Stakeholder Comments For Improving The CCI – Cal MediConnect
Submitted By The
California Association of Health Facilities
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We applaud the Department's efforts to evaluate and explore future options for improving California's management of the Coordinated Care Initiative. The initial startup phase of the program and its implementation experienced many significant problems. These included patients losing contact with existing physicians, enrollment confusion, practices without needed specialists on staff, significant provider billing issues and opt out for the program that is too complex to navigate.

While some of these initial startup issues have been reduced, many continue to date.

Below, we have highlighted ongoing issues that we believe the Department should re-examine and consider the recommendations in order to help improve the viability of the program in the future.

1. **Improving and strengthening Continuity of Care.**
CCI Continuity of Care policies are not uniformly applied by all Plans. Beneficiary's rights are challenged in their ability to continue seeing non-participating physicians for a limited time. It is recommended that working with CMS, DHCS match the Medicare continuity of care timeframes with what is required for Medi-Cal providers. This will extend the care period for Medicare services from 6 months to 12 months. Match the Cal MediConnect number of specialist visits with what is required on the Medi-Cal side.

2. Require all Plans and delegated entities to use a uniform Health Risk Assessment and LTSS Referral Program. Presently, Plans do not use uniform HRA's in assessing the needs of LTSS beneficiaries. Consequently, there is a disruption in the continuity of care for beneficiaries when referred from one Plan to another or to a delegated entity.

3. Cal MediConnect eligible beneficiaries who want to enroll into a Cal MediConnect health plans during routine communication with their current Plan are unable to make that enrollment choice seamlessly. Health plans are currently required to direct beneficiaries to Health Care Options (HCO) to required enrollment into a Cal MediConnect Plan. Health plans talking to beneficiaries over the phone must ultimately transfer beneficiaries to an HCO, which adds to the time a beneficiary must spend to make an enrollment decision. These limitations place additional and unnecessary burden on the beneficiary, many who have complex health needs. It requires them to take additional steps to make choices about health coverage and may impact their ability to join a Cal MediConnect health plans.
Beneficiaries in San Mateo and Orange counties are not subject to these rules. The Medi-Cal health plan in these counties can enroll members directly into the Cal MediConnect health plan. It is recommended that all CCI counties be authorized to enroll members directly into the Cal MediConnect health plans therefore allowing immediate access to required services in a timely manner.

Additional Recommendations/Issues

4. **Continuity of care after acute hospital discharge.**
DHCS must require that health plan entities verify that delegated entities are complying with continuity of care provisions. There have been a number of cases when a beneficiary is a resident/patient in a SNF and he/she is admitted to the acute care hospital. When the beneficiary is discharged, he/she must be given the option of returning to their "home" (initial SNF) for either skilled or custodial level of care. Delegated entities are refusing to authorize return to the initial SNF if it does not have a contract with that SNF. In several instances they have threaten or have moved residents to a contracted SNF.

5. **Education about Continuity of Care for Physicians:**
DHCS must insure that the Plans, delegated entities and physicians are complying with provisions of DPL 14-002. Presently, many delegated entities are not informing both the beneficiary and the provider about continuity of care provisions. It is recommended that the new physician work with the out-of-network physician, the beneficiary, the family and the SNF medical director prior to re-writing current or new treatment orders.

6. **Delegated Entity Contracts:**
Health plans must verify that delegated entities have executed Cal MediConnect contracts that are consistent with DPL 14-002. Required provisions include prompt payment, electronic claims payment, identification of responsibility for Medi-Cal share copayment/deductibles, continuity of care, change in beneficiary condition and discharge, and authorization of services. If the delegated entity is assuming risk for Medi-Cal services, Plans must require delegated entities to be responsible for Medi-Cal rates/retroactive payments and share of cost compliance, including Johnson v. Rank provisions, and honoring DHCS TARs for up to six months. DHCS must insure that Plans and delegated entities clearly state who is responsible for authorizations and claim submittal.

7. **Delegation of Contracts:**
Presently, there is a great deal of confusion in reference to delegated entities in terms of basic information. There needs to be an approved and published list of delegated entities for all CCI counties with contact information, including party responsible for authorizing care, and; claims payer, contracting entity, Management Services Organization (MSO).

8. **Confusion for Reimbursement for Out-of-Network SNF's**
Beneficiaries may be in the SNF receiving skilled care when they are enrolled into the health plan/delegated entity. Out-of-network SNF's are entitled to receive full RUGs payment for the duration of care. There is confusion among the health plans and frequent delays in reviewing who is responsible for payment. DHCS should oversee this issue to make sure the Plans and delegated entities take responsibility for these payments.

9. **Delays in Authorization and Payment for Out-of-Network Providers:**
This continues to be a growing problem in meeting requirements of the continuity of care provisions. If a beneficiary has initiated treatment at the Medicare skilled level of care under fee-for-service, then is enrolled in a health plan, the out-of-network provider is entitled to 100% of RUGs reimbursement. DHCS should require delegated entities to immediately issue letters of agreement. SNFs are having difficulty in obtaining authorizations and payments from delegated entities and are forced to file appeals in order to obtain payment.

10. **Lack of Timely Written Authorization of SNF Services:**
DHCS should require delegated entities to issue written authorizations within 24 hours of verbal authorization. Presently, most delegated entities will not issue authorization until the patient is discharged. This delays the billing for services and impacts cash flow. Additionally, it is not an uncommon occurrence for the written authorization to be markedly different than the verbal authorization because of "errors."

11. **Delayed Authorization of SNF Services:**
Delegated entities are refusing to authorize SNF services until the assigned physician can assess the beneficiary, but the acute hospital wants to discharge the patient to a SNF. This issue arises with newly enrolled beneficiaries who haven't established relationships with their new physicians. In addition to impacting continuity of care requirements, and to avoid extended hospitalizations, DHCS should require that IPAs and delegated entities to issue prior authorizations for at least 7 days until physician/patient contact has occurred.

12. **Electronic Claims Processing:**
Although APL 15-004 mandates that Plans must be able to accept and pay claims electronically, many plans do not meet this requirement. Manual intervention at the plan level frequently results in payment delays and errors. Plans are repeatedly requesting hard copies of supporting documents resulting in significant increases in SNFs labor costs in manual submissions and appeals. DHSC should require standardization for all Plans of their billing and claims processing systems and compliance with APL 15-004

13. Failure to pay AB 1629 SNF Retro Rates for 2014-15:
Final rates were published in May 2015. Plans have failed to initiate appropriate payments to skilled nursing facilities for services provided from August 1, 2014 through July 31, 2015. DHSC should immediately require compliance by the Plans and immediately pay the long overdue retro rates.

Thank you for your review and consideration of our comments and recommendations.

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The California Association of Health Facilities (CAHF) is a nonprofit professional association.
Members include skilled-nursing facilities, subacute-care facilities, intermediate-care facilities, intermediate-care facilities for the developmentally disabled, and institutes for mental health facilities.