NLSLA

Neighborhood Legal Services
of Los Angeles County

Changing Lives and Transforming Communities Since 1965

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RE: **Consumer Stakeholder Perspective: Implementation Pitfalls Enrolling Seniors and Persons With Disabilities Into Medi-Cal Managed Care**

Honorable Ladies and Gentlemen of the Legislature,

It is my pleasure to represent Medi-Cal recipients at this Joint Oversight Hearing of the Senate and Assembly Health Committees into moving Seniors and Persons with Disabilities into Medi-Cal Managed Care. My name is Katie Murphy and I am the Supervising Attorney of the Health Consumer Center at Neighborhood Legal Services of Los Angeles County. NLSLA serves over 70,000 low-income Los Angeles County residents a year to alleviate the harmful effects of a life of poverty.

NLSLA has worked closely with LA Care to improve implementation as much as possible, troubleshooting cases and delivering 20 trainings to hundreds of provider groups and community organizations to help reduce confusion and help consumers learn to use managed care. However, despite these efforts and the hard work of our health counselors, assisting Seniors and Persons with Disabilities as they enroll into mandatory managed care has been the most confusingly implemented, frustrating policy change in health care in at least a decade. These cases are incredibly time-intensive for our advocates, often with uneven results and bad health outcomes.

Through case examples and recommendations, I highlight the labyrinthine unavailability and uneven application of Medical Exemption Request (MER) and continuity of care processes, which cause harmful interruptions and delays in care. These problems exist because of uneven and incomplete implementation by DHCS, and often a refusal to fix problems as systemic and a focus only on individual circumstances, dismissed as aberrations. This is unacceptable. Poor Californians' health and lives hang in the balance. Our clients need enforcement and clarification of existing policies to ensure a successful transition to managed care. I will highlight common consumer experiences and include more in the handout of my testimony.

A. <u>Many Enrollees Do Not Receive Notice of Mandatory Enrollment</u>

1. Mr. Ricardo never received any notice or information about mandatory managed care enrollment. He had not moved and his current address is on file with Medi-Cal. He would

have been defaulted in October, except that his doctor knew enough about managed care to fax the exemption form to HCO. Mr. Ricardo is severely ill: he has diabetes, asthma, chronic back and knee pain, sleep apnea, and obesity. His exemption request is still pending.

If DHCS invested in a more purposeful default process, not relying solely on linkage but ensuring knowledge and choice before transition, Mr. Ricardo and others like him would not be defaulted without ever getting notice of the mandatory managed care requirement. Also, if DHCS had held more than one consumer meeting in all of Los Angeles County, SPDs may have better understood the process and its requirements.

B. Health Care Options Routinely Denies Managed Care Exemption Requests

2. Baby Elsa, who has dwarfism/acrhondoplasia, receives medical care from specialists at UCLA and Cedars Sinai Medical Centers. None of her specialists contract with the Medi-Cal Managed Care Plans in Los Angeles. One of her genetic specialists is the only provider in this specialty in all of Southern California. Despite a very complicated medical condition, HCO denied her request for an Exemption. Her appeal is pending.

   If DHCS followed its own exemption regulation, Baby Elsa's doctor's medical opinion that her condition is severe and complex needing his management and coordination would be relied upon and her exemption granted to remain under his care.

3. Mr. Thompson is on dialysis and has submitted 13 Emergency Disenrollment Requests to HCO, most of which HCO denies ever receiving. The requests that were received were denied on technicalities. Frustrated by the lack of true response from HCO, Mr. Thompson's dialysis social worker finally sent the Disenrollment Request by Federal Express, only to be told later that HCO does not accept any mail and the Request should again by faxed to HCO. Mr. Thompson's vascular surgeon is not enrolled in any managed care plan, and the social worker has been unable to arrange for authorization for Mr. Thompson to receive out-of-plan care to repair Mr. Thompson's dialysis shunt.

   If DHCS had better procedures in place to monitor and respond to exemption requests, the fact that Mr. Thompson's surgeon and dialysis provider argue for continued treatment would be evaluated, and Mr. Thompson would not be going without care for his dialysis shunt.

C. Continuity of Care Denials Result in Delays and Poor Coordination of Care

4. Mr. Rios, age 63, has bilateral leg amputations. He is blind and also has epilepsy, schizophrenia and diabetes. He is on multiple medications and requires care coordination. Because Venice Family Clinic had coordinated his care since 1994, he completed the Choice Form and selected HealthNet and an Independent Physician Association (IPA) that included Venice Family Clinic. At the time he became mandatory, he had Treatment Authorization Requests that had been approved with Fee-For-Service providers for eye surgery, a replacement wheelchair, diabetic wound care and physical therapy. Not only did HealthNet refuse to authorize continuity of care with Mr. Rios' prior treating physicians, it also refused to honor the approved authorizations for care. Because Mr. Rios' many conditions require coordination, his advocate attempted an emergency disenrollment from mandatory managed

care. The very broken disenrollment process took nearly a month, at which time it was denied because Mr. Rios had been in the plan more than 90 days.

If DHCS enforced its own rule in MMCD Plan Letter 11-19 requiring continued treatment and medications upon enrollment in a plan, the plan would have to coordinate with his Fee-for-Service physician and provide the treatments and medications already authorized by Medi-Cal.

5. Ms. Irena, age 58, defaulted into managed care. She was not allowed to stay on FFS after she timely appealed the denial of her exemption request. She is undergoing follow-up care from a hysterectomy for cervical and ovarian cancer. When she came to us, she had missed her follow-up appointments for months while L.A. Care engaged in the cumbersome contracting process with her oncologist. Ms. Irena also missed a scheduled MRI and an appointment pending with a rheumatologist.

   If DHCS kept Ms. Irena in Fee-for-Service and provided additional guidance and assistance to plans and Fee-for-Service providers to make continuity of care a reality, Ms. Irena would not have missed care while the new business model was arranged between the Fee-for-Service provider and the plan.

D. <u>Individuals Are Not Receiving Aid-Paid-Pending While Disenrollment Requests and Appeals Are Being Processed; Information From HCO and the Managed Care Ombudsman is Frequently Misleading</u>

6. Ms. Robinson was undergoing chemotherapy for breast cancer when she defaulted into a managed care plan. Her oncologist is not on any managed care plan and submitted several exemption requests to HCO. HCO denied each request on a technicality. When HCO was unresponsive to Ms. Robinson, we assisted her in contacting the Medi-Cal Managed Care Ombudsman's Office. The Ombudsman's Office agreed to assist with the Exemption Request, but told Ms. Robinson, in contravention to DHCS policy, that she had to remain in managed care pending the Exemption processing.

7. Mr. Sahidi, age 61, sent his exemption request to HCO at least 5 times. HCO denies ever receiving it. HCO then defaulted Mr. Sahidi into L.A. Care. His exemption request lists neuralgia, complex neurological disorder, disc disorder, disease of spinal cord, vertiginous syndrome, and labyrinthine disorder. Mr. Sahidi timely requested a hearing on the exemption denial. He did not know to request Aid-Paid-Pending at the time he requested a hearing. When our office advised him of the Aid-Paid-Pending rules, he called the Medi-Cal Managed Care Ombudsman, who told him that he could not remain in Fee-For Service because he did not request Aid-Paid-Pending at the time he requested the hearing. This is contrary to stated DHCS policy on Aid-Paid-Pending for the SPD population. In addition, when Mr. Sahidi called to find out the status of one of his exemption requests, he was told it could not be approved because the state did not have enough evidence. Only when an advocate got involved did we learn this meant the state needed 5 treatment notes. No one had ever requested these from Mr. Sahidi or his doctor.

8. Ms. Wilson, age 42, defaulted into HealthNet despite a timely appeal of her MER denial. She is under active treatment for schizoprhrenic affective disorder and pituitary gland problems. When she called HCO to request an appeal, the HCO representative told her that

because she would be defaulted into Managed Care anyway in 12 months, she did not need to keep her FFS and might want to drop her appeal.

If DHCS required its vendor at HCO to adhere to its own policy to keep patients on Fee-for-Service pending an exemption request or appeal, these patients either would not have defaulted or could be restored to Fee-for-Service and continue seeing their doctors pending appeal.

E. Voluntary Enrollees are Being Defaulted into Managed Care, Causing Unnecessary Care Disruption

9. Mr. and Mrs. Saltado are enrolled in Medi-Cal and Medicare, and therefore should have remained voluntary managed care enrollees. Unfortunately, both were defaulted into a plan. Mrs. Saltado went 3 days without her insulin before she called our office for assistance. She had not received any notices about the transition to managed care, and was unaware of the plan assignment. She was defaulted to a primary care provider nearly 30 miles from her home. HCO refused to disenroll her. Our office spent significant time advocating for Mrs. Saltado to get her medication from the Plan. Mr. and Mrs. Saltado are still having difficulty returning to Fee-for Service Medi-Cal.

10. Ms. Henderson is a new Medi-Cal recipient who also just received her Medicare card. She has stage 3 colon cancer and had stage 2 thyroid cancer, and her blood work is not currently normal as to either, requiring close monitoring by her physicians. Just this week, DHCS and DMHC tell us that she has to enroll in Medi-Cal managed care in early 2012, even if her Medicare card is in effect a month or two later. She will need to enroll in January and undergo the exemption process, even though her Medicare will begin March 1, 2012, which will make her voluntary.

If DHCS required careful scrutiny of voluntary managed care categories and allowed flexibility for those about to transition into one, neither of these patients would have to grapple unnecessarily with these complex procedural requirements and could keep their Fee-for-Service Medi-Cal.

F. Individuals are Experiencing Delays and Interruptions in Care Upon Enrollment Into Managed Care

11. Mr. and Mrs. Rubichov do not speak or read English and did not understand that they needed to sign up for managed care and may not have received notices, so they defaulted. Once they were enrolled, they have had tremendous difficulty knowing where to receive care and obtaining medical equipment that was authorized under Fee-for-Service Medi-Cal, such as adult diapers.

12. Mr. Rios described above has been unable to fill his various prescriptions authorized under Fee-for-Service, despite many refills remaining.

If DHCS enforced its own rule in Plan Letter 11-19 requiring plans to honor existing prescriptions and treatment authorizations while working out an affirmative treatment plan with the previous physician, these patients would not go without necessary medical equipment and prescription drugs.

These consumer stories are not aberrations. We start advocacy with every single client by educating the client about managed care and seeing if we can facilitate enrollment. Only if they have severe health needs and providers who are not in managed care do we proceed with MER and continuity of care requests. The stories demonstrate common problems for patients who make it to our office for help.

It is also very common for patients to experience multiple problems, such as denial of an exemption request, inability to get aid paid pending the request, and difficulty getting prescriptions or services already authorized. Stories like this come into our office daily. We know they represent many more who are unaware of their rights and do not know what to do.

RECOMMENDATIONS

To improve health outcomes and give consumers a smooth transition into managed care, we make the following recommendations:

1. **There must be a warmer handoff to the plan to ensure continuity and minimize interruptions of care, drug and treatment interruptions.**
   - Consider a cooling period to allow individuals to stay with their FFS provider and ease in to plan enrollment for patients with indicia such as numerous providers, specialty care, or ongoing treatment and multiple medication needs.
   - Enforce MMCD Plan letter 11-19 which says (9-21-11 at p.3) that refills will be honored. If a drug is not on the plan formulary, the plan must obtain verifications from the provider within 24 hours, and provide the drug while working out a care plan with the physician.

2. **Fee-for-Service "status quo" coverage must be automatically available pending a Medical Exemption Request or appeal of a denial, consistent with DHCS's stated policy.**
   - There needs to be training of the HCO and Ombudsman and scripts that identify this issue anytime a consumer requests or appeals an MER.
   - Systems should be automated to ensure FFS without requiring a patient to know to ask for it.
   - Patients and providers should be given notice with the MER instructions that FFS is available and will be extended pending the MER.
   - A new provider bulletin and plan letter should issue.

3. **Policy for MER approvals must be published, clarified, and modified.**
   - The existing standards for approval should be made publicly available to minimize uneven application and confusion.
   - DHCS should revise the MER approval policy to consider factors such as coordination of many specialists, ongoing treatment, care that is stable only because of delicate coordination, care that has been progressive such as engaging in step therapy
   - DHCS should revise the MER form to clarify what is requested/required of the doctors, including doctors' notes.

4. **Continuity of care should be much more user-friendly and made readily available for anyone who seeks it.**
   - DHCS should give consumers notice that they can ask to stay with their doctors. Plan letter 11-19 (9-21-11 at pp. 1-2) says consumers can stay with their providers by requesting. As demonstrated by the stories I am sharing with you, this is not happening.
   - DHCS should enforce rules regarding the plan's obligation to affirmatively work with the provider for ongoing treatment or medication and provide treatment in the interim
   - DHCS should enforce rules that TARs and refills must be honored pending transition to new plan by PCP.
   - DHCS must do a better job of educating Fee-for-Service providers and IPA's on the new continuity of care rules, in addition to plans.

5. **Procedural disconnects must be eliminated so agencies handling consumer requests and questions are well-informed and reliable.**
   - HCO and the Ombudsman should be re-trained and consumer stakeholders be given information about the current protocols and training materials.
   - All requests should be tracked with date stamping and consumers or providers be issued a receipt.
   - DHCS should install a formal complaint process for HCO and Ombudsman.
   - Data should be made publicly available with more information about MER and continuity of care than is in the dashboard, and without a 5-month delay, including HCO and Ombudsman requests for information and clarification.

Thank you for the opportunity to give voice to these consumers' plights today. We provide these recommendations to enforce existing rules, clarify and improve procedures and requirements in an attempt to ease this very difficult transition for the clients we serve. We have raised these issues as well as these fact patterns, albeit from clients assisted in an earlier month, several times in meetings with DHCS since the beginning of implementation. We are pleased the legislature is exercising its oversight function and ask your assistance in getting DHCS to clarify, enforce, and improve its policies and procedures.

Many Seniors and Persons with Disabilities cannot simply transition to managed care without assistance. It is unacceptable to require the sickest and most vulnerable among us to become their own medical care managers, particularly when the rules affecting their access to life-saving care are moving targets. We urge the members of the legislature to continue oversight of implementation, seek data and reports, and consider a cooling off period of further implementation until key policies are stabilized and clarified.

Sincerely,

Katie Murphy

Katie Murphy
Supervising Attorney, Health Consumer Center