

# **Basic Consumer Protections**

**For Seniors and People with Disabilities  
in Organized Delivery Systems:  
Medi-Cal 1115 Waiver**

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# Working Families vs. SPDs: More Complex, More Vulnerable

- Medi-Cal managed care was designed primarily for working parents and children
- Knox-Keene which regulates managed care plans, including Medi-Cal managed care, was designed for commercially insured populations, generally individuals under age 65 with the vast majority without significant disabilities
- Neither Medi-Cal managed care nor Knox-Keene were designed for seniors and persons with disabilities
- Low-income seniors and persons with disabilities who rely on Medi-Cal have greater and more complicated health care needs than generally healthy populations under age 65.

# CHCF Performance Standards for SPDs in Managed Care

- Health Access California generally supports the adoption of the CHCF performance standards for SPDs in organized delivery systems
- Health Access recommendations:
  - Provide greater specificity
  - Address other issues
- Protections should be in statute, not just in contract language

# Usual Source of Care?

- Enrollees with usual source of care in Medi-Cal managed care:
  - 52% of pregnant women
  - 37% of adolescents (HEDIS)
- **93% of persons with disabilities on Medi-Cal have a usual source of care**, including both managed care and fee-for service (CHIS, 2009, exhibit 44,p.67).
- Transitioning SPDs likely to disrupt usual source of care
- Many SPDs rely on safety-net of county hospitals & community clinics; Any network needs to build on these institutions, maintain their viability

# Continuity of Care Under Existing Law

- Knox-Keene continuity of care or block transfer provisions if plan-provider contract termination:
  - An acute condition until completion of care
  - A serious chronic condition for as long as 12 months
  - Pregnancy, through the post-natal trimester
  - A terminal illness
  - Care of a newborn child to age 36 months
  - Performance of surgery previously authorized by the plan
  - Additional requirements with respect to mental health services
- CHCF recommendation: less consumer friendly than Knox-Keene Act (60 days vs 12 months)

# Continuity of Care: Recommendations

- Assessment of each consumer's needs prior to enrollment, including cognitive/behavioral needs as well as physical health
- A consumer with 5 or more providers: transition case manager plus 24 months
- Consumer with 4 or fewer providers: one on one assistance from organized delivery system
- Until transition complete, consumer receives care from pre-existing provider under Medi-Cal fee-for-service

# Basic Protections: Knox-Keene Act

Basic consumer protections provided to those in commercial managed care needed by Medi-Cal beneficiaries in organized delivery systems, available in a 1115 waiver:

- Right to a second opinion
- Independent Medical Review
  - Medically Necessary Care, including expedited review
  - Investigational and Experimental Treatment
- Standards for grievances and appeals, including urgent grievances
- Standards for utilization review
- Right to sue an HMO

# Basic Protections: Knox-Keene Act (cont.)

Basic consumer protections provided to those in commercial managed care needed by Medi-Cal beneficiaries in organized delivery systems, available in a 1115 waiver:

- Reasonable person standard for emergency care (more consumer friendly than prudent layperson standard)
- Prescription drug formulary, including availability of brand-name drugs if no generic available
- Public availability of criteria for denial of care
- Timely Access (urgent care within 48 hours, appointment with a doctor within 10 days, etc, or more quickly if consistent with clinically appropriate care)
- Application of all these requirements to contracting providers, including contracting medical groups that accept capitation
- Adequately staffed and trained HMO Help Line: 24/7, 365 days a year

# Network Adequacy: Physical Health

- Medi-Cal plans should be required to demonstrate network adequacy quarterly by county, including specialist access (*beyond CHCF*)
- Contracting primary care providers should accept no more than 1,200 patients from any source, including Medicare and commercial carriers (*beyond CHCF*)
- Ability to go out-of-network if network lacks specialists (*consistent with CHCF and Knox-Keene*)

# Network Adequacy: Social, Community

- Long term care, mental health, substance abuse and other community supports
- Active and regular care coordination and management between Medi-Cal plan and other providers in the community: MOUs are not enough! (*beyond CHCF*)
- Annual consultation between consumer/family member and involved providers (*similar to CCS clinic or IEP for children with disabilities*)

# Disability Access: Compliance

- Measurable, replicable access standards for access for those with disabilities beyond HEDIS/CAHPS
- Annually updated provider directories of accessible providers (*CHCF*)
- Plain-language information to enrollees about their right to accessible care in multiple formats (*CHCF*)
- Consumer quality committees at both the state and local levels to review compliance with contract requirements.
- Audits regarding access for persons with disabilities should be made public.

# Fiscal Solvency: Organized Delivery System

- Insolvency among organized delivery systems unless fiscal solvency standards:
  - Medi-Cal HMOs in early 1970s
  - Medical groups in 1990s
- Entities that accept financial risk must demonstrate adequate financial resources, consistent with Knox-Keene standards for risk bearing organization or health care service plans

# Fiscal Solvency: Rate Methodology

- Medicaid managed care:
  - Often paid at 95% of fee-for-service.
  - Is it adequate if provider rate reimbursement is 47<sup>th</sup> or 51<sup>st</sup> in nation?
- Rate methodology:
  - Reflect complexity, range of care for persons with disabilities, seniors
  - Updated annually
  - Sufficient to assure adequate networks and appropriate incentives
  - Assess cost-effectiveness compared to fee-for-service

# Public Accountability: Public Oversight, Consumer Input

- Public accountability for care: Strong preference for organized delivery systems with publicly elected boards or boards appointed by publicly elected officials
- Local advisory committees familiar with delivery of care and community resources
- Local advisory committees include affected seniors and persons with disabilities
- Organized delivery systems operated by for-profit entities accountable to shareholders, not local constituencies: how do Medi-Cal consumers assure accountability?

# Enrollment: Default, Marketing & Outreach

- Any default mechanism should give preference to:
  - Remaining with existing providers in fee-for-service if unable to arrange adequate network of specialists
  - Publicly accountable organized delivery systems
  - Reliance of the organized delivery system on the safety net of public hospitals and community clinics
- Outreach and enrollment primarily by the State of California, not providers paid by HMOs
- Marketing materials by an organized delivery system subject to prior review and approval by both DHCS and DMHC to minimize risk selection by plans
- Stakeholder input on materials
- Literacy, language access and need for alternative formats should be key considerations