NSCLC
National Senior Citizens Law Center
PROTECTING THE RIGHTS OF LOW-INCOME OLDER ADULTS

January 30, 2015

Department of Health Care Services
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Re: Comments on the Duals Plan Letter addressing Continuity of Care for Cal MediConnect Plans

We are submitting comments in response to the recent amendment to Duals Plan Letter (14-004) addressing continuity of care (COC). We strongly object to the proposed policy, which fundamentally alters the structure of the demonstration as set out in the MOU and three-way contracts by severely limiting a beneficiary's right to access a plan's network of providers. The DPL states that if a beneficiary's in-network specialty provider is not in the same IPA/PPG as the beneficiary's primary care provider, the beneficiary only has continuity of care rights to continue seeing the in-network specialist, and, at the end of the continuity of care period, must switch to a specialist within the IPA/PPG network. As discussed below we specifically object to:

- The DPL provision applying care continuity limits to in-network providers who are not part of the network of the delegated entity.
- The broader restrictions that underlie this policy, restrictions that deny a CMC member full access to the plan's network of providers.

The proposed policy narrows the network of providers available to the beneficiary and consequently encourages beneficiaries to disenroll from the plan. The following examples from the Cal MediConnect Ombudsman program illustrate the deleterious impact of the policy in practice.

## I. Beneficiary Examples

### Beneficiary A

Beneficiary A is 53 years old and suffers from congestive heart failure. She was under the care of a cardiologist she had been seeing for over five years. She called the Ombudsman on the day before an upcoming cardiology appointment. Her cardiologist had told her that she could not be seen because of her passive enrollment in a Cal MediConnect plan. The Ombudsman contacted the Cal

MediConnect plan and was informed that the cardiologist was in fact a contracted provider with the plan, but because the cardiologist was not contracted with the beneficiary's PPG, she would need to first see her PPG primary care physician to obtain a referral to see the cardiologist. Because the member had decided to disenroll from Cal MediConnect effective the following month, she decided not to schedule an additional appointment with her Cal MediConnect primary care physician, but instead postponed her cardiology care until the disenrollment from the plan was processed.

**Beneficiary B**

Beneficiary B is 70 years old and is diagnosed with liver cancer, dementia, diabetes, and other conditions. While the beneficiary was living in a nursing home, her authorized representative called the Ombudsman after the beneficiary's appointment for a CT SCAN had been canceled due to her passive enrollment into a Cal MediConnect plan. The beneficiary was scheduled for the imaging so that her oncologist could determine the course of her chemotherapy. After the Ombudsman requested continuity of care, the plan said that she would need to see her in-network PPG primary care physician in order to receive referrals to see her oncologist and neurologist. The beneficiary had to request continuity of care to see her neurologist who was contracted with the Cal MediConnect plan but not with the beneficiary's PPG. Due to the delay in obtaining her care and the limited access to her current providers, the member decided to disenroll from the Cal MediConnect plan and postponed her cancer treatment until her disenrollment was processed.

These two examples highlight a number of significant issues with the proposed policy:

1. The proposed policy restricts access. It increases the likelihood that a beneficiary will experience disruption in their care from providers with whom they have a pre-existing relationship by placing an additional hurdle in retaining access to them. Although plans can, at their discretion, continue to grant COC after the six month period is over, an effective, beneficiary-centered policy would not apply COC to in-network providers. Additionally, even if beneficiaries may not have pre-existing relationships with in network providers, those who enroll in a health plan expect to have access to – and have been told they will be able to see – the plan's *entire* network of providers, not a limited network defined by their PPG assignment (See Section III below).

2. The proposed policy creates procedural inconsistencies in how to access COC. Beneficiaries who have providers who are in their plan's network but who are not in their PPG network may have more difficulty accessing their providers than if their providers were outside of the plan network entirely. If beneficiaries have providers outside of the plan's network, they only need to request continuity of care and do not need to obtain a referral from their PPG primary care physician to see their provider.

3. The proposed policy encourages disenrollment. In both examples, beneficiaries disenrolled from the plan to maintain access to their providers – providers who are in fact contracted with the plan from which they are disenrolling. Unfortunately, even if beneficiaries change

their mind and decide to re-enroll into a plan, they are discouraged from doing so because per the policy outlined in the DPL, continuity of care does not apply again if a beneficiary disenrolls and returns to fee-for-service Medicare.

4. The policy will also encourage beneficiaries to switch primary care physicians in order to retain continued access to their specialists. This undermines the primary goal of the Cal MediConnect program – to provide coordinated care. Relationships with providers will also be harmed when beneficiaries are forced to change to a new provider to maintain access to others.

**II. The policy is contrary to the core design of the Cal MediConnect program**

The Memorandum of Understanding (MOU) entered into between the Department and CMS does not envision or permit the limitations on provider networks contained in the DPL. The MOU provides that participants "will select their health care providers in the Participating Plan network (or as allowed for by continuity of care provisions) and control care planning and coordination with their health care providers" (p. 80).

The network adequacy provision in the MOU also clearly links beneficiary provider choice to the network adequacy standards for the plan, not for some more limited subset of providers: "Network adequacy standards are described in section IV.C. Under these standards, beneficiaries will have a choice of providers among a broad network of primary care providers, behavioral health providers, specialists, ancillary providers, hospitals, pharmacists, and providers of long-term services and supports" (p. 81). Further, the network adequacy standards set forth by CMS for Cal MediConnect plans defines adequacy at the plan level, not the delegated level.[1] The proposed policy renders network adequacy standards meaningless.

The three-way contract echoes the requirements set forth in the MOU, requiring annual demonstration that the plan is meeting network access standards of both Medicare and Medi-Cal (p. 62, sec. 2.10.2). The three-way contract also explicitly indicates that an enrollee choice of a PCP overrides a plan assignment, yet says nothing that allows plans to use that PCP choice to limit rights to access other providers in the plan network (p. 64, sec. 2.10.4.5). The contract requires plans to maintain up-to-date provider directories, but the required content is silent on limits related to IPA/PPG affiliation (p. 120, sec. 2.17.5.11 et seq.).

Finally, we endorse the comments submitted by the Health Consumer Alliance outlining how the proposed policy is contrary to existing state law governing continuity of care protections applicable to Medi-Cal plans.

[1] See CMS Memo dated October 30, 2014, addressing network adequacy standards for dual demonstration plans available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MMPMedicareNetworkAdequacyStandardsMemo10302014.pdf

## III. Consumer outreach and communication provides for continuity of care at the plan level

Consumer outreach and communication throughout the demonstration have told beneficiaries that they have the right to use providers in the plan's network. For example, the Los Angeles choice booklet (p. 14) includes the following FAQ:

> **Can I still go to my regular doctor(s) if I join a Cal MediConnect plan?**
>
> Yes, if your doctor(s) is part of your Cal MediConnect plan's provider network. You can see each plan's provider directory on its website, or call a plan to request they send you a provider directory in the mail. You can ask your doctors if they work with the Cal MediConnect plans in your area. Under certain circumstances, if you see doctors who are not part of the Cal MediConnect plan's network, you can keep seeing those doctors for up to six months if they agree to work with your new health plan. See page 16 for more information.

The online provider directory lists providers by plan, not IPA/PPG and nowhere tells beneficiaries that they will be restricted from seeing some in-network providers due to IPA/PPG affiliation.

Similarly, Cal MediConnecToons tells beneficiaries: "Call your health plan or HICAP to find out if your doctor is in-network."

Moreover, the continuity of care portion of the CalDuals website states:
Dual eligible enrollees in a Cal MediConnect plan will eventually be required to receive all covered services from physicians and ***other providers who are part of the plan's network***. However, enrollees in a Cal MediConnect plan will have continuity of care rights – the right to temporarily continue seeing an existing physician ***outside the Cal MediConnect network*** for a specified period following enrollment. (Emphasis added).

During trainings, speeches, and one-on-one counseling, the Department, its consultants, HICAPs, and consumer advocates, including the undersigned organizations, have echoed these themes and relied on their accuracy. The uniform message has been that (1) beneficiaries should look at the network of a Cal MediConnect plan (not an IPA/PPG) in making a plan decision; (2) continuity of care protections are needed and available for out-of-plan-network (not IPA/PPG) providers; (3) beneficiaries have the right to choose providers within the plan (not IPA/PPG); and (4) there are no limits on that choice within a plan, and a decision to change one provider does not necessitate a change to other in-network providers. Beneficiaries have relied on this messaging to make important enrollment decisions.

## IV. The proposed policy is not justified by the plans' contractual agreements with its delegated entities

We understand that the justification set out for this proposal is that the plans have set up capitated arrangements with the delegated entities that do not allow for seeing providers outside the IPA/PPG network. We recognize that DHCS and CMS have given plans wide latitude to design

payment structures with contracted providers. However, plan sub-contracts do not alter basic plan responsibility to comply with the terms of the demonstration. The three-way contract provides:

> 2.9.9.1. The Contractor remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract (p. 52).

Plans cannot use the payment structures that they designed to limit basic beneficiary access rights because they are inconvenient for the payment designs of the plans' own creation.[2]

If the Department were to adopt the DPL's proposed amendment, it would undermine the hard work that many have undertaken to accurately inform beneficiaries and providers about how the Cal MediConnect program works and beneficiary rights to access providers. Also, it would undermine the goals and design of the entire program. At a time of unexpectedly high opt out numbers and a Governor's budget message encouraging plans to undertake new efforts to increase enrollment, it is counterintuitive to adopt a policy that will limit choice and make the demonstration less attractive to beneficiaries.

Thank you for the opportunity to comment on this important policy change. We welcome the opportunity to discuss our position further. Please contact Amber Cutler, Staff Attorney with the National Senior Citizens Law Center at acutler@nsclc.org.

Sincerely,

National Senior Citizens Law Center
Cal MediConnect Ombudsman Program
California Health Advocates
Center for Healthcare Rights – Los Angeles County HICAP
Disability Rights Education and Defense Fund
Legal Aid Foundation of Los Angeles
National Health Law Program
Western Center on Law and Poverty

[2] The Department should maintain a consistent definition of "in network." By comparison, in the context of Medi-Cal only seniors and persons with disabilities (SPDs) whose Medical Exemption Requests (MERs) from managed care require that current providers are not in network, the Department interprets that requirement at the plan and not the delegated level.