

California Department of Health Care Services Health Plan Requirements under California's Waiver

California's new comprehensive waiver will ensure more organized, accountable delivery models to improve care for seniors and persons with disabilities (SPDs). Plans serving SPDs will have to meet enhanced requirements for access and performance improvement.

Access Standards:

Network Adequacy – Department of Health Care Services (DHCS), working closely with the Department of Managed Health Care (DMHC), will determine SPD enrollment capacity based on the provider networks available in managed care plans and on any updated information related to expansions of capacity. Network adequacy for the enrollment of SPDs will require sufficient specialists necessary to care for the specialized needs of this population consistent with the Department of Managed Health Care and DHCS processes and any enhancements DHCS deems necessary to further support the care of the SPDs. Network adequacy will determine each model's SPD enrollment capacity and will be monitored quarterly to ensure enrollment does not exceed capacity.

Access to Information – Current contracts require Medi-Cal managed care plan communication with members be provided in ways that meet the cultural and language needs of the members. Additional plan instructions will be added to require the communication be made available in alternative formats or plain language to assure that all members have access to communications that take into account hearing, visual, or other limitations.

Physical Accessibility – DHCS will adopt an enhanced facility site review (FSR) tool that focuses on the access needs of people with disabilities and chronic conditions to be used by plans to assess the physical and non-physical accessibility of their network providers. The plan will make available to members and prospective enrollees the information from the assessment for each provider. The enhanced FSR tool will be implemented by the contracted Medi-Cal managed care health plans and county alternative option models and monitored by DHCS.

Access to Existing Providers – Members will have the opportunity to select a plan that includes their preferred providers in the network. DHCS will require plans to allow new plan members under active treatment with an out-of-network provider to continue with the existing out-of-network provider for a period of up to 60 days. However, medical exemptions are available for up to one year to Medi-Cal beneficiaries that have been assigned to managed care plans and are already under treatment for a complex medical condition or pregnancy by a FFS-Only provider until the medical condition stabilizes.

DHCS will also ensure that Medi-Cal managed care health plans involved in the demonstration project provide access to out of network providers for SPD members who have an ongoing relationship with an FFS provider if the provider will accept the rates offered by the plan, and the plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues.

Performance Monitoring and Improvement:

Expand Required Performance Measures – DHCS will develop and publish results for existing and additional performance measures in ways that provide quality indicators not only for each plan’s entire Medi-Cal managed care population, but also specifically for each plan’s enrolled SPDs. DHCS will expand current annual utilization data submitted by plans for emergency room use, inpatient and outpatient care, and prescription drugs to present results not only for each plan’s entire Medi-Cal managed care population shown in standard age bands, but also specifically for SPDs or other eligibility categories. In developing new performance measures and expanding reporting of performance measures and utilization data, DHCS will develop technical specification, sample sizes, audit procedures, and reporting methodology. Initial results of new and expanded performance measures and initial reporting of expanded utilization data will begin in the year after SPDs have been enrolled in the delivery models for at least 12 months.

New HEDIS measures – DHCS will adopt and report on new HEDIS measures that provide qualitative assessments that reflect the specific conditions relevant to the SPD population. DHCS will also expand reporting of results on existing HEDIS measures to include results specifically for SPDs and will adopt and report on new HEDIS measures that provide quality indicators not only for each plan’s entire Medi-Cal managed care population, but also reflect the specific care needs of the SPD population. DHCS plans to begin work with its External Quality Review Organization by January 2011, select measures by August 2011, so a first report can be issued August 2012.

SPD Representation – DHCS already requires plans’ advisory committees to include members who represent the needs of the SPD population so they can participate in establishing public policy for these populations. DHCS will provide additional oversight through review of meeting agenda and participants.

Complaint and Grievance Procedures – DHCS will continue to provide beneficiaries with accessible methods to support the submission and resolution of member complaints and grievances. DHCS requires health plans to implement and maintain a Member Grievance System. DHCS provides complaint resolution support through the DHCS Ombudsman Program’s toll-free telephone line. At any time during the grievance process, whether the grievance is resolved or unresolved, members or their representative may request a State hearing from the California Department of Social Services through the State’s Hearing Process. An additional avenue to file complaints is through the DMHC which provides members with a resolution process that includes a toll free number.

DHCS also requires health plans to maintain a complaint and grievance resolution system to address and resolve provider issues. When providers have not achieved resolution through this plan process, they can contact DHCS for grievance and complaint resolution. DHCS provides assistance and contacts the health plan to discuss a resolution. Providers associated with a Knox-Keene licensed health plan will continue to have the option to obtain resolution support through the DMHC who requires licensed plans to maintain a complaint and grievance resolution system designed to assist providers with resolving complaints regarding payment and contract issues.