October 31, 2013

Department of Healthcare Services
Delivered via email to: info@calduals.org, sarah.brooks@dhcs.ca.gov

Re: Comments on All Plan Letter: Continuity of Care

Greetings:

Thank you for providing a second opportunity to comment on the All Plan Letter (APL) addressing Continuity of Care (COC) for Cal MediConnect.[1] We are pleased that this revised APL contains many of the recommendations we suggested in our initial comments and that DHCS has sought to address many of the problems with care continuity that arose in the SPD transition. We believe, however, that there remains several areas where further improvements are needed to ensure beneficiaries will be protected.

We have provided brief comments on the APL (attached) and have presented more extensive comments below. We welcome continued collaboration with DHCS to develop guidance that ensures that all beneficiaries maintain access to the services and providers they need as they navigate managed care plan transitions.

Continuity of Care Definition

We are happy to see that the APL addresses that COC applies to both continuity of services and continuity of provider relationships. However, we believe that the APL should be clearer and more definitive with regard to these protections. We have highlighted in the APL where language should be added to further emphasize that COC applies to services and provider relationships. Additionally, we recommend that this section of the APL contain a reference to

[1] The revised APL is limited to the Cal MediConnect program. The prior APL addressed other transitions including, for example, SPDs moving into managed care that were not previously enrolled, Healthy Families children, and LIHP beneficiaries. We anticipate that DHCS is drafting APLs addressing COC for these programs as well, and will provide an overarching summary for plans of how each COC policy is distinct and when it applies.

Attachment 1 and include clarification of how Attachment 1 applies to the Cal MediConnect population. Specifically, there are three sections of Attachment 1(HSC § 1373.96) that require clarification in the APL.

1. 1373.96(c)(6) - this section provides that a pre-scheduled surgery or other procedure "that is authorized by the plan" can occur under certain circumstances. The quoted language is not applicable to new enrollees in Cal MediConnect. In the case of a new enrollee, there is no plan involvement. The APL should clarify that these services should be continued if authorized by a plan or where such surgery or procedure is ordered by the enrollee's providers as a part of a documented course of treatment.

2. 1373.96(e)(2) - this section describes what rates the service providers will receive. The APL should specify that for Cal MediConnect, the provider will receive the Medicare or Medi-Cal rate, whichever is applicable.

3. 1373.96(j) - this section states that the provision will not apply to newly covered enrollee who "had the option to continue with his or her previous health plan or provider and instead voluntarily chose to change health plans." All Cal MediConnect enrollees have the option not to participate in Cal MediConnect. The APL should specify that protections offered pursuant to §1373.96 are available to Cal MediConnect enrollees and subsection (j) is not applicable.

<u>Existing Relationship</u>

The APL states that an ongoing relationship can be established for a primary care provider by one visit in the previous twelve months and for a specialist by two visits in the previous twelve months. The APL does not provide any explanation for the different, more restrictive approach to care continuity for specialists.

While we are pleased to see that the state has revised its requirements for access to PCPs, we are concerned by the continued, more restrictive approach to specialists. It is at least, if not more, important that dual eligibles be able to maintain connections to specialists. In the SPD transition there was no such distinction between PCPs and specialists – beneficiaries were allowed to continue to see any provider they had seen once in the previous twelve months. It is not uncommon to only see a specialist, like an oncologist, once a year or less. The APL does not explain why a more restrictive approach to specialists is necessary or will better protect beneficiary access to the providers and services they need. Further, having two different

standards is confusing and creates additional complexity for plans in complying with these requirements and beneficiaries in understanding their rights. We request that DHCS adopt the SPD standard for both specialists and primary care providers.

Continuity of Care Periods

We commend DHCS for recognizing COC periods are important and allowing for an additional COC period when switching plans. We recognize that DHCS fears that providing more than two COC periods may result in beneficiaries switching plans multiple times causing administrative challenges and disruptions. However, we believe that the number of beneficiaries who will misuse this protection will be limited and that most beneficiaries switching plans do so for legitimate reasons. Accordingly, we recommend that a COC period be available whenever a beneficiary joins a new plan. A blanket approach to transitions provides the strongest protection for beneficiaries and will reduce administrative complexity for plans and the state. Furthermore, providing COC protections for as wide a scope of providers as possible, and including DME providers for example, will act to diminish a beneficiary's need to switch plans or return to FFS.

We would like to note that the Medicare Part D program provides transition protections whenever a beneficiary switches plans or enrolls in a new plan. There are no limits on how many times a beneficiary can get the benefit of the transition policy. Beneficiaries have not taken advantage of this protection. In fact, very few beneficiaries change plans even when changes in plan pricing and formularies suggest that they should. We do not believe there is any reason to suspect that Cal MediConnect enrollees will frequently change plans just because care continuity protections are available. If DHCS finds that many beneficiaries are switching plans repeatedly to extend continuity of care provisions this policy could be revisited.

Accessing COC Rights

Accessing COC rights should be simple and streamlined to prevent disruptions in 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 must be more automatic, with a presumption that COC be provided. We have clear evidence from the SPD transition study that over 80% of beneficiaries did not know their COC rights and therefore could not exercise them, regardless of need. 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.[2]

We also encourage DHCS to ensure that enrollees have an additional safety net by instituting a hold-harmless provision that would allow out-of-network providers to provide 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. DHCS should establish such a provision and inform plans of the requirement in this APL.

Nursing Facilities

We are very pleased to see that individuals who have resided in a nursing facility for six months or more can continue to do so even where the facility is not in the plan's network throughout the demonstration period. We do not see, nor does the APL provide, any reason to not extend this protection to those who have resided in a facility for less than 6 months. This protection should be available to all individuals residing in a nursing facility prior to enrollment in the demonstration.

Durable Medical Equipment

[2] 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.

We applaud DHCS for extending COC protections to DME. We encourage DHCS to also apply COC protections to DME providers. We have spoken to many beneficiaries who believe access to their DME providers is as important as access to their primary care physicians. These individuals have seen their DME providers for many years and these providers are familiar with the very unique needs of the beneficiary. No other state with an MOU has excluded DME providers from COC rules.

We suggest that DHCS put in place a safety-valve policy by developing an exception process for beneficiaries to maintain access to their DME providers under certain circumstances.

Again, thank you for the opportunity to comment on this APL. We look forward to continued collaboration and discussions regarding continuity of care.

Sincerely,

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