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**Consumer Protections for Seniors and  
People with Disabilities on Medi-Cal  
Proposed for Mandatory Enrollment into  
Organized Delivery Systems**

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# Consumer Standards / Protections

- Paper developed with other legal aid and disability advocates.
  - Framed as protections and standards for any mandatory organized delivery system.
  - This presentation won't cover everything in our paper, e.g. disability access standards, stakeholder processes, performance standards & monitoring, medical transportation, provider adequacy, an effective delivery system for SPDs – all of which are critical.
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# Consumer Standards / Protections

- Today, I'll be focusing on issues that we have not discussed as much such as the transition and enrollment processes and consumer grievances and appeals.
  - Important for this group to spend time looking at delivery systems other than managed care and how plans can develop a full patient-centered health care home model.
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# Why These Standards are Important

- The reason we're all here – helping improve and protect the health of Real People.
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# General Standards

- Necessary standards must be contained in statutes and regulations. Contract provisions are insufficient because unlike legislation and regulation private contracts:
    - They are not publicly available.
    - They are not enforceable by consumers.
    - They are not subject to public input and negotiation.
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# General Standards

- The Department's Medi-Cal Managed Care Division (MMCD) should separate its enforcement unit from its other units and engage in more rigorous enforcement activities.
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# General Standards

- The Department should use independent and local ombudsman programs, like the Health Consumer Alliance to assist beneficiaries with:
    - Understanding the new system and their choices;
    - Picking a delivery system to achieve continuity of care; and
    - Explaining and assisting with the exemption process.
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# General Standards

- Certain Populations Should Remain Optional for Managed Care Enrollment:
    - CCS
    - Specialty Mental Health Section 1915(b) Waiver
    - Other medical home and community based services Section 1915(c) waivers (Nursing Facility-Acute Hospital Waiver, AIDS waiver, MSSP waiver)
    - Dual eligible beneficiaries, and
    - Those with other health coverage (OHC)
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## Transition and Enrollment

- The Administration proposes putting hundreds of thousands of SPDs into a mandatory closed delivery system. This would be a monumental transition and we must tread carefully. Because of the complexity of this diverse population, many of whom have serious health conditions, they cannot be enrolled into a closed network without careful outreach and education and then careful selection of the appropriate network and a careful transition **prior** to enrollment.
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## Transition and Enrollment: Education & Outreach

- First step is an aggressive education and outreach campaign to educate affected beneficiaries about the upcoming changes.
    - Build on efforts to date, e.g. “*What Are My Medical Choices?*” booklet
  - Important to consult with stakeholders about ensuring effective communication with this diverse community.
    - e.g. Special outreach to the deaf community.
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# Transition and Enrollment

- Beneficiaries must be given adequate time, assistance and information to make an informed choice.
    - After the period of education and outreach, beneficiaries can be sent an enrollment packet and should be given at least 90 days to enroll in a health plan or other choice of system.
    - As with the education and outreach important to carefully craft the enrollment packet to be understandable and accessible.
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# Transition and Enrollment

- Beneficiaries must have assistance in navigating the transition and enrollment process.
    - Entity who is knowledgeable about the needs of SPDs and the local health care systems.
    - Entity who can help beneficiaries exercise their exemption and continuity of care rights, including to stay with providers who do not contract with the delivery system.
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# Transition and Enrollment

- For beneficiaries who do not make a choice within 90 days, an individualized assessment must be made before they are enrolled in a mandatory closed system of care.
  - In many cases, the beneficiaries who do not make an affirmative choice will be the most vulnerable and least able to navigate a new health care delivery system, e.g. homeless people and people with mental health conditions, developmental disabilities, and cognitive impairments. **They should not simply be defaulted into a system / network.**
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# Transition and Enrollment

- For beneficiaries who don't make a choice, a qualified entity should examine their claims data to get as much information as possible about their health conditions, providers and usual sources of care.
  - The beneficiaries should be contacted to assist in making delivery system choice and a transition plan.
    - May need to meet with some people in person.
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# Transition and Enrollment

- Beneficiaries should have the ability to continue receiving services from their current providers even if they are not contracted with the closed network for at least 12 months or longer, if medically necessary.
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# Transition and Enrollment

- For each enrollee, the Department must provide the health plan or other delivery system data on FFS claims, including diagnosis codes, provider information and a list of Medi-Cal services received from other systems: mental health plans, drug and alcohol programs, regional centers, CCS, GHPP, personal care services, and ADHC.
  - The Department or the enrollment entity shall identify enrollees with more complex or extensive health care needs and alert the plans accordingly.
  - In addition, the health plan or delivery system should ensure an assessment of each beneficiary within 30 days of enrollment.
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# Transition and Enrollment

- Enrollment into a mandatory delivery system must be done gradually and be evaluated for progress.
  - The Department must closely monitor network capacity during transition.
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# Disenrollments & Medical Exemptions

- The right to disenrollment must be protected and expanded. The current procedure is onerous and time-consuming.
  - Available exemptions from plan enrollment should be broadened to allow persons receiving FFS Medi-Cal treatment and services for a complex medical condition to continue in FFS Medi-Cal for at least one year until the condition has stabilized, or indefinitely if the condition is not subject to change, i.e transplant recipients.
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# Grievances and Appeals

- Notices to beneficiaries must be standardized and meet all legal requirements.
  - Plans must ensure flexibility and accommodations with grievances and appeals.
  - Grievance and Appeals procedures must comply with Medicaid **and** Knox-Keene requirements.
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# Presenter's Contact Information

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