Overcoming Barriers to Care and Treatment

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Chronic Care Policy Alliance
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“We advocate for patients who cannot stand up for themselves.”
- Joan Werblun, Chair, California Chronic Care Coalition

We’re About People. We’re About Health.
The California Chronic Care Coalition (CCCC) is a unique alliance of more than 30 leading consumer health organizations and provider groups that promote the collaborative work of policy makers, industry leaders, providers, and consumers to improve the health of Californians with chronic conditions.

We envision a system of care that is accessible, affordable, and of a high-quality that emphasizes prevention, coordinated care, and the patient’s wellness and longevity. Features of the CCCC include the early diagnosis of chronic conditions, access to effective and appropriate treatment and improved chronic care management.
Regulations

• Barriers and Access
  ▫ CCS – Children Services – Into Managed Care
  ▫ MSSP - Multiple Senior Services Program
  ▫ Out of Pocket Costs
  ▫ Coverages
  ▫ Long Term Care
  ▫ Step Therapy – Prior Authorization
  ▫ Continuity of Care
  ▫ Formularies
  ▫ Accumulators
Prescription Drug Benefit Design

What’s in your coverage?

✓ Medical Benefit
✓ Pharmacy Benefit
✓ High Deductible
✓ Low Deductible
✓ Co-pays vs co-insurance
✓ Medication Optimization – Comprehensive Medication Management
Specialty Medications
Co-pays vs. Co-insurance

Advocates Unite
✓ Call to Action
✓ Access, Affordability, Quality and Adherence
✓ Discriminatory Practices
✓ Stakeholders Collaboratory
Know Your Rights

Prescription Drugs
See a Specialist
Cancer Treat
Continuity of Care
I've been denied health care coverage

What do I do? »
My Patient Rights (MPR) is a one stop shop for patients to file complaints with their health plan and state regulators to access the care they need.

MPR helps patients who experience:

- Denials to important procedures
- Barriers to prescription medicines
- Medical bills from out-of-network providers
- Delays receiving tests for chronic diseases
- Denials to specialists
- Billing issues
Many patients either don’t understand their health care treatment options or are subject to their health plan’s barriers to care.
Patients who have been denied treatments often don’t know where to go for help. MPR streamlines and simplifies the complaint processes for patients in 17 states:

- California
- Colorado
- Florida
- Illinois
- Louisiana
- Maryland
- Massachusetts
- Michigan
- Nevada
- North Carolina
- Ohio
- Oregon
- Pennsylvania
- Texas
- Virginia
- Washington
California

STEP ONE – Notify Your Health Plan

The first thing you need to do is file a complaint with your health plan. By California law, complaints must be resolved within 30 days. Follow the steps below to file a complaint and appeal with your health plan:

- Call the member/customer service phone number for your health plan.
- State clearly that you want to file a formal complaint and then explain the problem.
- You can also file your complaint by letter, email, or online through your health plan’s website (see below).
- If you disagree with your health plan’s decision, you have the right to file an appeal.

Below are links to the complaint forms of California’s top health plans:

- Anthem Blue Cross of California/Blue Shield of California
- Assurant Health
- Chinese Community Health
- Health Net
- Kaiser Permanente
- L.A. Care Health Plan
- Molina Healthcare
- Sharp Health Plan
- Valley Health Plan
- Western Health Advantage
- My plan isn’t listed

STEP TWO – File a Complaint

You have the right to file a complaint with the California Department of Managed Health Care (DMHC) and the California Department of Insurance (DOI) if you have a problem getting the services you need, including quality and affordable health care coverage. To file a complaint you must first complete your health plan’s appeal process.

Depending on your coverage, you may need to file your complaint with the DMHC, the DOI or both. Call the DOI to determine which agency handles your health plan: (800) 927-4357.

- File a complaint with the DMHC and submit an Independent Medical Review application [here](#) or call the DMHC help line: (888) 466-2219.
- File a complaint with the Department of Insurance [here](#).
Filing a Complaint

After clicking on California via the interactive map, patients are given a step-by-step guide on how to file a complaint with their health plan and the California Department of Managed Health Care (DMHC) or California Department of Insurance (DOI):

- Links to complaint forms of California’s top health plans
- Contact information and links to the complaint forms of the DMHC and DOI
- A link to MPR’s contact form if the patient’s health plan is not listed
"Standing Up For Your Rights Creates Results"

**Over 4,000** IMR cases submitted to the DMHC in 2017

**The Result:** More than 61% of health plan decisions were reversed or overturned

**Care Received In 61% Of Cases**

We took a harder look at **1,011 IMR Cases**

- **489** Reversed or Overturned
- **22** Partially Overturned

My Patient Rights
1225 8th Street, Suite 485 | Sacramento, CA 95814 | (916) 531-3585 | mypatientrights.org
“Standing Up For Your Rights Creates Results”

**TOP FIVE DENIAL PERCENTAGES**

- Cancer: 15.73%
- Mental Health: 15.03%
- Orthopedic Musculoskeletal: 7.52%
- Cardiac/Circulatory: 7.72%
- Hepatitis: 12.96%

**THE TAKEAWAY:**
If you’ve been denied coverage, you have options—don’t give up!
Visit [www.mypatientrights.org](http://www.mypatientrights.org) for help appealing your insurance denial and to share your story.
# CHOOSE SMART NEVADA HEALTH PLANS

Be smart. Choose the right plan for YOU! Not all health plans are the same.

## CONSIDER
- What ongoing care do I need – is it covered?
- What are my out-of-pocket costs under the plan?
- Deductible
- Copayment
- Coinsurance
- What is the annual out-of-pocket maximum?

## BE AWARE

These are not the only questions you should ask – use this checklist to evaluate and compare important plan benefits and restrictions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Plan A</th>
<th>Plan B</th>
<th>Plan C</th>
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</thead>
<tbody>
<tr>
<td>Can I keep seeing my current doctor?</td>
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<tr>
<td>Is my doctor in my plan’s network?</td>
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<td>Do I need a referral to see a specialist (doctor with special training)?</td>
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<td>Can I see a doctor outside the plan network?</td>
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<td>Is there a specific hospital I must use?</td>
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<td>Do I need prior authorization for treatment?</td>
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<td>Are my current medicines covered (on formulary)?</td>
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<tr>
<td>Are my drugs on a high tier? How much will that cost?</td>
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<td>Is there a step therapy program, which may require a certain drug to be tried first, rather than a drug originally prescribed by my doctor?</td>
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<td>Does my plan have a copay accumulator adjustment program?</td>
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<td>Are there restrictions on the pharmacy I can use?</td>
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<td>What are the mental health and substance abuse benefits?</td>
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<td>Does my plan cover out-patient drug rehabilitation?</td>
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<td>Does my plan cover home health care?</td>
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<td>Does my plan cover durable medical equipment?</td>
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<td>Does my plan offer health education?</td>
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## GLOSSARY

### COINSURANCE
The money you have to pay for health services after you have paid the deductible.

### COPAY
A fee you pay each time you see a doctor or fill a prescription.

### COPAY ACCUMULATOR ADJUSTMENT PROGRAM
When payments made from copay cards aren’t counted toward your deductible.

### DEDUCTIBLE
The amount you must pay for health services before your insurance starts to pay.

### OUT-OF-POCKET MAXIMUM
The most you have to pay for health services. Once you have paid this amount, your insurance pays 100% of your health care costs.

### DURABLE MEDICAL EQUIPMENT (DME)
Examples are wheelchairs, hospital beds, canes, crutches, walkers, ventilators and oxygen.

### FORMULARY
A list of drugs covered by your health plan.

### HEALTH EDUCATION
Is done through programs and services dedicated to educating you on topics like staying fit, managing diseases, maintaining a healthy weight, eating healthy.

### HIGH S TIER
Even though a drug may be covered by your health plan, there are often several levels, or tiers, (1-6) that drugs may fall into, with each level having an increasing copay amount. For drugs on the highest tier, you may have to pay as much as 20-30% of the total cost. Some health plans may also use tiered copays for medical coverage as well.

### PRIOR AUTHORIZATION
Your health plan’s approval process before you receive services. This process lets a provider know if the health plan will cover a needed service.

### STEP THERAPY
Requires “certain” drugs to be tried first, rather than the drug originally prescribed by your doctor.

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As a patient, you have rights – visit: [www.mypatientrights.org](http://www.mypatientrights.org)
Keeping You Informed

You can stay up to date on current events and hear of other individuals’ health care journeys via the MPR blog and social media channels.
Sharing Stories

- Amplifies your voice to make policymakers understand how health plans and others block access to care
- Empowers patients to tell their stories and impact public policy changes

Patients have the right to share their story publicly or not; for confidentiality reasons, they must agree to allow MPR to share their story publicly.
Toolkit

Help us impact change by educating, activating and mobilizing people like you. Legislators and policymakers need to hear our stories. We need your help to share them.

This toolkit provides you with the following:

• Social media content
• Blog or newsletter content
• MPR badge to share on your website

Email info@mypatientrights.org to receive the toolkit.