

# AARP PROPOSED AMENDMENTS TO

## Department of Health Care Services Proposed May Revision Trailer Bill Legislation New 1115 Waiver: Enrollment of Seniors and Persons With Disabilities in Medi-Cal Managed Care Pilot Program

June 9, 2010

Add Section 14183 to the Welfare and Institutions Code to read:

### 14183. Medi-Cal Managed Care Expansion

(a) In furtherance of the demonstration project developed pursuant to Section 14180, the department may require that seniors and persons with disabilities be ~~assigned as mandatory enrollees~~ enrolled into a new or existing Medi-Cal managed care health plans plan which meets the criteria specified in this section, provided there exists a choice of such plans serving the area in which the person resides. To the extent that such mandatory enrollment is required, an enrollee's A person's access to fee-for-service Medi-Cal shall not be terminated until (1) the enrollee has selected a plan, or if the person has not selected a plan after a reasonable period of time after receipt of information and counseling regarding the person's choices, has been assigned to a managed care provider plan, and (2) the person has been assessed and a care plan developed as provided in this section. A person enrolled in a plan pursuant to this section shall at least annually be provided an opportunity to enroll in an alternative plan meeting the criteria specified in this section. If no such alternative plan exists the person may receive services from any licensed provider.

(b) In exercising its authority pursuant to subsection (a), the Department shall:

- 1) Assess and ensure the readiness of the enrollment system to adequately address the unique needs of seniors and persons with disabilities;
- 2) Develop and implement an outreach and education program to seniors and persons with disabilities to inform them of their enrollment options and rights under the demonstration;
- 3) Implement an appropriate awareness and sensitivity training program for Plans , plan providers and staff in the DHCS Medi-Cal Managed Division;
- 4) Coordinate with Medi-Cal managed care health plans to develop and implement a ~~mutually acceptable~~ mechanism to identify, within the earliest possible timeframe, persons with special health care and long term service and support needs, particularly seniors and persons with disabilities;
- 5) Provide Medi-Cal managed care health plans, not less than 30 days prior to enrollment, with a list containing the names of fee-for-service providers that are providing services to beneficiaries who are to be enrolled in a managed care health plan, diagnoses, and claims history (including pharmacy claims), so that the plans involved in the demonstration project are better able to assist beneficiaries in continuing their existing provider-patient relationships and prioritizing assessment and care planning for enrollees in the demonstration project.

6) Develop and provide Medi-Cal managed care health plans involved in the demonstration project with an enhanced Facility Site Review tool for use in assessing a clinic or provider site's accessibility.

7) Develop a process to enforce legal sanctions, including but not limited to financial penalties, withholds, enrollment termination, and contract termination, in order to sanction any Medi-Cal managed care health plan involved in the demonstration project that consistently or repeatedly fails to meet performance standards. Persons enrolled in a plan receiving any sanction pursuant to this paragraph shall be notified and provided an opportunity to enroll in an alternative plan.

8) Ensure that enrollees under the demonstration project are provided with an opportunity for members to select a specialist as a primary care provider.

9) Ensure that Medi-Cal managed care health plans involved in the demonstration project are able to provide communication access to seniors and persons with disabilities in alternative formats or through other methods that assure communication, including assistive listening systems, sign language interpreters, captioning, pad and pencil, plain language or written translations and oral interpreters, including for those who are limited English-proficient or non-English speaking, and that all such Medi-Cal managed care health plans are in compliance with applicable cultural and linguistic requirements.

10) Ensure that Medi-Cal managed care health plans involved in the demonstration project provide access to out of network providers for individual seniors and persons with disabilities members who have an ongoing relationship with such a provider if the provider will accept the rates offered by the plan to its contracted providers, and ~~the plan determines that~~ the provider meets applicable professional standards and has no disqualifying quality of care issues.

(c) The department shall contract to provide services to seniors and persons with disabilities only with plans the department has certified as ready to meet the needs of this population. Prior to exercising its authority under this section and Section 14180, the Department shall ~~ensure~~ certify that each Medi-Cal managed care health plan involved in the demonstration project is able to:

1) Comply with the applicable readiness evaluation requirements set forth in Section 14087.48. The assessment of network adequacy, including the assessment of the adequacy of specialists for the population makeup, shall be determined in collaboration with the Department of Managed Health Care;

2) ~~Ensure an appropriate provider network, including primary care physicians, specialists, professional, allied, and medical supportive personnel and an adequate number of facilities within each service area.~~ Provide care management and coordination services for persons identified as having a need for greater care management than can be provided by the person's primary care physician under standards promulgated by the department. Care management and coordination services shall use a multidisciplinary team approach that places the person at the center of care so that all medical, social and personal needs are considered, and uses a qualified case manager who coordinates services among the multidisciplinary team members, the person, and his or her family or guardian. Qualified care managers may include

nurses, social workers, rehabilitation counselors or therapists, physicians' assistants, physicians, or other appropriate qualified individuals. Care management and coordination includes identification and assessment of a person's needs, advocacy, facilitation and coordination of plan, carved-out and other related social, educational and other services needed by the person, using a process that integrates the person's strengths and needs, resulting in mutually agreed upon services that meet the person's medical, functional, and medically-related social needs.

3) Assess the health care and long term support and service needs of beneficiaries who are seniors and persons with disabilities and coordinate their care across all settings, including coordination of discharge to necessary services within and, where necessary, outside of the plan's provider network. A comprehensive, in-person assessment, including cognitive, behavioral, and substance abuse, shall be completed and a care plan developed not more than 90 days after enrollment. Those with recent or complex health needs shall receive an assessment as soon as possible and not later than 30 days after enrollment;

4) Ensure that the provider network and informational materials meet the linguistic and other special needs of seniors and persons with disabilities, including providing information in an understandable manner in plain language, maintaining toll-free phone lines, accessible facilities, and offering member or ombudsmen services;

5) Provide clear, timely and fair processes for accepting and acting upon complaints, grievances and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits. Each plan involved in the demonstration project shall have a grievance process that complies with Health & Safety Code sections 1368 and 1368.01;

6) Ensure stakeholder and member participation in advisory groups for the planning and development activities related to provision of services for seniors and persons with disabilities;

6) Contract with traditional and safety net providers to ensure access to care and services;

7) Inform seniors and persons with disabilities of procedures for obtaining transportation services to service sites that are offered by the plan or are available through the Medi-Cal program; and

8) Monitor and improve the quality and appropriateness of care for children with special health care needs, including children eligible for or enrolled in the California Children Services Program, and for seniors and persons with disabilities.

9) Maintain a dedicated liaison to coordinate with each regional center operating within the plan's service area to assist members with developmental disabilities in understanding and accessing services and act as a central point of contact for questions, access and care concerns, and problem resolution.

(d) Beneficiaries enrolled in Medi-Cal managed care health plans pursuant to this section shall have the choice to continue an established patient-provider relationship in a Medi-Cal managed care health plan involved in the demonstration project pursuant to paragraph (10) of subdivision (b) or if his or her treating provider is a primary care provider or clinic contracting with the Medi-Cal managed care health plan and has available capacity and agrees to continue to treat that beneficiary.

(e) The Department, or as applicable, the negotiator, may contract with existing Medi-Cal managed care health plans operating under the demonstration project to provide or arrange for services under this section. Notwithstanding any other provision of law, the Department, or as applicable, the negotiator, may enter into the contract without the need for a competitive bid process or other contract proposal process, provided the Medi-Cal managed care health plan submits a written proposal with adequate documentation that demonstrates it meets all qualifications and requirements for certification under of this section. Alternatively, and notwithstanding any provision of law to the contrary, the Department, or as applicable, the negotiator, may seek applications and thereafter contract with any qualified individual, entity, or organization to provide or arrange for services under this section.

(f) (1) Except for counties operating under the County Organized Health Systems Model and notwithstanding any requirements outlined in 14087.3-14087.48 and 14089 –14089.8, a county shall have the option, subject to approval by the department, to develop an alternative model of care consistent with the terms of the demonstration project to provide all necessary health care services to beneficiaries categorized as Seniors or Persons with Disabilities under the demonstration project. The county alternative model of care may be managed by county staff and shall not be required to obtain Knox-Keene licensure unless otherwise required by the Knox-Keene Act.

(2) For purposes of this subdivision, alternative models of care may include, at the discretion of the department, administrative services organizations, primary care case management, and such other models as the department shall determine acceptable.

(3) The county alternative model option must be established ~~prior to commencement of mandatory enrollment of seniors and persons with disabilities into the county and~~ no later than January 2012, and enrollment of seniors and disabled in a county that establishes an alternative model will not be required until the plan is established.

(4) The department shall determine an actuarially sound rate for the county alternative model ~~that shall be~~ , and shall not approve a county alternative model unless it provides all necessary and appropriate services to seniors and persons with disabilities and is budget neutral to the state.

(g) This section shall be implemented only to the extent that federal financial participation is available.

(h) The development and negotiation of capitation rates for Medi-Cal managed care health plan contracts shall ~~involve the~~ be based on an analysis of data specific to the seniors and persons with disabilities population. For the purposes of developing or negotiating capitation rates for payments to Medi-Cal managed care health plans, the director shall have the authority to require Medi-Cal managed care health plans, including existing Medi-Cal managed health care plans, to submit financial and utilization data timely in a form and substance as deemed necessary by the Department.

(j) Persons meeting participation requirements for the Program of All-Inclusive Care for the Elderly (PACE) may select a PACE plan if one is available in that county.

(k) ~~Notwithstanding~~ To the extent consistent with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement, interpret or make specific this section and any applicable federal waivers and state plan amendments by means of county letters, plan letters, plan or provider bulletins, or similar instructions. If the department adopts regulations to implement this section, any applicable federal waivers and state plan amendments, the adoption of such regulations shall be deemed an emergency.

(l) Consistent with state law that exempts Medi-Cal managed care contracts from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code and in order to achieve maximum costs savings, the Legislature hereby determines that an expedited contract process is necessary for Medi-Cal managed care plan contracts entered into or amended pursuant to this section. Such contracts and amendments shall be exempt from Chapter 2 (commencing with Section 10290 of Part 2 of Division 2 of the Public Contract Code) and the requirements of State Administrative Management Manual Memo 03-10, provided the contracts are presented to the stakeholder advisory committee required pursuant to subdivision (b) of Section 14181 at a publically noticed meeting and made available to the public on the department's website for not less than 30 days prior to such meeting.

(m) In the event of a conflict between the terms and conditions of the approved demonstration project, including any attachment thereto, and any provision of this Part, the terms and conditions shall control until January 1 following the date the conflict arises. In the event the conflict is not resolved by January 1 following the date the conflict arises, the demonstration project authorized by this section shall terminate on the following September 30.

(n) In the event of a conflict between the provisions of this article and any other provision of this Part, the provisions of this article shall control.

(o) Any otherwise-applicable provisions of this Chapter or Chapter Eight not in conflict with this article or with the terms and conditions of the demonstration project shall apply to this section.

(p) To the extent that the director utilizes state plan amendments or waivers to accomplish the purposes of this article in addition to waivers granted under the demonstration project, the terms of such state plan amendments or waivers shall control in the event of a conflict with any provision of this Part until January 1 following the date the conflict arises. In the event the conflict is not resolved by January 1 following the date the conflict arises, the demonstration project authorized by this section shall terminate on the following September 30.

(q) Enrollment of seniors and persons with disabilities into a managed care organization or county alternative option under this section shall be accomplished using a phased-in process to be determined by the department. This process shall not commence until all necessary federal approvals have been acquired, until a sufficient number of plans have been certified under this section to provide persons being enrolled at least two choices, or until February 1, 2011, whichever occurs later.

(r) Any managed care arrangement established pursuant to this section or under the terms and conditions of the demonstration project shall be subject to and shall comply with the

requirements for submission of encounter data under Welfare and Institutions Code section 14xxx.

(s) The Department shall provide the fiscal and policy committees of the Legislature with annual updates, commencing February 1, 2012, and continuing through February 1, 2014 regarding ~~core activities for the enrollment of seniors and persons with disabilities into the Medi-Cal Managed Care Program~~ the implementation and outcomes of the demonstration project. The report shall include, but not be limited to, information concerning the certification of the readiness of plans to serve seniors and persons with disabilities, the transition of persons into certified plans, including the timeliness of the initial assessment and development of care plans, the care management and coordination process and results, the satisfaction of enrollees in each of the certified plans, an assessment of the nature and extent of complaints from beneficiaries in each of the certified plans, and such other information determined relevant to an assessment of the demonstration. The annual updates shall include key milestones and objectives of progress regarding changes to the existing program, submittal of state plan amendments to the federal Centers for Medicare and Medicaid Services, submittal of any federal waiver documents, and applicable key functions related to the mandatory enrollment of seniors and persons with disabilities.

Add Section 14xxx to Welfare and Institutions Code to read:

(a) Commencing on January 1, 2011, all Medi-Cal managed care plans and such other managed care arrangements, including county alternative models under Section 14183, as the department shall specify, shall be required to submit data, including but not limited to encounter data and financial data, in the form and to the specifications prescribed by the department for the development of rates, monitoring plan performance, and ensuring quality. Data shall be made available to independent researchers to assist in the evaluation of the demonstration project in a format that does not allow individuals to be identified.

(b) Failure of a managed care organization or arrangement to comply with the requirements established by the department under this section shall result in a penalty, imposed by the department monthly, of two percent of the total monthly capitation rate for that plan or organization per months until the organization or arrangement has fully complied with such requirements.

(c) The requirements for reporting data, pursuant to subdivision (a) shall apply to all services provided to members under this Chapter and Chapter 8, regardless of whether or not such member is a senior or a person with a disability or disabilities.

(d) Failure of a provider or subcontractor to submit data to a managed care organization or arrangement shall not relieve the organization or arrangement from its responsibilities under this section and shall not affect imposition of the penalty established in subdivision (b).

(e) ~~Notwithstanding~~ To the extent consistent with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), the department may implement, interpret or make specific this section by means of plan letters, plan or provider bulletins, or similar instructions ~~without the necessity for adopting regulations.~~ If the department elects to ~~adopt~~ adopts regulations, such adoption shall be deemed an emergency.

Add Section 14183.5 to the W&I Code to read:

14183.5. In conjunction with the implementation of Section 14183, the department shall work with counties to develop a formula to be used in determining the appropriate contribution to cover the non-federal share of inpatient hospital expenses for seniors and persons with disabilities in the Medi-Cal program.