Comments to the Board

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December 15, 2014 Board Meeting

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November 19, 2014

Secretary Diana Dooley, Chair
Covered CA Board

Peter Lee, Director
Covered California
1601 Response Road
Sacramento, CA 95814
Submitted electronically to Peter.Lee@covered.ca.gov

Re: Translation of Covered CA Notices

Dear Mr. Lee and Ms. Dooley:

We are writing to express our concerns regarding the lack of translation of consumer notices generated by the California Healthcare, Eligibility and Enrollment Retention System (CalHEERs) into Medi-Cal Managed Care threshold languages other than Spanish. California state law requires that forms and notices developed by CalHEERs:

> "…be developed using plain language and shall be provided in a manner that affords meaningful access to limited-English-proficient individuals, in accordance with applicable state and federal law, and at a minimum, provided in the same threshold languages as Medi-Cal managed care." Cal. Welf. & Inst. Code Sec. 15925 (2)

The lack of meaningful access for limited-English-proficient (LEP) individuals to consumer notices through the CalHEERs system is a major concern for both Medi-Cal and Covered California consumers who specifically indicated a preference for written and spoken communications in languages other than English and Spanish. The lack of translated notices into the other threshold languages impacts over 96,000 consumers in Covered California alone. These notices are vital documents as they contain important

information pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal.

The lack of translated notices has led to confusion and in the worst case scenario, loss of coverage. We know this because our organization Asian Americans Advancing Justice-LA and our Health Justice Network partners process these cases and while we have been able to resolve some of them, the experience is still very disruptive for the LEP consumers we represent. These cases are also very time intensive which means we often end up having to refer them to legal services providers or risk taking away from the other important client services we provide.

We can only speculate about what happens to those LEP consumers who lose health coverage and are unaware of where to go for help. We appreciate that Covered California notices do come with a separate page translated into the threshold languages indicating the availability of language assistance services at no cost. However notice of the availability of language assistance services is no substitute for clear information about the urgency and need for consumers to take specific actions in order to keep and maintain their health coverage as required by state law.

We hope that the Board will work with Covered California to prioritize the lack of availability of translated notices for LEP consumers applying for coverage through CalHEERs as well as the other concerns about Covered California notices raised by the Health Consumer Alliance in their November 14th letter to the Board. Thank you for your time. We look forward to discussing our concerns and recommendations with you.

Sincerely,

Doreena Wong
Asian Americans Advancing Justice- Los Angeles

Cary Sanders
California Pan-Ethnic Health Network

Cc: Covered California Board members

November 24, 2014

Mr. Peter Lee
Executive Director
Covered California
1601 Exposition Blvd.
Sacramento, CA 95815

VIA ELECTRONIC MAIL:
Peter.Lee@covered.ca.gov

Re: 2015 Renewal Process/Medi-Cal Eligibility

Dear Peter:

The California Association of Health Plans ("CAHP"), Health Access, and Western Center on Law and Poverty call your attention to the Covered California renewal process.

We are advised that Covered California informed the Qualified Health Plans (QHPs) that 5-10% of the consumers in the renewal process have been determined *likely eligible for Medi-Cal* based on 2013 income and 2014 Federal Poverty Level tables. It is also our understanding that these consumers are currently in the process of being terminated from their QHP and sent to the counties for a final Medi-Cal eligibility determination. This violates the mandate in Welfare and Institutions Code § 15926(h)(1) to provide a seamless transition between programs with no gaps in coverage.

This process may leave these consumers with no coverage – and, therefore, no access to services – for the time period during which they have been terminated from Covered California but have not yet been determined eligible for Medi-Cal. Some of these consumers may have needed medical appointments in the interim that they may not be able to access if their coverage is not clear. In many cases the consumer will actually be eligible for APTC coverage in Covered California and should have never been terminated. Either way, the result is potentially harmful to the consumer.

In order to prevent a lapse in coverage, these consumers should remain enrolled with their QHP using their 2014 APTC and, starting in 2015, the 2015 premium until they have been *determined* ineligible for Covered California. *See* 10 CCR §6506(b)(1). "Likely eligible for Medi-Cal" is not a determination of ineligibility. Such determination of ineligibility requires that consumers be notified (§6506(e)) and informed of their ability to request eligibility pending appeal (§6608) – in other words, consumers should be given the choice to continue their enrollment in a Covered California plan if they disagree with the determination. QHPs would maintain the enrollment of these consumers until such time that they are notified by Covered California that the enrollee has

been determined eligible and been enrolled in Medi-Cal. This would maintain continuity of care for consumers. Consumers who are certain they are Medi-Cal eligible and do not want to stay in their QHPs can stop paying their premiums at any time. This approach would be consistent with the federal marketplace and what is required under federal law.

This issue is extremely time sensitive as the renewal process is already underway. We request that you work with your staff to implement a change that will prevent the loss of coverage for these consumers. We appreciate your consideration of this very urgent matter and we are available to discuss the details at your earliest convenience. We look forward to continuing to work with you and your staff to make the 2015 open enrollment a success.

Sincerely,

Patrick Johnston	Anthony Wright	Jen Flory
Chief Executive Officer	Executive Director	Senior Attorney
California Association of Health Plans	Health Access	Western Center on Law & Poverty

California Medical Association
Physicians dedicated to the health of Californians

December 8, 2014

Mr. Peter Lee, Executive Director
Ms. Diana Dooley, Chairwoman
Ms. Kim Belshé, Board Member
Mr. Paul Fearer, Board Member
Ms. Susan Kennedy, Board Member
Dr. Robert Ross, Board Member
Covered California
1601 Exposition Boulevard
Sacramento, CA 95815

Submitted electronically to *Info@Covered.ca.gov* and *Peter.Lee@Covered.ca.gov*.

RE: Lessons Learned from Recent Non-Routine Surveys by the Department of Managed Health Care (DMHC)

Dear Mr. Lee and Board Members:

On behalf of our more than 40,000 physician and medical student members, the California Medical Association (CMA) would like to congratulate you on what is already shaping up to be another successful open enrollment period and again pledge our commitment to helping Covered California maintain its success in connecting Californians to affordable healthcare coverage. We hope to engage in more joint efforts getting the word out to physicians, such as the December 2nd press event and joint letter to physicians. It is in this same spirit of cooperation that we are reaching out to you now.

On November 18, 2014, the Department of Managed Health Care (DMHC) publicly released its findings from a non-routine survey of Anthem Blue Cross and Blue Shield of California, which unfortunately were consistent with our own findings. We have long been concerned with the state of provider directories in some of California's largest health plans and have conducted numerous internal surveys and analyses to this effect, some of which involved direct testing (e.g., calling practices to verify participation status) similar to that employed by DMHC. We applaud DMHC on utilizing direct testing of directories as a regulatory tool, as recently recommended by the U.S. Department of Health and Human Services' (HHS) Office of Inspector General[1] with regards to state Medicaid programs.

We further agree with the DMHC approach of adopting a consumer experience focus in conducting the surveys. Despite criticism of DMHC in the plan responses for using telephone contact as the primary means of assessing a physician's participation status, both directories audited in the report used directory disclaimers that instructed the enrollee to call or otherwise

[1] U.S. Dept. of Health and Human Services (HHS), Office of Inspector General (OIG), *State Standards for Access to Care in Medicaid Managed Care* (OEI-02-11-00320), 25 September 2014.

contact the listed provider to verify participation status. We believe, furthermore, this emphasis on point-of-service access appropriately places the responsibility for clear communication, comprehensible administrative policies, user-friendly information updating processes, and unambiguous contracting, among other things, in the hands of those best equipped to do something about it, the health plans, as opposed to relying primarily on DMHC to have the capacity required to effectively police the vast documentation this entails.

We agree with both Anthem and Blue Shield that miscommunications and misunderstandings were the likely cause of a significant percentage of DMHC's reported inaccuracies and failures to verify participation, and we further agree that, in such instances, physicians have a role in confirming participation status and ensuring that demographic data remains current. We all must work together to ensure the access for which consumers understand they are paying is the access that consumers are getting: physicians have a role in understanding their participation status and updating demographic information on a timely basis, while health plans have a role in ensuring that consumers can rely on directories being accurate and in ensuring that physician contracting is unambiguous and that updating information is straightforward and prompt for physicians. None of us should be satisfied with the current state of directories, and we accordingly believe that more can be done in our respective roles to improve the directories that consumers must rely upon to navigate plan networks.

The results of the DMHC surveys suggest that much more can be done to facilitate the role of the physician in increasing directory accuracy, particularly in two broad areas. First, active engagement and clarity about participation in a network from the outset is critical. After an opportunity to review clear and direct information on the network, an express assent or, at a minimum, an express acknowledgement of participation in a new network can substantially reduce or eliminate the potential for later confusion regarding participation status. Second, the process of and systems for updating demographic information with the plans could be significantly improved. For instance, the promptness of demographic updates would be improved if physicians could update their own demographic information online and if health plan systems utilized external data sources more effectively, such as in the identification of a discrepancy between data sources followed by the prompting of the physician to verify or update his or her demographic data. Such systems have been employed successfully in a number of other industries (e.g., banking) for more than a decade.

We offer three initial recommendations below to Covered California with the goal of improving the issues of communication and understanding that were discussed in both the DMHC's reports and the health plans' responses as contributing factors to the deficiencies.

RECOMMENDATION 1: Foster improved collaboration among providers and health plans to improve communication, the contracting process, and the means by which demographic information is verified and updated.

With over 40,000 physician and medical student members, CMA can often very quickly gauge the effectiveness and clarity of a major health plan's notices to and contracting efforts with,

among other things, the average physician practice in California. When we see or hear of significant issues in this respect, we raise them with our contacts at the health plan. Historically, our efforts have rarely resulted in a change to the document or practice at issue (assuming CMA received advance notice, which is also rare) or even resulted in changes going forward.

We do, however, believe that this dynamic with the health plans may be showing signs of improvement. The California Association of Health Plans (CAHP) has responded positively to our request to meet on the topic of improving provider directory information, and we will soon begin initial discussions to identify potential opportunities for collaboration here. We have also had a productive discussion with Blue Shield representatives regarding the company's evolving strategy, in concert with Anthem, to improve their systems for achieving and maintaining current provider data – a critical component of which involves streamlining the administrative demands on providers. Finally, we hope to resume joint meetings in 2015 among CMA, Covered California, and the four major participating health plans with a new energy and a focus on collaboration to improve the consumer experience.

With continued and assertive attention from Covered California, for at least the near-term, we are hopeful that the aforementioned collaborative efforts can produce significant improvements in DMHC's findings. A CMA role in producing such improvements may include the following:

- CMA member-wide communications publicizing new network or product names, important health plan notices or other mailings, and new health plan tools to verify and update demographic information and participation status;
- Cross-plan educational materials covering topics such as how to verify and update demographic information and participation status with the respective health plans, as well as stressing the importance of understanding participation status for all staff members who might respond to patient inquiries; and
- Offering a rapid review of important health plan notices, contract templates, and other materials from the physician practice perspective prior to them being distributed – with a particular focus on improving clarity and eliminating potentially problematic sources of confusion.

RECOMMENDATION 2: Using Covered California's authority as an active purchaser, require that providers' participation in reduced networks be only obtained via a separate, affirmative assent.

As we have stated in many of our previous comments to the Covered California Board, the overwhelming majority of confusion among our physician members over their participation status in the networks serving Covered California products stemmed from ambiguity in the initial health plan contract itself or from the current ability of preferred provider organization (PPO) health plans to passively include physicians in the new networks. Though the bulk of contracting for these networks is over, patients and providers would benefit from greater clarity in contracting as we move forward and networks continue to change.

Previous CMA surveys of physicians in the new networks identified contracting practices as the prime culprit of confusion over participation status – with 80 percent of physicians responding that they were at one point confused about their participation status and 20 percent responding that they were still unclear as to how they became a participating provider in a Covered California network. The contracting practices at issue for our members have been the use of "all products clauses," which are often exceedingly vague contract provisions that can bind a provider to participating in unspecified current and future products offered by the health plan, and the use of what are known as "silent amendments," which are unilateral changes to a provider's contract with the provider's lack of response to the amendment taken as acceptance of the changes. If such changes are made to a health maintenance organization (HMO) agreement, current law requires that the change first be negotiated and agreed to by the provider.

While we understand that Covered California seeks to avoid the perception of being a "third regulator," we contend that it would be fully within the exchange's power as an active purchaser to set standards as to how it wants the networks serving its consumers to be built, particularly in light of DMHC's survey findings. Ensuring that there is an understanding and acknowledgement of participation up front for the physician can largely eliminate the potential for lingering confusion over participation status down the road.

RECOMMENDATION 3: To achieve greater network transparency and improved directory reliability, continue encouraging and pursuing consumer-friendly technological improvements, such as creating an interface between health plan network management systems and a Covered California cross-plan directory.

Because the management of immense datasets is fundamentally a job for computers, technology is at the heart of administering a broad provider directory. Unfortunately, the technology utilized in the health insurance industry for directory management has not kept pace with the expectations of today's consumers – with some exceptions. For example, most consumers would expect the updating of a provider's listing to be almost instantaneous from the time that an update is submitted, but one health plan response to the DMHC survey quoted processing timeframes ranging from within 10 days to updates done on a monthly schedule. However, CMA has witnessed timeframes of up to six months, at times, for some plans to update practice demographic information as requested by the physician. Meanwhile, for many, if not most, banks, if an account holder signs into his or her online portal from a new computer, he or she is required to verify or update demographic information before proceeding.

For these reasons, CMA was truly excited to hear of Blue Shield's and Anthem's commitment to invest in upgrades to the systems managing providers' demographic information, which would include the capability for providers to manage their own respective data profiles online and automatically prompt providers to verify their information when a claim has not been submitted on an enrollee of the plan within a certain period of time. Such a system holds great promise for effectively addressing a number of the issues touched on above. We further hope that Blue Shield and Anthem will keep Covered California, DMHC, and relevant stakeholders apprised of their progress towards these new upgrades beyond DMHC's six-month reassessment of the health plans' directory information.

One potential capability of such a system, which we have not yet heard discussed by Blue Shield or Anthem, would be an interface between the health plan system and a Covered California cross-plan directory. An interface of this kind could allow for efficient or even automated updates of a cross-plan directory when a health plan's directory information updates. We strongly agree with many of the consumer stakeholder organizations that a Covered California cross-plan directory would greatly benefit consumers and we hope that Covered California can begin testing of a cross-plan directory in 2015.

A high-functioning cross-plan directory would provide significant benefits to both consumers and providers. Consumers would benefit from the ability to quickly and easily compare the providers available in their area across plans within Covered California's online enrollment system. The cross-plan directory would also serve as a single point of verification for physicians and other providers with regards to both participation status and demographic information, as discrepancies in information among plans would be flagged or potentially result in erroneous duplicate entries. Links to submit data updates and participation queries to the respective health plans could also be provided on the cross-plan directory page or window to aid in directory accuracy efforts.

Thank you for considering our input as we all strive to improve upon the consumer experience for 2015. We would welcome the opportunity to discuss these issues and recommendations as part of an agenda item at a future Board or Plan Management Advisory Committee meeting. We look forward to continuing to work with the Board and staff to realize the vision of improving the health of all Californians by assuring access to affordable, high quality care.

Respectfully Submitted,

Brett Johnson, Associate Director, Medical & Regulatory Policy, California Medical Association

Cc: Shellie Rouillard, Director, Department of Managed Health Care
Francisco Silva, Chief Counsel, CMA