



**CALIFORNIA  
HOSPITAL  
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*Providing Leadership in  
Health Policy and Advocacy*

February 15, 2019

Jennifer Kent  
Director  
California Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, CA 95814

**SUBJECT: Cal MediConnect Program Recommendations**

Via e-mail: [Jennifer.Kent@dhcs.ca.gov](mailto:Jennifer.Kent@dhcs.ca.gov)

Dear Director Kent:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide recommendations to the California Department of Health Care Services (DHCS) on the Cal MediConnect Program. CHA appreciates that DHCS has invited stakeholders to propose new ideas for how Cal MediConnect can provide a better member experience or otherwise improve care and care coordination. CHA shares the state's goals of alleviating fragmentation and improving coordination of services for Medicare and Medi-Cal enrollees, enhancing quality of care, and reducing costs for both the state and federal government under the Coordinated Care Initiative.

While CHA is committed to these goals, we remain concerned about a three-year extension of the Cal MediConnect Program. We previously shared our reasons for this concern with DHCS in the attached comment letters on Cal MediConnect Program data sharing, the long-term care and disenrollment process, continuity of care, and discharge planning for Cal MediConnect members.

More than four years since the implementation of the Coordinated Care Initiative, hospital case managers continue to report that the discharge planning process remains one of the most challenging aspects of the program, often delaying patients' placement in the appropriate level of care on a timely basis. Due to the lack of coordination within the discharge planning process, hospital case managers have reported many instances in which patients are ready for discharge to another setting — such as a skilled-nursing facility or a community setting with home health or other services — but the hospital case manager receives minimal support from Cal MediConnect plans. Our members report increasing difficulty in securing appropriate post-hospital care for some patients, particularly those with certain medical or behavioral health needs, often leaving the responsibility for identifying and accessing an appropriate post-hospital placement to the hospital. For example, multiple individuals have been awaiting placement into a post-hospital care setting for 180 days or more. Retaining patients unnecessarily in the acute hospital setting denies access to medically necessary post-hospital and community-based care, and ultimately compromises patient outcomes.

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Corporate Members: Hospital Council of Northern and Central California, Hospital Association of Southern California, and Hospital Association of San Diego and Imperial Counties

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Moreover, housing patients who no longer need acute care services in hospital beds is an inappropriate and costly allocation of resources that may be needed by other patients.

CHA urges DHCS to consider again our previous comments and suggestions on ways to improve care coordination for Cal MediConnect members, including the development of improved metrics and oversight in the following areas:

- Plan provision of care coordination for Cal MediConnect members, including access to long-term services and supports
- Access to specialized case management services for complex patient and patients with behavioral health needs
- Timely access to community-based primary care services
- Access to post-hospital care, including delays in care transitions
- Discharge rates from skilled-nursing facilities

CHA appreciates the opportunity to provide the recommendations on the Cal MediConnect Program. We hope our recommendations help to inform new Cal MediConnect Program improvement initiatives that DHCS indicates it will release in the spring, along with a timeline for implementation. We would like to collaborate with DHCS to ensure the issues identified by our members on behalf of the patients they serve are resolved prior to a three-year extension of the Cal MediConnect Program. If you have any questions, please contact me at (916) 552-7543 or [akemp@calhospital.org](mailto:akemp@calhospital.org), or my colleague, Patricia Blaisdell, at (916) 552-7553 or [pblaisdell@calhospital.org](mailto:pblaisdell@calhospital.org).

Sincerely,



Amber Kemp  
Vice President, Health Care Coverage



Patricia Blaisdell  
Vice President, Continuum of Care

cc: Ms. Mari Cantwell, Chief Deputy Director, Health Care Programs  
Ms. Jacey Cooper, Senior Advisor, Health Care Programs  
Ms. Sarah Brooks, Deputy Director, Health Care Delivery Systems



**CALIFORNIA  
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August 10, 2018

Jennifer Kent  
Director  
California Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, CA 95814

**SUBJECT: Cal MediConnect Data Sharing Workgroup Draft Recommendations**

Via e-mail: [Jennifer.Kent@dhcs.ca.gov](mailto:Jennifer.Kent@dhcs.ca.gov)

Dear Director Kent:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide comments to the California Department of Health Care Services (DHCS) on its *Cal MediConnect Data Sharing Workgroup Draft Recommendations* on how to best ensure continuity of care is maintained when a Medi-Cal member switches from one Cal MediConnect (CMC) plan to another CMC plan. We recognize that these draft recommendations address plan-to-plan communication and request that they be revised to incorporate plan-to-provider communication, which would go a step further in promoting improved care coordination for CMC members.

We offer our comments below regarding 1) the proposed data-sharing package elements, 2) CMC members included in the policy and 3) stakeholder engagement.

#### **I. Data-Sharing Package Elements**

As stated, the goal of the data-sharing package is to promote continuity of care for CMC members moving between CMC plans. As such, CHA requests that plans be required to also provide this information to providers.

##### *Single Point of Contact*

The guidance requires that the legacy plan contact information be included in the data package for any follow-up questions that the gaining plan may have. CHA requests that DHCS revise the guidance to require plans to include the contact information of the CMC member's designated care coordinator. Requiring the plans to list the contact name of the CMC member's designated care coordinator would be one way to ensure plans are assigning care coordinators to each CMC member.

As we shared in our March 24, 2016, comments related to *Draft Duals Plan Letter 16-003: Discharge Planning for Cal MediConnect*, many hospital case managers report that a CMC members' designated care coordinator is oftentimes not known to providers, nor does it appear to be clear to the CMC member who their care coordinator is. CHA has previously requested that DHCS further clarify CMC

plans' responsibility to have a care coordinator (i.e. single point of contact) and to clarify how CMC plans are required to make the care coordinator known to providers. CHA recommends that CMC plans be required to provide hospitals with the name and contact information of a CMC beneficiary's designated care coordinator. This information should be readily available in a manner and mechanism that will allow for 24-hour access, seven days a week.

#### *Health Risk Assessments/Individualized Care Plans*

As we have previously shared, many hospital and skilled-nursing facilities (SNFs) report not routinely being included when CMC plans conduct health risk assessments (HRAs) or develop interdisciplinary care teams (ICT) and individual care plans. Including a provider-based case manager or other clinician able to provide meaningful input on the patient's clinical and functional status would enhance the overall care planning process and improve plan-provider communication to support effective plan implementation. CHA recommends that DHCS require that hospital and SNF-based personnel be informed about the results of HRAs and that they be included in ICTs. In addition, CHA recommends that the lookback period for sharing data should be, at a minimum, 18 months rather than 12 to guarantee that the latest HRA and care planning documents are shared with the receiving plan. Since an HRA may only happen on an annual basis, there may be instances in which an HRA was not conducted within the preceding twelve months of the change.

#### *Claims Data*

CHA recommends that the guidance be revised to specifically outline the different types of claims data that must be shared to ensure all plans are operating under the same definition. For example, in addition to provider data, claims data would include prescription drugs, transportation and durable medical equipment. To avoid confusion, the guidance should be clear on this point. Likewise, shared claims data must include carved out services, including in-home supportive services, specialty mental health services and dental care. Lastly, shared claims data must include Care Plan Option (CPO) services the legacy plan provided within the lookback period and any community-based services the member was receiving (e.g. meals on wheels, case management through the Area Agency on Aging, etc.). This ensures that continuity of care across the entire spectrum of benefits is maintained and beneficiaries do not experience a disruption in care or lapse in services that the plans know about or help coordinate but are not covered under Medicare or Medi-Cal.

CHA recommends that the guidance require legacy plans to share data they have on a member's accessibility needs including language, physical and programmatic accommodations with the receiving plan.

Lastly, CMC members should be provided an opportunity to review the data being shared with the receiving plan and how to access their full electronic record. This will ensure that the member has a chance correct any errors in their record.

## **II. CMC Members Included in Policy**

The guidance states, "While permitted, CMC plans are not required or expected to share data for members if there is a break in CMC plan enrollment. The process is designed for members directly transferring from one CMC plan to another." CHA requests that the guidance be revised to require plans to share data for all CMC members, regardless of a break in CMC plan enrollment. CHA members

frequently report difficulty obtaining information and support from CMC plans that are presumably responsible for long-term services and supports, regardless of their enrollment status. CHA believes that both the hospital and CMC plan play significant roles in ensuring safe and effective care transitions, but this responsibility is increasingly left to the provider, with little support from the CMC plan. CMC members are some of the most fragile, complex Medi-Cal members that necessitate enhanced continuity of care safeguards, particularly when there has been a break in CMC plan enrollment.

### III. Stakeholder Engagement

CHA appreciates that DHCS convened a workgroup of plan, DHCS and Centers for Medicare & Medicaid Services representatives that met over the course of seven times over four months to determine what data should be shared and how. For future discussions, CHA respectfully requests that DHCS include provider and patient representatives in any ongoing efforts to strengthen the CMC program and to discuss recommendations for improved continuity of care. The provider and patient advocate perspectives are invaluable, based on their experience of sitting beside CMC members and helping them to navigate the oftentimes complex CMC program.

CHA appreciates the opportunity to provide input on the draft guidance, and looks forward to our continued collaboration. If you have any questions, please contact me at (916) 552-7543 or [akemp@calhospital.org](mailto:akemp@calhospital.org), or my colleague, Patricia Blaisdell, vice president, continuum of care, at (916) 552-7553 or [pblaisdell@calhospital.org](mailto:pblaisdell@calhospital.org).

Sincerely,



Amber Kemp  
Vice President, Health Care Coverage



Patricia Blaisdell  
Vice President, Continuum of Care

cc: Ms. Mari Cantwell, Chief Deputy Director, Health Care Programs  
Ms. Sarah Brooks, Deputy Director, Health Care Delivery Systems  
Ms. Jacey Cooper, Assistant Deputy Director, Health Care Delivery Systems



August 9, 2017

Jennifer Kent  
Director  
California Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, CA 95814

**SUBJECT: All Plan Letter 17-XXX: Long-Term Care Coordination and Disenrollment**

Via e-mail: [Jennifer.Kent@dhcs.ca.gov](mailto:Jennifer.Kent@dhcs.ca.gov)

Dear Director Kent:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide comments to the California Department of Health Care Services (DHCS) on its draft All Plan Letter (APL) 17-XXX: Long-Term Care Coordination and Disenrollment. The APL clarifies the requirement that all Medi-Cal managed care health plans (MCPs) coordinate care and placement for Medi-Cal members requiring long-term care (LTC), and clarifies the requirement that MCPs initiate disenrollment for Medi-Cal members requiring LTC when the provision of LTC is no longer a contractual requirement for the MCP.

CHA believes that MCP requirements related to LTC care coordination and LTC disenrollment would be better addressed under two separate APLs, as these concerns are much broader than are outlined in this draft APL. As we have stated in previous communications, Medi-Cal members who require specialized medical or therapeutic services, or who have behavioral health issues, frequently remain in the acute hospital for costly extended stays due to the plan's inability to identify and secure an appropriate post-hospital destination. This lack of care coordination is an issue separate from disenrollment from the plan upon transition to LTC, and thus in our view would be addressed most effectively with separate and distinct policy communication. That said, we offer comments related to both LTC care coordination and LTC disenrollment below, and welcome the opportunity to discuss our comments and why we believe two separate APLs are needed.

We are pleased to provide comments in the following areas: 1) MCP responsibility for the provision of LTC, 2) application of policy in Coordinated Care Initiative (CCI) counties and for patient type, 3) application of policy in circumstances when patients reside in hospitals for extended stays, 4) provider notification of disenrollment, and 5) the provider option to request disenrollment.

**I. MCP Responsibility for Identification of and Facilitation to Appropriate LTC Facility**

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CHA appreciates that the APL clarifies that MCPs are required to provide coordination of care to beneficiaries who meet medical necessity criteria for LTC, including coordinating placement in a LTC facility that provides the level of care most appropriate to the beneficiary's medical needs. We also appreciate DHCS' statement that coordination of placement in a LTC facility includes coordinating the transfer to the LTC facility, notifying the beneficiary and his or her family or guardian of the transfer, assuring the appropriate transfer of medical records to the LTC facility, assuring that continuity of care is not interrupted, and providing all medically necessary covered services to the beneficiary while he or she is enrolled in the MCP. The APL also clarifies that the responsibility to coordinate the placement of a beneficiary in a LTC facility is not contingent on the beneficiary's expected length of stay at the LTC facility.

CHA requests that DHCS also clarify that MCPs are responsible for identifying an appropriate care facility in addition to facilitating the patient's transfer to the facility. CHA members have reported many instances in which patients are ready for discharge to another setting — such as a skilled-nursing facility (SNF) or a community setting with home health or other services — but the hospital case manager receives zero to minimal support from MCPs. Our members have also reported increasing difficulty in securing appropriate post-hospital care for some patients, particularly those with certain medical or behavioral health needs, often leaving the hospital responsible for identifying and accessing appropriate post-hospital placement. Notably, hospitals report that they receive little to no assistance from the plans in securing admission to even those SNFs that have been identified by the plan as in-network.

In addition, CHA requests that DHCS revise the APL to include specific actions MCPs must take in the event that a Medi-Cal member remains in the hospital for an extended stay, such as documentation of consideration of SNF alternatives or of efforts to work with in-network SNFs to facilitate a transfer. CHA requests that DHCS develop a mechanism to track MCP compliance with this policy.

## **II. Application of Policy in CCI Counties and for Patient Type**

CHA appreciates that the APL clarifies that MCPs operating in county organized health system counties (COHS) counties are contractually responsible for all medically necessary LTC, and that MCPs operating in non-COHS counties are contractually responsible for medically necessary LTC provided from the time of admission and up to one month after the month of admission for LTC. CHA requests that DHCS clarify in this APL that the disenrollment process does not apply to plans in CCI counties (for ages 21 and up), as LTC is covered by the MCPs in these counties. CHA also requests that DHCS clarify whether the policy varies by patient type (i.e. Medi-Cal only, dual, opt-out, etc.).

## **III. Application of Policy in Circumstances When Patients Reside in Hospitals for Extended Stays**

CHA requests that DHCS include language within the APL that addresses the disenrollment process for patients who remain in an acute care setting after their medical needs have been addressed because the MCP does not transfer the patient to a more appropriate post-acute care setting in a timely fashion, due to lack of either community resources or access to post-hospital care. CHA members have reported that in some cases the MCP will proceed with disenrollment while the patient continues to receive care in the acute care hospital, and makes no effort to transfer the patient out of the acute care setting. Retaining patients unnecessarily in the acute hospital setting results in denial of access to medically necessary post-hospital and community-

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based care, and ultimately compromises patient outcomes. Moreover, housing patients who no longer need acute care services in hospital beds is an inappropriate and costly allocation of resources that may be needed by other patients. CHA requests that DHCS clarify MCP responsibility in these circumstances.

#### **IV. Provider Notification of Disenrollment**

CHA appreciates DHCS' clarification that, upon the disenrollment effective date, the MCP is required to coordinate the beneficiary's transfer to the Medi-Cal fee-for-service (FFS) program, including notifying the beneficiary and his or her family or guardian of the disenrollment, ensuring the appropriate transfer of medical records from the MCP to the Medi-Cal FFS provider, assuring that continuity of care is not interrupted, and completing all administrative work necessary to assure a smooth transfer of responsibility for the beneficiary's health care. CHA requests that DHCS also include language in the APL that requires the MCP to communicate to the provider confirmation of the patient's change in status and disenrollment effective date. CHA members report this level of communication rarely occurs, despite its necessity in ensuring that providers bill the right entity for services, and maintain continuity of care.

#### **V. Provider Option to Request Disenrollment**

CHA requests that DHCS incorporate language into the APL clarifying for MCPs that providers have the option to contact the MCP to request disenrollment. CHA is aware of internal guidance to MCPs that addresses the provider option and would like the option memorialized within this APL.

CHA appreciates the opportunity to provide input on the draft APL, and looks forward to our continued collaboration. If you have any questions, please contact me at (916) 552-7543 or [akemp@calhospital.org](mailto:akemp@calhospital.org), or my colleague, Patricia Blaisdell, at (916) 552-7553 or [pblaisdell@calhospital.org](mailto:pblaisdell@calhospital.org).

Sincerely,



Amber Kemp  
Vice President, Health Care Coverage



Patricia Blaisdell  
Vice President, Continuum of Care

cc: Ms. Mari Cantwell, Chief Deputy Director, Health Care Programs  
Ms. Sarah Brooks, Deputy Director, Health Care Delivery Systems





March 24, 2016

Jennifer Kent  
Director  
California Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, CA 95814

**SUBJECT: Draft Duals Plan Letter 15-XXX: Discharge Planning for Cal MediConnect**

Via e-mail: [Jennifer.Kent@dhcs.ca.gov](mailto:Jennifer.Kent@dhcs.ca.gov)

Dear Director Kent:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide comments to the California Department of Health Care Services (DHCS) on its draft Duals Plan Letter (DPL) 15-XXX: Discharge Planning for Cal MediConnect. CHA shares the state's goal to alleviate fragmentation and improve coordination of services for Medicare/Medi-Cal enrollees, enhance quality of care, and reduce costs for both the state and federal government under the Coordinated Care Initiative (CCI).

CHA appreciates DHCS' guidance on discharge planning for Cal MediConnect members, as hospital case managers report that this process remains one of the most challenging aspects of the CCI, often delaying patients' placement in the appropriate level of care on a timely basis. We have limited our comments to the discharge planning process, as that is the focus of this DPL. However, we request that DHCS clarify this DPL's overlap with draft DPL 15-003: Continuity of Care, released for stakeholder comment in September 2015. While some of CHA's comments on draft DPL 15-003: Continuity of Care, which were submitted to DHCS on October 2, 2015, are addressed in this DPL, others are not. We request that DHCS clarify the status of DPL 15-003: Continuity of Care, including how it will address previously raised concerns that are not addressed in this DPL.

Before providing specific comments on this DPL, CHA would like to acknowledge our appreciation of DHCS staff for our recent collaboration in developing a case manager toolkit for hospital case managers as they support CCI beneficiaries before, during and after hospitalization. CHA appreciates DHCS' acknowledgement that these beneficiaries often need extra support during hospitalizations and in the transition back into the community or into a nursing facility. We look forward to continued collaboration as we release the toolkit throughout CCI counties via webinars and roundtable discussions with Medicare/Medi-Cal plans (MMPs). The toolkit is a step in the right direction to promote a shared understanding of MMP responsibility under the CCI, and to promote a consistent understanding and application of Medicare Advantage (MA) policies between MMPs and providers. DHCS' clarification of CCI policy and of MMP requirements in the form of DPLs, based on feedback from providers and patients, is another vital step in ensuring consistent understanding of CCI policy and program objectives — ultimately ensuring patients are provided with ap-

propriate and timely access to care. Our comments below acknowledge areas of this DPL that we believe will enhance CCI beneficiary access to care, as well as other areas that require additional clarification.

## **I. Clarify Application of Guidance to all CCI Enrollees**

CHA appreciates DHCS' guidance for MMPs on discharge planning for Cal MediConnect enrollees; however, this DPL does not clearly address MMPs' responsibility to ensure post-hospital placement for non-Cal MediConnect enrollees, which, our hospital case managers report, is also a challenge. In addition to enrollment in Cal MediConnect, the CCI includes mandatory Medi-Cal managed care enrollment for dual eligible individuals and the inclusion of long-term services and supports (LTSS) as a Medi-Cal managed care benefit for seniors and persons with disabilities (SPD) who are eligible for Medi-Cal only, as well as for SPD dual eligible individuals. **The requirement to ensure appropriate post-hospital care is necessary for all CCI beneficiaries, including dual eligible individuals who choose to opt out of Cal-MediConnect and Medi-Cal-only CCI members. As such, CHA requests that DHCS include this clarification in the DPL.**

## **II. Ensure Cal MediConnect Enrollees Have Access to Full Range of Medicare Benefits**

CHA appreciates DHCS' clarification that "MMPs shall maintain the standards for determining levels of care authorization of services for both Medicare and Medi-Cal services that are consistent with policies established by the federal Centers for Medicare & Medicaid Services." However, the preceding language addressing authorizations references only nursing facility and subacute care services. Medicare benefits include a range of post-acute care and other services, including acute inpatient rehabilitation provided in inpatient rehabilitation facilities (IRFs), long-term acute care provided in long-term care hospitals (LTCHs) and partial hospitalization programs (PHPs).

As we have previously shared, our hospital members report that Cal MediConnect beneficiaries are frequently denied access to IRFs, LTCHs and PHPs — even when their clinical condition and functional status clearly meet Medicare criteria for these benefits. In our discussions with individual MMPs to try to remedy such occurrences, it is apparent that MMPs do not have a clear understanding of the Medicare benefits to which Cal MediConnect members are entitled. This is incredibly discouraging and must be remedied so that CCI beneficiaries are not inappropriately denied access to care. **As such, CHA requests that the DPL be revised to ensure that MMPs adhere to MA policies on beneficiary access to all levels of care, including IRF, LTCH, and PHP. CHA requests that DHCS include a link to Medicare criteria for IRF, LTCH, and PHP services within the DPL so MMPs have a common understanding of the medical criteria for these services and of their obligation to provide these services to Cal MediConnect members. These are services that MMPs have already attested to being able to provide, as part of the readiness review process for health plans participating in Cal MediConnect/CCI.**

Moreover, hospital case managers report that in many cases, MMPs' decisions to deny access to Medicare benefits is not communicated in writing via an Integrated Denial Notice (Notice of Denial of Medical Coverage), making it challenging for patients to appeal plan determinations. **As such, CHA requests that the DPL clarify MMPs' obligation to provide patients with denials in writing, using the Integrated Denial Notice, and to include information on the rationale for the decision – information that is already required to be provided to patients. Additionally, we urge DHCS to develop and implement an appropriate appeals process to ensure that inappropriate care denials can be reversed on a timely basis and**

**do not result in harmful limitations of access to care. Information on appealing a denial of a Medicare benefit should be included in the written denial letter.**

While CHA recognizes that DHCS does not provide oversight for application of MA policy, we believe it is incumbent upon DHCS in operationalizing this Demonstration to ensure that MMPs “protect and provide the necessary continuity of care, ensure access to the spectrum of Medicare, Medicaid, and pharmacy providers most frequently utilized by the Medicare-Medicaid population, and fully meet the diverse needs of the Medicare-Medicaid population,” so that CCI beneficiaries receive access to the right care, at the right time, in the right setting.

### **III. Ensuring CCI Beneficiary Placement Within 72 Hours**

Hospital case managers have reported many instances in which patients are ready for discharge to another setting — such as a skilled-nursing facility (SNF) or a community setting with home health or other services — but the hospital case manager receives minimal support from MMPs. Our members have also reported experiencing increasing difficulty in securing appropriate post-hospital care for some patients, particularly those with certain medical or behavioral health needs, often leaving the responsibility for identifying and accessing an appropriate post-hospital placement to the hospital. Retaining patients unnecessarily in the acute hospital setting results in denial of access to medically necessary post-hospital and community-based care, and ultimately compromises patient outcomes. Moreover, housing patients who no longer need acute care services in hospital beds is an inappropriate and costly allocation of resources that may be needed by other patients.

**CHA appreciates that the DPL clarifies MMPs’ responsibility to ensure that beneficiaries are placed in a facility within 72 hours. CHA requests that DHCS clarify when the 72 hours begins, so patients are placed in the appropriate level of care on a timely basis. We also appreciate and support DHCS’ clarification that “should placement exceed seventy-two (72) hours, MMPs must coordinate with hospitals in order to facilitate discharge as soon as possible to the most appropriate level of care.” CHA, however, believes the language “as soon as possible” is too vague, particularly in the context of ensuring CCI beneficiaries have timely access to care. CHA requests that DHCS revise the DPL to include a reasonable time frame for MMPs to meet their contractual obligation to place CCI beneficiaries in a facility in the event it takes longer than 72 hours. In addition, CHA requests that DHCS revise the DPL to include specific actions MMPs must take in the event that a CCI beneficiary remains in the hospital for an extended stay, such as documentation of consideration of SNF alternatives, or of efforts to work with in-network SNFs to facilitate a transfer. CHA requests that DHCS develop a mechanism to track MMP compliance with this policy as this issue, though prevalent, has not been acknowledged in any reports or assessments of the CCI, and yet provides valuable insight regarding the opportunities that exist to provide enhanced care coordination for this fragile population.**

**CHA also requests that DHCS clarify MMPs’ responsibility to provide transition planning/discharge planning from non-hospital settings.** Many individuals transition to a SNF for a short stay for post-hospital medical and rehabilitative care and may require support for discharge from the SNF to their home or community. Our hospital case managers have reported many cases of MMPs not providing transition planning/discharge planning from non-hospital settings, resulting in CCI beneficiaries remaining in SNFs for long-term care. It is our understanding that by consolidating the responsibility for Medicare/Medicaid cov-

ered services into a single health plan, the CCI aims to maximize beneficiaries' ability to remain safely in their homes and communities with appropriate services and supports, in lieu of institutional care. **As such, CHA requests that DHCS revise the DPL to clarify that MMPs are responsible for providing care coordination, support and discharge planning from all levels of the care continuum.**

#### **IV. Ensuring CCI Beneficiaries Have Access to Care in Community-Based Settings**

A major goal of the CCI is to reduce utilization of skilled-nursing services by diverting admissions to long-term care and by facilitating transitions to community-based care, or the least restrictive living environment that meets the beneficiary's needs. The DPL, as currently written, appears to address primarily SNF placement, without including the MMPs' responsibility to provide care coordination services to reduce unnecessary SNF utilization — as opposed to a straight denial of services, which hospital case managers report occurring too frequently. **CHA recommends that the DPL be revised to clarify the requirement that MMPs provide care coordination services that support community-based care across the full continuum of care. In instances where a CCI beneficiary's medical condition does not require continued 24-hour skilled nursing and medical management after hospitalization, MMPs should be required to, in coordination with the hospital, seek alternative community-based settings for the patient, including home care or other community-based services. CHA requests that DHCS revise the DPL to include specific actions MMPs must take to provide care coordination services that support community-based care across the full continuum of care, such as documentation of consideration of home care or other community-based services, or of efforts to facilitate a transfer home care or other community-based services.**

#### **V. Promote Improved Plan/Provider Communication**

**CHA believes that both the hospital and MMP play significant roles in ensuring safe and effective care transitions, but this responsibility is increasingly left to the provider, with little support from the MMP.** As outlined in the Memorandum of Understanding between CMS and the state, care coordination services include assuring appropriate referrals and timely two-way transmission of useful enrollee information; obtaining reliable and timely information about services other than those provided by the primary care provider; participating in the initial assessment; and supporting safe transitions in care for enrollees moving between settings. Many hospital case managers report that a CCI beneficiaries' care coordinator is oftentimes not known to providers, nor does it appear to be clear to the CCI beneficiary who their care coordinator is. **CHA urges DHCS to further clarify MMPs' responsibility, under the Demonstration, to have a care coordinator (i.e. single point of contact) accountable for providing such services. CHA also requests that DHCS clarify how MMPs are required to make the care coordinator known to providers.**

**CHA recommends that MMPs be required to provide the hospital with the name and contact information of a CCI beneficiary's designated care coordinator. This information should be readily available in a manner and mechanism that will allow for 24-hour access, seven days a week. CHA also recommends that DHCS establish care coordination standards, including timelines for MMP responses to hospital requests, and to provide for oversight and reporting to ensure MMP compliance with established policy.**

CHA appreciates the opportunity to provide input on the draft DPL, and looks forward to our continued collaboration. We welcome additional dialogue between DHCS, MMPs and providers to ensure lessons learned can be implemented in a timely manner, allowing CCI beneficiaries access to the full range of services to which they are entitled under the CCI. If you have any questions, please contact me at (916) 552-7543 or [akemp@calhospital.org](mailto:akemp@calhospital.org), or my colleague, Patricia Blaisdell, at (916) 552-7553 or [pblaisdell@calhospital.org](mailto:pblaisdell@calhospital.org).

Sincerely,



Amber Kemp  
Vice President, Health Care Coverage



Patricia Blaisdell  
Vice President, Continuum of Care

cc: Ms. Mari Cantwell, Chief Deputy Director, Health Care Programs  
Ms. Sarah Brooks, Deputy Director, Health Care Delivery Systems



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October 2, 2015

Jennifer Kent  
Director  
California Department of Health Care Services  
1501 Capitol Avenue  
Sacramento, CA 95814

**SUBJECT: Duals Plan Letter 15-003: Continuity of Care**

Via e-mail: [Jennifer.Kent@dhcs.ca.gov](mailto:Jennifer.Kent@dhcs.ca.gov)

Dear Director Kent:

On behalf of our more than 400 member hospitals and health systems, the California Hospital Association (CHA) welcomes the opportunity to provide comments to the California Department of Health Care Services (DHCS) on Duals Plan Letter 15-003: Continuity of Care. CHA shares in the state's goal to alleviate fragmentation and improve the coordination of services for Medicare-Medi-Cal enrollees, enhance quality of care, and reduce costs for both the state and federal government under the Coordinated Care Initiative (CCI).

CHA appreciates the language DHCS has included in DPL 15-003, clarifying that if a skilled-nursing facility (SNF) resident leaves a SNF, and the beneficiary requires a return to the SNF level of care, the beneficiary has the right to return to the same SNF where they previously resided under the Leave of Absence and Bed-hold policies outlined under DPL 14-002, as well as the Continuity of Care policies in DPL 15-003. CHA has raised this issue with DHCS, as our members have reported that Cal MediConnect plans may deny discharge back to the SNF where an individual lived for an extended period prior to a short stay in the hospital. We believed this was a violation of state policy on continuity of care principles and appreciate that DHCS is providing additional guidance to plans on this issue.

While we appreciate that DHCS' additional guidance on this particular issue, we have also previously raised other concerns — related to network adequacy/access, care coordination, opportunities for plan/provider education, and reimbursement — that the Department has not yet addressed. These concerns are noted below. CHA requests that DHCS address these additional concerns in future DPLs.

## **I. Network Adequacy/Access**

### *Skilled-Nursing Facilities*

Our members have reported that many SNFs identified as in-network will not accept many CCI beneficiaries. The SNFs report that they do not want to accept these patients because of their payor (Medi-Cal), not because they are full. Additionally, contracted SNFs may decline to admit certain patients, secondary to their level of medical need or the presence of a behavioral issue.

As a result, CCI beneficiaries may remain in hospital beds beyond the time required to treat their medical condition, often for extended periods – weeks, months or even more – with limited or no payment. When we have discussed this issue with plans, they appear unwilling to exert any influence over the contracted SNF, and they absolve themselves from responsibility for these patients by saying that providers are being adequately reimbursed under APR- DRGs.

However, the APR-DRG payment is designed to cover the average length of stay for an acute admission, and these patients typically exceed the average length of stay by several days, sometimes weeks. This means the hospital is caring for non-acute patients in an acute setting, without any reimbursement to cover the associated costs. Under the traditional fee-for-service Medi-Cal payment system, hospitals can bill an administrative day for beneficiaries who no longer require acute care but who need nursing home placement or other sub-acute or post-acute care that is not available at the time. Unfortunately, the Medi-Cal managed care plans are not required to make a similar payment for administrative days and, therefore, they have no financial incentive to work with the provider to find an appropriate post-hospital care setting or skilled-nursing bed.

Retaining patients unnecessarily in the acute hospital setting results in denial of access to medically necessary post-hospital and community-based care, and ultimately compromises patient outcomes. Moreover, housing patients who no longer need acute care services in hospital beds is an inappropriate and costly allocation of resources that may be needed by other patients.

A major goal of the CCI is to enable individuals to reside in the least restrictive setting, and to decrease utilization of skilled-nursing services in favor of community-based options. Our members report that they receive limited information from Cal MediConnect plans about alternatives to skilled-nursing care, and are not aware of efforts to develop and implement community-based residential and care alternatives for beneficiaries who may be able to benefit from them.

**CHA urges DHCS to update current policy to require plans to demonstrate their ability to provide timely case management services to all hospital inpatients requiring post-hospital rehabilitative and medical care and support. Additionally, CHA requests that DHCS require plans to reimburse hospitals for care provided to individuals whose hospital stay extends beyond the time needed to address the medical need for which they were admitted.**

Our members also report that available in-network SNFs are frequently located many miles away from the inpatient hospital and beneficiary residence. **CHA requests that DHCS modify network adequacy criteria to reflect the need to place the beneficiary in care in the least restrictive environment, including proximity to the beneficiary's home community.**

#### Long-Term Care Hospitals/Inpatient Rehabilitation Facilities

Following a hospitalization for injury or illness, many patients require continued medical and rehabilitative care either at home or in a specialized facility. Timely access to the most appropriate level of post-acute care is an important factor in a patient's ability to achieve and maintain optimal medical and functional outcomes. The post-acute care continuum includes inpatient programs such as inpatient rehabilitation facilities (IRFs), long-term acute care hospitals (LTCHs) and SNFs, as well as home and community-based services such as home health care, hospice and outpatient services.

Our hospital members report that Cal MediConnect enrollees are frequently denied access to long-term care hospitals (LTCHs) and inpatient rehabilitation facilities (IRFs), even when their clinical condition and functional status clearly meets Medicare criteria for these benefits. For example, case managers in some regions have reported that plan case managers communicate that they do not have the ability to offer care in an LTCH, and direct the hospital to seek SNF placement instead. In other cases, hospital clinicians are informed that patients who are eligible for IRF care can receive adequate care in a SNF with physical therapy. This is a clear violation of Centers for Medicare & Medicaid Services (CMS) policy governing Medicare Advantage (MA) services. More importantly, the patient is denied access to the critical medical services they need, which negatively impacts patient outcome and level of independence.

Our members also report that there is often disagreement between physicians and plans about a CCI patient's appropriate level of care. For example, the attending physician may determine that his/her ventilator-dependent patient would benefit from LTCH care, but the plan physician may deny that level of care. A patient in this circumstance will likely remain in the hospital for an extended time, as they stabilize sufficiently to be discharged to a less intensive and less expensive subacute SNF setting, and they are denied the opportunity to receive the specialized respiratory care services that could allow them to wean from the ventilator care and live as independently as possible.

**CHA urges DHCS to provide oversight to ensure that Cal MediConnect plans adhere to MA policies regarding beneficiary access to all levels of care, including IRF and LTCH care. We also urge DHCS to ensure that each plan has an adequate network of service and providers at every level of care, and timely case management and authorization services, to ensure the patient does not remain in the hospital setting longer than necessary.**

**Additionally, we urge DHCS to develop and implement an appropriate appeals process to ensure that inappropriate care denials can be reversed on a timely basis and do not result in harmful limitations to care access.** Medicare FFS beneficiaries can readily access medically necessary post-acute necessary transitional and rehabilitative care, including hospital-level care (inpatient acute rehabilitation or long-term care hospital), skilled-nursing care, or home health or outpatient care. By contrast, beneficiaries enrolled in MA have variable access, secondary to the issues discussed above. An effective "real-time" appeals process is essential to ensure beneficiary access to the Medicare services they require.

Many hospitals face significant difficulty securing appropriate post-hospital care for patients who no longer require acute care and may have specialized needs. When the post-acute care services are not available in the Medi-Cal managed care plan's provider network, patients and hospitals are disadvantaged. As a result, these individuals may remain in hospital beds beyond the time required to treat their medical condition, often for extended periods – weeks, months or even years. Medi-Cal managed care plans should be incentivized to ensure that they provide a full range of post-acute care services in their provider networks.

#### *Partial Hospitalization Providers*

A number of partial hospitalization providers (PHP) have reported Cal MediConnect plans denying authorizations for PHP services. PHP, an intensive outpatient psychiatric service, is paid under Medicare Part B and is provided as an alternative to inpatient psychiatric care, to patients who have an acute mental illness. PHPs, which deliver intensive psychiatric treatment four to seven days per week, are cost-effective in that they allow this beneficiary population to remain in outpatient levels of care rather than being admitted to higher-



cost inpatient settings. However, inadequate access to appropriate PHP services results in increased in emergency department (ED) crowding and increased readmissions.

The reported denial reasons we are seeing from our Part B PHP providers are “due to [the patient] using [its] maximum amount of treatment days.” CHA is unaware of any limit on treatment days. We are concerned that plans are denying this treatment to keep costs down; however, this is very short-sighted strategy considering the potential long-term cost of patients being denied PHP services, and having a subsequent mental health crisis and needing inpatient care.

Lack of access to this benefit is a serious problem because Medicare does not cover a wide range of services less intensive than inpatient hospitalization. **The PHP benefit is drawn very narrowly so that it covers care only for the most acutely ill patients who would otherwise require hospitalization.** The parts of the continuum missing from the current Medicare benefit include formal coverage of intensive outpatient care, residential treatment, psychosocial rehabilitation and care management. This makes it difficult for providers to provide Medicare beneficiaries with mental health services at the right level and time. **Without access to PHP services, patients’ conditions deteriorate, leading to ED visits and hospitalizations.** Due to the instability and fragile nature of our behavioral and mental health system in California, these providers are essential. For this program to continue to work and further its goals toward integration, we need to continue to provide services in the outpatient setting and help these patients remain in the community rather than in our institutions, allowing room for those who do need inpatient care.

**While CHA recognizes that DHCS does not provide oversight for application of MA policy, we urge DHCS to provide Cal MediConnect plans with clarification of their responsibility to cover this service to ensure that CCI beneficiaries – particularly the highest costs beneficiaries with behavioral health issues – receive access to the right care, at the right time, in the right setting.**

#### Physicians

Our members have reported that residents in SNFs are often assigned to physicians who will not travel to SNF where beneficiary resides. In at least some reported cases, an on-site physician (not the assigned physician) is providing care but is not getting paid. In some cases, SNFs are reportedly able to develop a mechanism for the payment for the SNF-based physician(s), but in others, the requesting physicians have been unable to become part of the network or receive payment for care. In addition, assigned physicians are often located at some distance from patients and as a result, many CCI beneficiaries are not seeing their physician for a post-hospital visit. Our members also report difficulty identifying a physician for a CCI patient’s post-discharge care. In some areas, it is the hospital case manager’s understanding is that the CCI patient will receive primary care through a community clinic, but the clinic is unable to accommodate them.

**CHA urges DHCS to require that Cal MediConnect plans provide hospital case managers with the names and contact information of the individual’s primary care physician, in a manner and mechanism that will allow for 24-hour access, seven days a week. Additionally, for SNF residents, we request that the plans be required to reimburse on-site physicians for necessary medical services, without a requirement for additional authorization.**

## II. Care Coordination

Authorization Process

CHA members have reported that CCI authorizations can be delayed and time-consuming. In our members' experience, many plans require multiple calls for care coordination (e.g., one contact for hospital admission authorization, another for utilization review, and a third for authorization for post-hospital care). Our members also report that plans are difficult to reach and that hospital discharge planning staff often spend hours on the phone, resulting in need for increased staffing. Additionally, case managers frequently encounter confusion regarding responsibilities for authorization between the plan and the delegated medical group. **CHA requests that DHCS require plans to establish a plan provider help line that will provide clarification and assistance in identifying responsible entities for authorization and address problems with the authorization process.**

In addition, our members report that Cal MediConnect plans are not providing denials in writing which then makes it difficult for CCI beneficiaries to dispute denials. **CHA requests that DHCS provide additional guidance to Cal MediConnect plans regarding their obligation to provide patients with denials in writing.**

Discharge Planning Process

Many of our members have reported that Cal MediConnect plans have transferred some of their contractual care coordination activities to providers. For example, many hospital case managers report to CHA that when a patient is ready for discharge to another setting, such as a SNF or a community setting with home health or other services, they receive minimal support from the Cal MediConnect plans. Our members also experience increasing difficulty in securing appropriate post-hospital care for certain patients, in particular individuals with certain medical or behavioral needs, with the responsibility for identifying and accessing an appropriate post-hospital placement left to the hospital. Additionally, Cal MediConnect plans are providing hospitals with lists of vendors, facilities, etc., and it is the hospital case manager that must coordinate a CCI beneficiary's discharge planning, including contact with multiple suppliers. Our members report that they receive little to no information or support regarding community services, or to develop alternatives to SNF placement. **CHA urges DHCS to provide clear guidance to clarify that care coordination is a Cal MediConnect plan responsibility.**

**CHA further recommends that the Cal MediConnect plans be required to provide to the hospital the name and contact information of the beneficiary's designated care coordinator. This information should be readily available in a manner and mechanism that will allow for 24-hour access, seven days a week. CHA also recommends that DHCS establish care coordination standards, including timelines for plan responses to hospital requests, and provide for oversight and reporting to ensure compliance.**

**CHA believes that both the hospital and the plan play significant roles in ensuring safe and effective care transitions, but increasingly more of this responsibility is left to the provider, with little support from the Cal MediConnect plan.** As outlined in the Memorandum of Understanding between CMS and the state, these services include assuring appropriate referrals and timely two-way transmission of useful enrollee information; obtaining reliable and timely information about services other than those provided by the primary care provider; participating in the initial assessment; and supporting safe transitions in care for enrollees moving between settings. Many of our members report that a patient's care coordinator is not known to the providers, nor does it appear to be clear to the beneficiary who their care coordinator is. **CHA urges DHCS to further clarify for Cal MediConnect plans their responsibility under the Demonstration to have a care coordinator accountable for providing care coordination services. CHA also request that DHCS**

**clarify how plans are required to make the care coordinator known to providers. CHA requests that DHCS implement processes for providers to report, and for DHCS to track, when plans have shifted their administrative responsibilities to providers, as the absorption of such responsibilities by providers should be acknowledged through increased provider rates.**

*Health Risk Assessments/Individual Care Plan Process*

Many SNFs report not routinely being included when health plans conduct health risk assessments (HRA) and/or develop interdisciplinary care teams (ICT) and individual care plans. Including a provider-based case manager or other clinician able to provide meaningful input on the patient's clinical and functional status, would enhance the overall care planning process, and would support improved provider-plan communication to support effective plan implementation. **CHA recommends that DHCS require that hospital and SNF-based personnel be informed about the results of HRAs and that they are included in ICTs.**

### **III. Opportunities for Plan/Provider Education**

*Consistent Understanding and Application of Medicare Advantage Policies*

CHA believes many opportunities exist for plan and provider education. In addition to the concerns noted above, our members have reported incorrect and inconsistent application of MA policies under the CCI. As an example, CHA is still in the process of resolving an issue with a Cal MediConnect plan that we have determined didn't have a clear understanding of the MA authorization process.

Specifically, it was reported to CHA that a Cal MediConnect plan's representatives routinely requested complete clinical information within 24 hours of a CCI beneficiary's admission. For example, two case managers reported that, for patients who presented to the ED, they submitted preliminary information to this plan to ensure notification within 24 hours. However, secondary to the course of treatment, the case managers were not able to provide complete test results until shortly after that time. When that clinical information was subsequently offered, the Cal MediConnect plan representatives said that the stays had already been denied and that nothing could be done because of a "Medicare 24-hour rule."

CHA is in the process of facilitating communication with this plan and case management staff at the affected hospitals to 1) clarify mutual understanding of appropriate authorization procedures, and 2) address payment issues related to several past cases that were denied incorrectly due to the plan inappropriately denying authorization for inpatient hospital services based on a "Medicare 24-hour rule" that does not exist.

In the course of researching this issue, CHA sought clarification and guidance from CMS. CMS personnel has since reported that a CMS representative had met with the plan's medical director to ensure that they understood the MA authorization process.

### **IV. Reimbursement**

*Timely Processing of Claims for Payment*

On numerous occasions, CHA has needed to intervene with Cal MediConnect plans on behalf of our members, as multiple facilities have indicated that they have significant underpayments and unpaid claims associated with Cal MediConnect plans. Our understanding is that current policy requires 90 percent of all clean

claims from contracting nursing facility service providers be paid within 30 calendar days after the date of receipt of the claim. **CHA requests that DHCS clarify for Cal MediConnect plans their obligation for the timely processing of claims for payment and the associated penalty for non-compliance.**

CHA commends DHCS for its commitment to transform the state's Medi-Cal delivery system to better serve low-income seniors and persons with disabilities, and we look forward to continued collaboration to ensure successful CCI implementation. If you have any questions, please contact me at (916) 552-7543 or [akemp@calhospital.org](mailto:akemp@calhospital.org); or my colleague, Patricia Blaisdell, at (916) 552-7553 or [pblaisdell@calhospital.org](mailto:pblaisdell@calhospital.org).

Sincerely,



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