The Health Consumer Alliance

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December 26, 2014

Peter Lee
Covered California

Toby Douglas
California Department of Health Care Services

Dear Mr. Lee and Mr. Douglas:

The Health Consumer Alliance (HCA) is writing to raise concerns about the current policies and procedures in place for current Covered California enrollees who have been redetermined eligible for Medi-Cal at annual renewal and who will lose Covered California coverage effective January 1, 2015. We believe that the current plans, as we understand them, will be extremely disruptive to patient care and will cause consumer confusion. Due to the short time frame and IT issues, we understand that delaying the transition from January 1 to mid-January may not be possible. Instead, we strongly recommend that consumer protections and workarounds be put in place immediately to ensure that the transition between programs is as seamless as possible and that coverage translates into actual access. We write to both of you with our concerns because Covered California and the Department of Health Care Services (DHCS) each have specific roles and responsibilities to protect consumers during this transition from Covered California to Medi-Cal.

Our first concern is with the lack of sufficient notice to these affected consumers. As required under federal law, Covered California must provide enrollees adequate and timely notice of any change in their eligibility. 45 CFR §155.310(g). Specifically, at annual redetermination, Covered California must provide sufficient notice to an enrollee which "allows a reasonable amount of time for the enrollee to review the notice, provide a timely response, and for the Exchange to implement any changes in coverage elected." 45 CFR § 155.335(d)(2)(ii). Most importantly, when terminating coverage, Covered California must provide an enrollee ***at least 14 days notice*** before the "effective date of termination." 45 CFR § 155.430(d)(1)(i); 10 CCR § 6506(d)(1).[1] Based on our understanding, enrollees who will be losing Covered California coverage as of 12/31/14 will not receive proper notice of their termination until they receive a notice that is set to be mailed on 12/29, providing enrollees less than 14 days notice of their coverage termination.

[1] In addition, Medi-Cal applicants and beneficiaries are entitled to 10-days' written notice in order to appeal and challenge determinations that may be erroneous. 22 CCR § 50179(d)(1).

Although an earlier notice was sent to these affected enrollees, the content of the initial notice was not sufficient for proper notice. The initial automated notice sent from CalHEERS (NOD01) when they were newly redetermined only informed these affected enrollees that they are eligible for Medi-Cal; the notice did not indicate that they will be losing Covered California coverage as of 12/31/14. As a result, the NOD01 notice is an inadequate notice for informing consumers that they will be terminated from their existing coverage. Furthermore, neither version of the notices to these affected enrollees has been translated for enrollees whose primary language is other than English and Spanish and as a result, both versions of the notice remain insufficient notice for these enrollees. 45 CFR §155.205(c)(2).

Because the notice being sent on 12/29 does not provide timely notice, delaying the transition and termination of these consumers would have been a preferred solution. However, we understand that this is not possible based on all the IT fixes that would be needed to delay the transition. Although the transition from December 31 to January 1 may violate due process protections, we urge Covered California to ensure that due process protections are in place for future transitions. Proper notices, that are available in all threshold languages, must be received at least 14 days notice by any Covered California enrollees who transitions from Covered California to Medi-Cal in the future due to change in circumstances during the year or next annual renewal. The HCA would like to work with your staff and IT folks to ensure adequate notice is provided as soon as next month for enrollees moving from Covered California to Medi-Cal effective February 1, 2015.

In the absence of being able to provide adequate notice to enrollees losing coverage as of December 31, 2014 due to the current resource limitations, we strongly recommend the following steps be immediately taken to help mitigate the harm to these enrollees:

1) Provide Covered California enrollees with continued subsidized coverage pending appeal.

We understand that consumers who believe the terminations are erroneous will be able to file appeals and in doing so, will be able to continue their Covered California coverage if they choose to remain enrolled, but without premium assistance. However, under federal and state law, Covered California enrollees who file an appeal regarding their eligibility determination are also entitled to continue their premium assistance (or Advanced Premium Tax Credits (APTCs)) if the tax filer "accepts eligibility pending an appeal, the Exchange must continue the appellant's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed." 45 CFR § 155.525(b); 10 CCR § 6608(b). There is no mention of this right in the notice to consumers.

We now understand that it is the IT system that prevents Covered California from continuing the APTCs pending appeal rather than a policy decision that was made. In order to comply with federal law and protect consumers, we urge Covered California to develop a manual work-around as soon as possible to provide APTCs to any Covered California enrollee who files an appeal regarding the transition his or her transition from Covered California to Medi-Cal to preserve this right. We would like to work with your

staff on clarifying that protocol in writing. Once the protocol is adopted, that information should be provided to all call center staff as well as application assistors, agents, and the media. Most importantly, any future notices to affected enrollees should explain this right to continued subsidized coverage during an appeal.

2) Covered California must provide a process for timely redeterminations and retroactive reinstatement.

For many consumers who believe they remain eligible for Covered California and who file an appeal, we understand that it may take weeks to resolve the appeal. We recommend Covered California provide an expedited process specifically for reviewing requests from current enrollees who are newly eligible for Medi-Cal so that they may correct information and receive a timely new redetermination. We also understand that there are a number of consumers whose eligibility is being automatically redetermined based on information from the federal data services hub, yet consumers are unaware that this automatic "ping" of the hub resulted in a new eligibility determination and are not notified about the specific information that was updated in their account that led to the change in eligibility. Such consumers need to know what data the redetermination was based on in order to challenge information that may be erroneous. Covered California must ensure consumers whose eligibility has been redetermined know the basis for that action, whether the change was reported by the enrollee or via the federal data services hub.

In addition, if the appellant remains eligible for Covered California, we would like Covered California to clarify whether the coverage in the prior plan is retroactive in order to avoid gaps in coverage. We also request that Covered California service center representatives, application assistors and navigators be permitted to update information in CalHEERS for consumers who do not agree with the Medi-Cal determination to allow for quicker informal resolution for these affected consumers. It is our understanding that once a consumer has been found eligible for Medi-Cal, only the counties are able to make changes to the consumer's account and re-run the CalHEERS' business rules engine (BRE) for an updated eligibility determination. This places an unfair burden on the county workers who are already overwhelmed with fixing the application backlog as well as processing Medi-Cal renewals. Both Covered California and DHCS should be able to re-run the BRE regardless of whether or not the consumer has been found eligible for Medi-Cal or Covered California.

3) Protecting continuity of care for those transitioning from Covered California to Medi-Cal managed care:

Given the significant differences in the network of providers between an issuer's Covered California managed care plan and Medi-Cal managed care plan, we understand that consumers who cannot be cross-walked to Medi-Cal managed care plans will instead be randomly assigned to new health plans based on existing algorithms. This inability to transition individuals to the same plans or networks will inevitably disrupt existing care needs: prescription refills, prior authorizations that have already been approved, and existing appointments. Based on our experience assisting consumers with many disruptions during other transitions between programs (e.g., SPD, LIHP, CCI), existing continuity of

care requirements in Knox-Keene and Medi-Cal laws are not necessarily adequate to avoid confusion and disruption because the plans and providers require a great deal of education.

Therefore, we request DHCS require all Medi-Cal managed care plans to comply with continuity of care requirements and assist enrollees transitioning from Covered California to avoid disruptions in care. Specifically, we request that DHCS communicate the following points to the managed care plans and providers:

A) Even if a consumer remains in the same plan, provider groups may change. Therefore, it should be clarified that continuity of care protections exist to allow a transition between providers and to honor existing prior authorization requests.

B) If a consumer's issuer is different, then existing prior authorization requests should be approved until the consumer is able to meet with his or her new primary care doctor and obtain new authorizations. This would apply to scheduled surgeries, appointments with specialists, and all other approvals, such as for therapies, prescription drugs and durable medical equipment. We have confronted this specific issue in the CCI transition with respect to durable medical equipment and understand that DHCS is issuing an APL to make clear that existing authorizations will be honored. We would like to see a similar clarification for all existing prior authorizations for the affected enrollees transitioning from Covered California.

We also request that Covered California communicate to the newly eligible Medi-Cal enrollees' former Covered California plans that all prior authorizations will be approved under Medi-Cal and that they should cooperate with requests for information and justifications to support those approvals.

We believe the lack of due process and potential disruption in care for current Covered California enrollees who are newly eligible for Medi-Cal and who do not agree with the redetermination is urgent given the short notice and timing during the holidays. We appreciate that a meeting with Covered California staff is currently scheduled on December 30 to meet with us on these issues. We are already working very hard to prepare for the transitions locally and are certain that there will be many issues to resolve. Without these necessary consumer protections, we are prepared to pursue whatever legal recourse is necessary to protect our clients' interests. We look forward to discussing these recommendations with you as soon as possible.

Sincerely,
/s/
Michele Melden, Elizabeth Landsberg, and Sonal Ambegaokar on behalf of the HCA

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