NSCLC
National Senior Citizens Law Center

PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

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Department of Health Care Services
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Greetings:

We extend our thanks to the Department of Health Care Services (DHCS) for providing us with an opportunity to comment on the revised Dual Plan Letter (DPL) addressing continuity of care (COC) for Cal MediConnect beneficiaries and for your willingness to continue to refine this important consumer protection.

As we know you recognize, an effective, accessible, beneficiary-friendly COC policy is essential to ensuring the success of the demonstration. When COC is provided, beneficiaries remain connected to services they need and the providers they have longstanding relationships with. When COC is not provided, beneficiaries lose access to services and providers, miss needed medical treatments, experience negative health outcomes, and disenroll from the demonstration. DHCS should look for every opportunity to apply the COC protections broadly.

Unfortunately, since the enrollment into Cal MediConnect began we have heard numerous reports of beneficiaries having problems accessing the COC protections. While the revised DPL makes some positive progress in solving a subset of these problems, it includes policies which may actually accentuate other problems. It also fails to address many of the problems we have heard about and shared with DHCS and CMS.

COC Problems

We have heard reports of various problems beneficiaries have had accessing COC. Below we describe each problem and a recommendation on how policies can be clarified to ensure the problems do not continue.

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1. **Beneficiaries are required to make an affirmative request to receive COC and have that request approved before seeing existing providers.**

   The Problem. Ms. Y is a 79 year-old blind woman who was passively enrolled into Cal MediConnect in May. She reported not receiving any notices about her enrollment and did not understand that she had been enrolled into a Cal MediConnect plan. She visited her doctor as scheduled in May. In June, she received a bill from her doctor for the cost of her visit. The doctor was not a member of the plan's network and without a specific COC request from the beneficiary prior to the visit, the plan denied payment.

   Ms. Y's case reveals two problems. The first is that plans are requiring beneficiaries to affirmatively request COC by making a phone call or filing out a form. This is difficult for many beneficiaries to do. They must be aware they have been enrolled in the demonstration, know that a current provider is not in the new plan's network, understand that they can continue to see that provider, and find the appropriate plan phone number or form to make the request.

   The second is that plans are refusing to pay claims for services provided before that request was made. It is rare that beneficiaries will make a COC request, or even realize that they need to make one, before showing up in a provider's office for a scheduled appointment. These beneficiaries should not be turned away for failure to have made an earlier request.

   The Fix. A beneficiary's visit to his or her provider should be considered a de facto request for continuity of care. The fact that Ms. Y went to see her provider is a clear indication that she wanted to continue receiving care from that provider. Requiring her to take an additional step is unnecessary and unduly burdensome. The bill from the provider to the plan should suffice as the request and the plan should be required to pay the bill as long as the COC requirements are met (the beneficiary has an existing relationship with the provider, the provider is willing to accept the payment, and the plan has not indicated any concerns about provider quality).

2. **Plans are requiring the COC request to come from the beneficiary.**

   The Problem. Mr. Y's provider called the health plan to request COC so that the next visit can be paid. The plan indicated that only Mr. Y can make the request. Mr. Y's social worker at his CBAS center called the plan to make the COC request and is also told that only Mr. Y can make the request.

   In each case the COC request is denied because the request did not come directly from the beneficiary. Requiring the beneficiary to make the request is likely to result in fewer beneficiaries receiving this important protection. Few beneficiaries are likely to know that they have the right to continue seeing existing providers and fewer still will be able to exercise the right on their own.

The Fix: Any person with a relationship to the beneficiary should be able to request continuity of care on behalf of the beneficiary. This includes the beneficiary, the beneficiary's family member, caregiver, authorized representative, power of attorney, conservator, legal services advocate, or provider. A beneficiary's autonomy and right to direct his or her care is paramount. That autonomy, however, is not undermined by allowing a person who works with or is trying to assist the beneficiary to request continuity of care. The emphasis on autonomy should be placed on whether the beneficiary actually continues to see that provider not on whether the beneficiary made a request for the plan to continue paying the provider.

The revised DPL does allow for limited circumstances under which another individual may request COC on the beneficiary's behalf. The standard in the DPL, however, is too narrow. The DPL standard only applies to individuals who are living in an institution, despite that those living in the community are also experiencing this problem. The new standard also requires a determination that the beneficiary is incapacitated. This limitation does not address situations where the beneficiary is not incapacitated but is still unable or finds it difficult to make the request for any of a number of reasons (e.g., non-verbal, in treatment, simply does not know about COC protections, etc.).

Finally, we note that in the Medicare program a prescribing physician or other prescriber may act on the beneficiary's behalf to request a coverage determination, a redetermination, or an expedited reconsideration, establishing precedent for the authority that a provider has authority to make requests that would help beneficiaries maintain access to needed services.[1]

3. Plans are requiring beneficiaries to provide information that is irrelevant to the COC request.

The Problem: When Mr. G requested COC for a provider, the plan required him to complete a form that included questions about his next appointment and the reasons he needed to continue seeing the provider. It also asked for many details about the provider's practice that Mr. G did not know the answer to.

The form was asking for information that was not necessary to determine whether the provider met the existing relationship requirement that is the basis for approving or denying the request.

The Fix: Plans should be prohibited from requiring any information beyond what is needed to determine whether the three criteria for COC are met to approve the COC request.

[1] Medicare Prescription Drug Benefit Manual, Chapter 18, Section 10.5, available at http://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index.html

4. **Plans are denying COC to individuals residing in long term care facilities when they experience changes in level of care or transition out of inpatient hospitalizations.**

   The Problem: Ms. B is a resident of a long term care facility. In July, she was enrolled into a Cal MediConnect plan. In August, she was admitted as an inpatient in the hospital. Upon discharge, the plan refused to allow her to return to the long term care facility she had been living in. Initially, the plan claimed that the COC protection allowing her to return to her out-of-network nursing facility could not be provided because the beneficiary was inpatient. The plan then denied COC on the basis that her level of care had changed from custodial care to skilled nursing care.

   The Fix: The DPL should make clear that plans must provide COC to beneficiaries regardless of beneficiary status (e.g., inpatient vs. outpatient) and without regard to whether the beneficiary's level of care has changed in the nursing facility setting.

5. **Delegated entities are not applying COC provisions appropriately.**

   Problem: We are hearing more reports of problems accessing COC protections from individuals enrolled in plans where responsibility for their care has been delegated to another plan or an Independent Practice Association (IPA).

   The Fix: The DPL must reinforce the plan's responsibilities to ensure that its delegated entities, both physician groups and their providers, adhere to COC requirements. This includes robust training about COC that cover basics, like what actions providers must take in order to get COC authorized. The materials plans use for this training should be submitted to DHCS for review to ensure compliance and accuracy.

6. **Plans are often slow to approve COC requests even in urgent situations.**

   The Problem: Plans currently have up to 30 days to process a COC request and 15 days if the beneficiary's medical condition requires more immediate attention. If an individual is currently in a doctor's office or has an appointment scheduled next week, the current timeframes for processing the request will result in the beneficiary having to cancel an appointment or scheduled surgery.

   The Fix: The revised DPL takes a welcome step by shortening the processing times of COC requests to three days where there is a risk of harm to the beneficiary.

   The CCI Ombudsman, however, encounter circumstances where even shorter processing times are needed to ensure a beneficiary does not experience harmful disruptions in care. For example, in situations where beneficiaries are receiving chemotherapy treatments or have a

scheduled surgery, the ombudsman recommends that the plans process COC requests within 24 hours. Some Cal MediConnect plans have already recognized the need for this shorter processing time and have implemented procedures to expedite COC requests in these circumstances. The DPL should standardize this requirement across plans to minimize the risk of disruption for those in the most need of immediate continuity of care.

Of course, the recommendation above that any visit to an out of network provider would constitute a COC request and that claims would be paid retroactive would largely obviate the need to have faster processing times. However, in situations where a provider needs an assurance that they will be paid prior to providing the service, shorter processing times are essential.

7. Cal MediConnect plans are not proactively identifying COC needs of beneficiaries.

The Problem: Plan Z contacted Mr. P to complete a Health Risk Assessment. Throughout the entire phone call the plan never asked whether Mr. P had any providers that he would like to continue to see.

Cal MediConnect plans obtain utilization data for each enrolled beneficiary. Cal MediConnect plans also are required to conduct Health Risk Assessments (HRAs) and reach out to members through member onboarding. We are hearing, however, that plans rarely use the data provided and collected to identifying COC needs and to help beneficiaries proactively make requests.

The Fix: The DPL should more clearly spell out that plans are required to proactively identify COC needs using information provided by DHCS and CMS and collected during the HRAs. Plans should be required to submit evidence that their outreach efforts include attempts to assist beneficiaries with COC issues.

Other Issues

COC Protections for Nursing Facility Residents

The Three-Way Contracts have an important COC protection for individuals living in a nursing facility at the time of their enrollment into Cal MediConnect. These individuals will not be required to move to a different nursing facility for the duration of the demonstration.[2] The protection keeps people from being moved solely because their existing facility is not contracted with the Cal MediConnect plan they are enrolled in. It does not prevent the

[2] Three-way-contract § 2.8.4.1.3 (p. 49)

beneficiary from initiating a move and it does not prevent the plan for working to return the individual to a home and community based setting.

The revised DPL indicates that only "long term residents" are entitled to this protection and defines "long term residents" as those that have been in a facility for at least 90 days prior to their enrollment into Cal MediConnect. This new limitation on COC rights is unnecessary, difficult to understand and administer, arbitrary, and likely to lead to unintended consequences.

There is also no indication that the prior, more expansive protection had a negative impact on the demonstration or the health and well being of beneficiaries. The language in the Three Way Contract that created this right makes no reference to the protection only applying to "long term residents."

Under the previous DPL, any resident of a nursing facility, despite length of stay, is provided continuity of care for the length of the demonstration. This rule was easy to apply and has been in place and communicated as a protection in beneficiary communications as well as to the community at large. To limit the protection now – when some counties have already begun implementation - will cause unnecessary confusion.

Limiting the COC protection to those who have resided in a facility for more than 90 days is arbitrary. A beneficiary who has resided in a facility for 70 days is as much at home in the facility as one who has resided in the facility for 90 days.

Finally, the new proposed policy would likely lead to unintended consequences. A beneficiary who does not meet the new definition of "long term care resident" would still receive the broad Medi-Cal COC protection and be allowed to remain in the facility for 12 months. At that time – after they have been living in the facility for more than four times as long as was required for them to meet the definition of "long term care resident" when the first enrolled in the plan – they can be moved to a new facility. The result of this new policy is that plans will be allowed to move people who had been living in a facility for more than one year.

We recommend that the policy remain as it is today. Any individual residing in a nursing facility on the day they are enrolled in the demonstration should have the right to stay in the facility for the remainder of their enrollment in the plan. Individuals residing in a nursing facility should not be forced to move out of their home because the facility is not part of their plan's network. The increased risk of hospitalization and decline in health with the transition of nursing facility residents to another care setting far outweigh the cost of providing COC to these residents.

Continuity of Care Periods

We commend DHCS for recognizing that COC periods are important and allowing for an additional COC period when switching plans. We recommend that the DPL also provide for a period of COC for those beneficiaries who disenroll from Cal MediConnect within the first three months of their enrollment in the plan and who later decide to re-enroll. Failing to provide COC protections to this group will disincentivize them from re-enrolling.

These are complex issues. We would welcome the opportunity to further discuss the problems we are seeing and our ideas for how to fix them.

Sincerely,

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