommend redrafting the table with references to applicable COC provisions for the affected populations.

Thank you for the opportunity to comment on this APL. Again, we advise DHCS to rewrite the letter to provide clearer guidance to the plans. We look forward to continued collaboration in this process.

Sincerely,

Disability Rights Education & Defense Fund
National Health Law Program
National Senior Citizens Law Center
Neighborhood Legal Services
Western Center on Law & Poverty