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

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Pursuant to the 1115 Waiver, the Administration is considering a policy that will require involuntary enrollment of Seniors and People with Disabilities (SPDs) into Medi-Cal Managed Care plans and/or other organized delivery systems. This population includes people with complex health care maintenance needs and increased susceptibility to secondary conditions. As a result, this group is more vulnerable overall to disruptions and inflexibility in health care delivery than most members who are currently enrolled in mandatory managed care.

To be clear, we do not believe that SPDs should be required to enroll in Medi-Cal managed care plans beyond what currently is allowed. Instead, we believe that an enhanced care coordination or "patient-centered medical or health care home" model should be developed and implemented within the fee-for-service (FFS) system to serve the range of needs of this population – from very limited to intensive assistance. Such a model would be more cost-effective and would produce better health outcomes than what exists under the current FFS Medi-Cal system, providing the very kinds of services that many SPDs need and want, while protecting their ability to maintain choice and an appropriate level of control over their care.

If the state decides to mandate enrollment of SPDs into a mandatory closed delivery system, the state must develop and **implement** a set of minimum standards and protections **prior** to enrollment. The managed care plans should be required to create new delivery systems to provide a "patient-centered medical or health care home" to address the needs of these beneficiaries, and be responsible for the care of the whole person. While the state should impose many of these standards regardless of whether it mandates enrollment of SPDs, such protections are critical if the waiver includes mandatory enrollment of this population into managed care. These standards, once fully implemented by the state and health plans, should be monitored and enforced on an ongoing basis. Standards that are currently in place should be reviewed in light of the recommendations and revised, as necessary, before implementation to ensure they are in alignment with these recommended standards.

Some standards would have to be adopted by the Legislature, some implemented by the Department of Health Care Services (Department) and some implemented by health plans and providers of care.

General Standards

1. Necessary Standards Must Be Contained in Statutes and Regulations.

Standards for SPDs in organized delivery systems must be included in statutes and regulations that are applicable to all plans and systems. Including standards in contracts between the Department and health plans without codification in statute or regulation is insufficient for a number of reasons:

(2) **Accountability**: Plan contracts are not subject to enforcement by beneficiaries or advocates. By contrast, regulations and statutes allow for public input during the rulemaking process and beneficiaries can enforce the rules when they are not complied with. Even if the contract terms provide meaningful provisions or protections, beneficiaries and advocates would have little or no opportunity to rely on these terms to change the actions of a health plan. In the past, the Department has not used contractual terms to enforce rights and protections meaningful to beneficiaries or effectively monitored plans to ensure adherence to such terms.

(3) **Transparency**: Health plan contracts are not readily available to beneficiaries, advocates or the general public. Managed care plans may claim the information is "proprietary" and not subject to disclosure, even when the plan is providing services under a public program with public tax dollars. As such, the terms are not known to the very members they are designed to serve. The state must pass legislation clarifying that private managed care plans are required by law to make information available to enrollees, potential enrollees, and their representatives upon request.

(4) **Public Input**: Unlike legislation and regulatory rulemaking procedures, plan contracts are not subject to public input or negotiation. Contracts are also subject to modification at any time, with no notice or opportunity to object.

2. Health Plans Must be Knox-Keene Licensed.

Today, all currently operating Medi-Cal managed care plans are Knox-Keene licensed, but that has not always been the case. Plans must be Knox-Keene licensed to comply with the consumer protection provisions of the Knox-Keene Act (KKA). In addition, Medi-Cal enrollees of such plans should have access to

the consumer remedies available through the Department of Managed Health Care in addition to any right to address concerns through the Department, the Medi-Cal Ombuds office, or the County Mental Health Plans. While the Knox-Keene protections and accompanying regulations are neither specifically designed for nor adequate to address the needs of people with disabilities, they offer a minimal baseline of enforceable protection for beneficiaries.

3. Stakeholders Must Be Involved At All Levels.

The state should require meaningful involvement of consumers (SPDs) and consumer advocacy representatives at all levels and stages of the process of developing transition and implementation procedures and protections prior to initiating any mandatory enrollment process and throughout enrollment – oversight and advisory boards, ad hoc committees, and other decision-making bodies. The stakeholder processes and oversight boards or bodies must be in place well in advance of the beginning of any expansion of mandatory enrollment, with all necessary accommodations provided for meaningful participation from participants with communication and other disabilities. The state should impose similar requirements for health plans to include meaningful involvement of consumers in each county where they operate as part of this readiness process.

a. The Department Must Have an SPD Stakeholder Advisory Committee.

At least 12 months before the Department requires enrollment of SPDs, the Department should establish a stakeholder advisory board, composed of Medi-Cal beneficiaries, consumer representatives, disability advocates, health care professionals, county departments, labor union representatives, legislative representatives, health plan representatives, and other stakeholders to advise the Department on all aspects of the planning, implementation and operation of mandatory enrollment of SPDs in a closed delivery system. The stakeholder advisory board shall advise the Department and review and comment on all aspects of the planning, implementation and operation of mandatory enrollment of SPDs.

b. Each Plan or Delivery System Serving SPDs Must Have An Advisory Body.

Health plans and other delivery systems serving SPDs must have an advisory committee in each county where they operate for at least 18 months prior to

implementation and shall continue so long as mandatory enrollment continues. Stakeholders shall include but not be limited to: persons with disabilities, seniors, physicians, hospitals, consumer advocates, disability advocates, county or UC hospital, if any, and labor union representatives.

4. Education and Outreach for SPDs Must Occur Prior to Implementation.

The department should develop and implement – with the help of consumers and consumer advocates – an effective outreach and education plan to inform and educate SPDs about their right to voluntarily enroll in managed care (and to assist them in doing so) before mandatory enrollment in any organized delivery system begins. Particular care should be taken to provide outreach to the deaf community with culturally appropriate materials and communication in addition to printed materials. This plan must also educate SPDs subject to mandatory enrollment in certain counties about the enrollment process, their options and resources to address individual problems or complaints. A resource guide called, "*What Are My Medi-Cal Choices*" was developed through a contract with the University of Berkeley's Health Research for Action, and this model can be built upon. In Par. 20 below, we discuss specifically pre-enrollment consumer education and outreach.

5. The Department Should Use Independent and Local Ombudsman Programs to Assist Beneficiaries.

During transition and mandatory enrollment into any delivery system, the Department should contract with local ombudsman or consumer assistance programs, such as those in the Health Consumer Alliance, to assist Medi-Cal beneficiaries with questions or problems, including understanding the new system and their options, talking to their providers and evaluating delivery system options to achieve continuity of care, and explaining and assisting with the exemption process. This role would not be intended to duplicate the care coordination role which is also essential to assist beneficiaries directly with their medical care and treatment options.

Local ombudsmen or consumer assistance programs should continue to play a role after the initial transition phase, including assisting Medi-Cal recipients with problems navigating health plan processes, such as denials of care, grievances and appeals. The use of these local advocacy programs is critical because, unlike any

statewide system, they are locally based in the community and can therefore advise consumers in a particular county and community about their choices and resources. While it is important to maintain the Medi-Cal Managed Care Ombudsman to assist statewide with disenrollment and they should continue to advise consumers about their grievance and appeal rights, consumers need experienced local advocates to assist them with disenrollment, grievances and appeals.

6. The Department Must Ensure Compliance with Federal and State Disability Rights Laws.

The Department should utilize a health plan readiness and provider tool developed and/or approved by consumers with disabilities and disability advocates, including initial minimum requirements that a health plan and its network providers each must meet before enrolling SPDs. The plan must demonstrate that its services are available to all, regardless of disability. Additionally, before a provider is offered as a network provider available to people with disabilities, the provider must demonstrate that she or he can provide care and services that are physically and programmatically accessible to persons with various disabilities. The plan must show the administrative capacity to provide members with up-to-date information about physical programmatic accessibility of provider offices and the accommodations that plan providers will undertake.

7. The Department Must Ensure Compliance with All Laws Relevant to Communication with Enrollees.

The Department should utilize a health plan readiness tool to ensure health plans and providers can demonstrate their capacity and meet their legal obligations regarding communication access, such as the provision of alternative formats or other methods that assure effective communication with people who have limited communication abilities due to disability or limited English proficiency (assistive listening systems, sign language interpreters, captioning, pad and pencil, written translation, oral interpreters). Communication access may include video conferencing with interpreters. Communication access resources must be available through all points of contact, including at outpatient encounters (such as in pharmacies), appointment scheduling, and member services.

California law[1] provides the state's one direct reimbursement mechanism for providing American Sign Language (ASL) services. It provides a billing code that

[1] 22 CCR § 51503.3.

enables Medi-Cal enrolled providers with fewer than fifteen employees to be reimbursed at specified rates for the provision of certified or non-certified ASL translation services. "Large" providers with more than fifteen employees cannot separately bill for ASL and other communication services because in theory translation services are "built into" the general cost of the provision of services. In practice, communication access services are all too frequently not provided as plans and providers lack on-the-ground administrative mechanisms and coordination for meeting their obligations under federal and state law.

The Department should issue Policy Letter(s) and Guidance to Medi-Cal managed care plans clarifying that both plans and providers are required to provide communication access services within existing capitation rates. The Department should also develop an enhanced capitation rate for Medi-Cal managed care plans that voluntarily provide the Department with full information regarding the administrative policies and procedures through which plan providers are informed of and reimbursed for meeting their language access obligations, and with monitoring, tracking and enforcement information for how plan providers offer communication access services and fulfill their effective communication obligations under state and federal law. Finally, the Department should engage managed care plans and providers to study other options for the timely, consistent delivery of effective communication access services, such as the Department or plans contracting directly with language services agencies or directly with interpreters.

8. The Department Must Develop and Enforce Health Plan Performance Standards.

With an 1115 demonstration waiver, the Department should be able to monitor and demonstrate improvements in quality of care and outcomes as compared to fee-for-service Medi-Cal for SPDs. The Department can accomplish this assessment through retrospective reviews of patterns of practice, drug prescriptions, utilization management (including under- or over-utilization of specific services, including hospital admission), health outcome data (including management of chronic physical and mental health conditions), consumer outcome measures (including satisfaction surveys), rates of enrollee use of services, grievance and appeal data, and other related measures for Medi-Cal only SPDs. Outcome reviews should also be available to the public to promote transparency of health plan reviews. Health plans and contracting providers must be required to maintain and provide reliable and timely data, including utilization and encounter data, data required for EPSDT

reporting, and any other data necessary for the State to meet its oversight responsibilities. The performance standards used for employment-linked or family/children populations are not sufficient to address and measure performance for the SPD population. The standards, among other things, should relate to physical and programmatic accessibility, care management and coordination, treatment planning, carve-out services, member services, network capacity, access to specialty care, including hospital outpatient specialty care and specialty care clinics, and complaint, grievance and appeals procedures. Performance standards should be periodically updated and include consumer input from people with a wide range of disabilities into how outcomes are measured. Health plan performance measures targeted to the needs of people with disabilities should also be developed and included as part of the performance review.

9. The Provider Network Must Be Adequate to Serve SPDs and Include Providers Outside the Network where Medically Appropriate.

Any closed mandatory delivery system for SPDs must include, or provide access to, providers with both experience and expertise in addressing the myriad of disabilities and medical condition needs of the SPD population, including children with disabilities. SPDs must also have access to providers who have the language skills and cultural competencies necessary to engage and retain individuals in care. This standard may require the plans or systems to cover providers outside the geographic area served, to cover services through hospital outpatient clinics and specialty care centers, or to arrange and authorize standing referrals to specialists or specialty care centers outside the network when a physician with the necessary experience and expertise is not available within network.

The plans must be required to exercise flexibility in how primary care physician (PCP) responsibilities are shared with a specialist or specialty care center, when necessary. For example, in some cases, a beneficiary may need to have a particular specialist designated as the PCP, and the plans should be required to allow this designation when appropriate. Also, in addition to making available the usual range of necessary providers identified by area of specialty, plans should specify and ensure the availability of categories of providers that SPDs rely upon, including, but not limited to: Commission on Accreditation of Rehabilitation Facilities' accredited inpatient and outpatient rehabilitation programs, applied rehabilitative technology programs, wheelchair seating clinics (including access to wheelchair assessments) independent of durable medical equipment providers, specialty care centers (including those Ryan White Care providers serving people

living with HIV throughout California), the Genetically Handicapped Persons Program certified providers that serve SPDs, non-coercive reproductive health services, speech pathologists (including those experienced in working with nonverbal individuals, persons with developmental disabilities and persons who need speech generating devices), occupational therapy, orthotics providers and fabricators, physical therapy, programs that provide case management to people with significant non-medical barriers to care, and low vision centers. Where plans offer health education and wellness programs, they must identify ways to make those programs accessible both in terms of materials offered in alternative format and physical and programmatic access in facilities.

a. The Department must Ensure an Adequate Provider Network Exists.

Prior to beginning mandatory enrollment of SPDs**,** the Department must develop transition standards applicable to both the managed care plans and to the entities brokering or administering the enrollment process. These standards are necessary to ensure that SPDs are enrolled into managed care without any disruption to their system of care, that continuity of care and access to existing specialists is preserved and protected, and that access to fee-for-service (FFS) Medi-Cal covered services are not curtailed unless and until the providers have begun providing services as part of the health plan network (including the existing providers who are offered the opportunity to join). The Department must demonstrate that existing providers and specialists serving the SPD populations have contracts with plans, rather than that the plans' existing provider networks will see a population that they do not have experience serving.

Health plans must demonstrate the ability to provide directly or through one of its contracted providers for the immediate contact of individuals identified by the Department as a person with special health care needs or by the broker as someone requiring immediate attention. In order to preserve existing relationships, the managed care plan must require contracting PCPs to prioritize enrolling the PCP's FFS patients. For beneficiaries with co-occurring mental, medical, or substance abuse conditions, the health plans must demonstrate the ability to identify, provide face-to-face outreach and engagement services, and offer care management and coordination services to the beneficiary.

b. Plans Must Ensure Continuity of Care with Existing Providers.

Where providers in the enrollee's current care system are not also managed care providers and do not wish to become managed care providers generally, and where the enrollee wishes to maintain treatment and care management relationships with those providers, the plan shall be required to include the providers within their network for purposes of continuity of treatment or pay them on a FFS basis for twelve months or as medically necessary. This must include allied health providers such as an orthotics fabricator.

c. The Department Must Prevent Adverse Selection.

The Department must demonstrate how it will prevent or minimize the impact of adverse selection within the plans or medical groups. Adverse selection works in two ways and both need to be addressed: First, people with more complex needs may gravitate to the plan with providers better able to meet their needs. Adverse selection between plans needs to be addressed by readjusting capitation rates to reflect the skewing of risk and enforcement of provider network requirements and access to providers outside the network for the cherry-picking plan. Second, within a plan adverse selection comes into play when consumers with complex and expensive medical needs gravitate toward particular PCPs and medical groups or IPAs – usually those associated with children's hospitals and/or university affiliated hospitals. That may result in rationed access to particular providers that may require adjustment in how risk is devolved from the plan to the provider or provider group or may require compensating some providers within a plan on a FFS basis. There needs to be some way of delivering payments to participating providers so that the system does not compromise the ability of recipients with complex and more expensive needs to receive services from those specialists and providers within the network who have the experience and expertise needed by the recipients.

d. The Department Must Require The Provision of a Health Care Home.

Finally, the Department must develop policies and procedures for the plans to require the provision of a medical or health care home to SPDs. The policies and procedures shall require the plan or the medical or health care home to assess a beneficiary's needs for specialty care, for medical and social service care

coordination, for social service coordination, and for behavioral health care and to develop a care plan to address those needs.

10. **The Department's Medi-Cal Managed Care Division (MMCD) Should Separate its Enforcement Unit from its Other Units.**

The Department's MMCD must develop a better plan monitoring and enforcement arm to require health plans to follow the law. The Department's primary role should be to ensure that health plans, in fact, meet their obligations. Expansion of mandatory managed care cannot take place until the Department demonstrates its ability to take action to enforce the rights of consumers. This has not been a focus of the Department or its MMCD. For example, the MMCD's Quality Strategy, published in December 2009, is bullish on expanding the reach of managed care plans but offers little in the way of actual quality improvements. MMCD continues to contract with plans that meet only 25% of the national Medicaid rates. MMCD sets the bar so low that enforcement of standards becomes meaningless.

11. **Certain Populations Should Remain Optional for Enrollment into Managed Care.**

Even if some form of mandatory enrollment of the SPD population is initiated, enrollment in managed care should remain optional for certain beneficiaries, including CCS, Specialty Mental Health Section 1915(b) Waiver, and 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) in Geographic Managed Care and Two-Plan counties. In addition, while having OHC means managed care is optional in GMC and two-plan counties, it also should be optional in COHS counties when the OHC providers are not part of the COHS network or will not accept Medi-Cal through COHS as payment in full.

12. **Rates Must Be Sufficient to Ensure Sufficient Access and Networks and Avoid Adverse Selection Within Plans.**

Rates paid to health plans must be sufficient to attract and retain providers, including those with experience and expertise with the SPD population and therefore should be risk-adjusted according to the beneficiaries' health care complexities. Rates should include an administrative per member per month payment to provide care coordination that ensures access to medical appointments,

behavioral health care, and linkage to social services. Consideration must be given to separately contracting with plans to provide administrative case management to enrollees in a manner that would draw down a 75% federal match. If the capitation rate is insufficient to maintain an adequate network, mandatory enrollment must cease and exiting enrollees must be allowed to voluntarily disenroll without requiring enrollment in a different plan. The state must place limits on a plan's ability to obtain administrative expenses when these expenses do not include case management and assistance getting consumers to appointments. Provider reimbursement methodology must take into consideration cost of enrollee care and include methods to monitor the potential for adverse selection by plans to avoid costly enrollees.

13. **Information from the Department and Health Plans Must Be Publicly Available on the Internet and Made Available in Alternative Communication Formats.**

Data and analyses prepared by or for the Department in anticipation of proposed changes to the delivery system for SPDs must be made publicly available and posted on the Department's website, including proposed changes to the contractual language used with managed care plans, and the development of health plan performance standards, health plan readiness tools, and health risk appraisal tools. Prospectively, the Department must post on its website guidance letters and directional bulletins addressed to the plans with which it has contracts. Plans must post on their websites provider manuals and directives. Data the Department collects, including analyses and comparisons of plan performance, must be publicly available and posted on its website. Department and plan websites must meet W3C standards and accessibility guidelines (see http://www.w3.org/) and the requirements of Section 508 of the Rehabilitation Act of 1973.

14. **The Department Must Have A Contingency Plan for Plan Withdrawals, Insolvency, or Noncompliance.**

The Department must develop procedures and systems to address promptly plans with financial instability, plans that are no longer able to provide services to beneficiaries, and plans with difficulties meeting required performance standards, so that no disruption in services occurs and so that, when necessary, enrollees may be transferred to other plans or FFS Medi-Cal.

15. **The Department Must Ensure Medical Transportation Needs Are Covered and Reimbursed.**

The Department must ensure plans include mechanisms for getting Medi-Cal beneficiaries to and from health care appointments when beneficiaries do not have transportation. This responsibility must include providing, arranging, or reimbursing for transportation, particularly to providers or services outside the geographic area in accord with the Department's administrative responsibilities pursuant to federal law.[2] Non-urgent medical transportation must also be available and physically and programmatically accessible to those using service animals or mobility devices such as wheelchairs. Medi-Cal recipients have a right to be expressly told who has the responsibility – plan or some other entity – for assisting them in getting to and from medical appointments, and how to ask for help in getting to and from medical appointments. If the Department is transferring its administrative responsibility to the plan, then that shift in responsibility should be expressly stated in the contract. Alternatively, the plan could be reimbursed for providing non-emergency medical transportation brokerage services as allowed by federal law.[3] If the administrative responsibility is transferred to the plan, the state shall add the costs of providing transportation to administrative Medicaid funds to cover the plan's discharge of this responsibility.[4]

16. **Ongoing Legislative Oversight is Necessary.**

The Department must be required to submit reports to the Legislature on an ongoing basis detailing systems' readiness to serve SPDs, the transition from FFS to a mandatory system, plan performance, quality of care, consumer grievances and problems, and health outcomes. Such reports will ensure more transparency and accountability by the state and the health plans during any implementation.

Effective Delivery System

ABx4 6 (Evans 2009) requires the Department to submit a waiver which, "include[s] proposals to restructure the organization and delivery of services to be more responsive to the health care needs of Medi-Cal enrollees for the purpose of providing the most vulnerable Medi-Cal beneficiaries with access to better

[2] 42 CFR § 431.53.
[3] 42 U.S.C. § 1396a(a)(70).
[4] Transfer to Plan State's Administrative Responsibility under 42 CFR § 431.53.

coordinated and integrated care that will improve their health outcomes." This may include, "[b]etter care coordination for seniors and persons with disabilities . . . which shall include the establishment of organized delivery systems that incorporate a medical home system and care and disease management, as well as incentives that reward providers and beneficiaries for achieving the desired clinical, utilization, and cost-specific outcomes."[5] Accordingly, the waiver must include specific definitions of a medical home model and a delivery system which has been shown to improve health outcomes and provide care management. This model must include beneficiary participation in assessing and planning for his or her care.

17. **The Department Must Adopt Effective Health Delivery Models that Improve Health Outcomes for SPDs.**

People with disabilities have a range of needs and secondary conditions that are not well served by a "one-size-fits-all" approach to health care delivery. In order to design a "patient-centered medical home or health care home" delivery system that meets the needs of people with various disabilities, the Department must examine a range of delivery models. Some individuals with disabilities may require moving from one model that uses more extensive services to one that requires fewer interventions depending on the changing status of their secondary conditions.

Numerous health care delivery models exist across the nation. Disability Care Coordination Organizations combine attributes of the medical home model and community nursing and the client works with teams of nurses and social workers to arrange disability-competent medical and social services. AXIS Healthcare in Minnesota is one example of this model in action. The Targeted Disease Management Model focuses on individuals that have a specific secondary condition and combines self-management interventions with clinical monitoring to improve patient health outcomes. The Care Transitions Model focuses on an individual's transition between one health care setting or level of healthcare to another and is designed to ensure coordination and continuity of care as these transfers occur, through the use of interdisciplinary teams, targeted technology, and home-based clinical monitoring. Intensive multidisciplinary team models coordinate medical and behavioral health care and link beneficiaries to community agencies and organizations to meet the needs of beneficiaries with complex social barriers to care. The Washington State/King County Medical Home and Chronic Care Management Programs and the New York Chronic Care Initiative are

[5] *See* Cal. Welfare & Inst. Code § 14180 (b) (1).

examples of this. The Disability Health Coalition (DHC), www.disabilityhealthcoalition.org has additional information on these and other models.

18. **Plans Must Ensure Effective Care Coordination.**

The plan or delivery system adopted for SPDs must demonstrate that it has established a system or network designed to offer care coordination services to beneficiaries who have or are at risk of developing complex conditions or social barriers to appropriate care. The system must include standardized processes for identifying members for care coordination, including a process for self-referral. This system must include care coordinators with sufficient links to the community to be able to locate identified beneficiaries, engage those patients with intensive face-to-face outreach, work with the beneficiaries to create a plan to improve health outcomes and decrease avoidable hospital admission and emergency department visits, and connect high-risk beneficiaries to community resources. The plan must further offer intensive interventions to high-risk beneficiaries with routine face-to-face care coordination (with care coordinator/patient ratios of no more than 1:25 in the first year) that includes linkage to community services necessary to overcome social barriers to care, and, if applicable and appropriate, linkage to community-based behavioral health, PCP, and specialty providers.

The Department must work with the plans to stratify the intensity of interventions depending on the beneficiary's level of need. The Department must develop appropriate administrative fees for these services that vary according to the needs of the beneficiary, and that allow care coordinators to work outside the clinic walls. Levels of service intervention may graduate to less intensive interventions over time.

The plan may partner or subcontract with qualified community-based providers or care coordinators to fulfill these requirements, including but not limited to case managers in supportive housing, NF waiver case managers, MSSP, ADHC, independent living centers, Area Agencies on Aging, and programs designed to decrease emergency department visits and hospital admissions among people who frequent emergency departments. Care coordination provided by paraprofessional non-licensed staff with the skills, training, and clinical supervision to work as part of a multidisciplinary team that includes qualified clinicians would fulfill the requirements for care coordination in a medical or health care home.

19. **Plans Must Demonstrate Connection with Community Resources.**

The plan shall demonstrate that it has existing contracts or business agreements to link enrollees with community resources and other programs that are not covered, including but not limited to regional centers, Medi-Cal mental health plans, drug and alcohol programs, services provided by the Department of Aging, In-Home Supportive Services, ADHC, the NF waiver, dentists, AIDS service organizations, and local programs offering housing to people who are homeless or at risk of homelessness.

Transition & Enrollment

The state proposes to transition some 650,000 SPDs into a mandatory organized delivery system. Because of the complexity of this diverse population, many of whom have multiple serious medical and behavioral health conditions, SPDs cannot be enrolled into any closed system without careful outreach and education and then careful selection of the appropriate system and transition steps taken **prior** to enrollment. In addition, safeguards must be in place to correct the problems that will occur even with careful, individualized and collective preparation.

20. **The Department Must Conduct Consumer Education and Outreach Regarding Any New System.**

Before any FFS SPDs are mandatorily enrolled in a closed delivery system, there must be a carefully constructed, aggressive education and outreach campaign conducted to educate the community about the forthcoming changes. Consumers need to be informed that the way they get care will be changing and how, when the changes will occur, what will happen before their system is changed and what they can do to participate in the transition and to resolve problems. In developing this outreach and education, the Department shall consult with stakeholders about effective communication with this diverse population.

21. **Beneficiaries Must Be Given Adequate Time, Assistance and Information to Make an Informed Choice.**

While prior readiness standards and plans for SPDs envisioned an assessment to be done by the enrollment broker and passed on to the plan and then the plan to conduct its own assessment after enrollment, the point of enrollment is too late to

assess beneficiaries' needs. **FFS SPDs cannot be put into a mandatory closed delivery system where they may be cut off from life-sustaining services until it is determined that their new delivery system can meet their medical needs.**

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. Because SPDs may have more complex health maintenance needs, higher risks of acquiring secondary conditions, and a thinner margin of good health (and some of these beneficiaries will have more difficulty navigating managed care choices and the enrollment process), they must be provided more time to choose and enroll in a health plan.

The enrollment packet must be carefully tailored to explain to the beneficiary:

- what the delivery system choices are,
- how to make a list of all current and needed providers and types of care;
- how to assess each choice in relation to the list of needs (and at each level, e.g. health plan, medical group, medical home, and PCP);
- how to effectuate the choice; and
- how to resolve any problems.

We are aware of the pilot enrollment project in Sacramento and Los Angeles whereby the 50 closest providers are listed for enrollees, rather than the entire county's Medi-Cal providers. The SPD population should not receive this new packet, as it will likely not contain their existing network of providers. State MCMC Division must rethink the roll-out of this pilot to the entire state if mandatory enrollment of the SPD population occurs and should involve consumer advocates with that effort.

22. **Beneficiaries Must Have Assistance in Navigating the Transition and Enrollment Process.**

The Department must contract with an enrollment entity or entities to assist SPDs in navigating the managed care enrollment and transition process. This should be a local entity with experience with persons with disabilities who knows the local health care systems and how to navigate them. The entity shall also assist the prospective enrollees in exercising their exemption and continuity of care rights, including the invocation of procedures to maintain existing provider relationships with providers who are not providers in the closed network.

23. **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.**

Even with an aggressive education and outreach campaign and effective navigation and enrollment assistance, some beneficiaries will not respond and choose a delivery system. 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. These beneficiaries cannot be defaulted into a plan without an individualized assessment made of their health care needs, current provider network and a transition plan to the new system. A qualified entity must examine their claims data to get as full a picture as possible of their diagnoses, providers and usual sources of care and contact them via telephone or in person, based on their individual need, to assist them in making a delivery system choice and transition plan. The plan must refer high-cost beneficiaries into programs that offer intensive outreach and engagement case management services. If the Department does not have correct contact information, the entity should involve current providers and systems in contacting the potential enrollee. In assisting beneficiaries in selecting a plan, the entity will match their current providers and assess which are most critical to meeting the beneficiary's health care needs.

If the Department or entities contracted to assist with enrollment cannot make contact with a beneficiary, the Department should defer assignment to a plan until the enrollee seeks a Medi-Cal service. At that point, the provider will collect the beneficiary's contact information. If, even with this new contact information for some reason a beneficiary still cannot be contacted, the enrollment broker shall use claims data to assess the beneficiary's health conditions, services needed, and providers. The beneficiary can at that point be enrolled into a plan that includes the majority of the beneficiary's providers with a focus on making sure the beneficiary has access to the providers most critical to her or his medical support system. No SPD considered medically fragile or with known cognitive or other mental impairments shall be defaulted into a plan unless personal contact has been made, the Department can prove enrollment materials were actually received, and the default plan contracts with that person's existing providers.

24. **The Department Must Closely Monitor Plan Network Capacity During Transition.**

The Department must have in place a system for closely monitoring network capacity to serve SPDs during the transition period and six months thereafter, including the time between asking for and getting a routine or urgent care appointment. "Closely monitoring" means requesting information about access and capacity, and receiving that data within 30 days of the request. When the data indicates that a managed care plan does not have the network capacity to absorb the new enrollees at the rate they are being referred, the Department shall adopt all necessary steps to ensure adequate capacity is achieved during the enrollment period, including suspension of new enrollments into a plan, slowing the rate of enrollment, or other actions to enforce performance and the right to receive physically and programmatically accessible care in a timely fashion.

25. **The Department Must Provide Enrollee Data to Delivery Systems.**

For each enrollee, the Department must provide to the health plan or other delivery system data on fee-for-service claims, including diagnosis codes, provider information and a list of Medi-Cal services received from other systems, such as mental health plans, drug and alcohol programs, regional center case management systems, CCS and GHPP, personal care services, and adult day health. The Department or the enrollment entity shall identify prospective enrollees with more complex or extensive health care needs who likely will need the development of a transition plan so that they are enrolled in managed care without interruption of their health care and shall also develop and initially implement the transition plan. In addition, the health plan or delivery system should ensure an assessment of each beneficiary within 30 days of enrollment.

26. **Enrollment into a Mandatory Delivery System Must Be Done Gradually and be Evaluated for Progress.**

Even with safeguards in place, hundreds of thousands of SPDs should not be enrolled at once into a mandatory closed delivery system. Enrollment must be done at a speed that enables the plans to meet their obligations to ensure continuity of care and prompt assessments for all enrollees. Further, enrollment must be done at a speed that enables the Department to monitor how beneficiaries are being served. The enrollment into Medicare Part D plans – all done at once – with serious problems illustrates the folly of such an approach. When Medicare Part D

was enacted overnight, hundreds of thousands of individuals either lost access to existing medications they needed or were at risk of losing them. This prompted the Governor and Legislature to enact emergency legislation to protect almost a million dual eligible beneficiaries' access to their prescriptions.

Disenrollment & Exemptions

27. The Right to Disenrollment Must be Protected and Expanded.

SPDs must be allowed at any time or to switch to another plan. Switches must be handled in a way that will ensure the beneficiary does not experience gaps in services. SPD beneficiaries should be allowed to disenroll for any reason that would constitute an exemption to mandatory enrollment – for example, to continue receiving treatment for a complex medical condition from a provider not contracting with any of the plans. The Department shall establish an expedited process to immediately disenroll beneficiaries who move or are placed outside the plan's geographic area, for SPDs who may be adversely affected by a delay in receiving Medi-Cal services, or for SPDs requiring immediate non-plan provider treatment.

If, after enrollment commences, the Department determines that a plan has ceased to be in substantial compliance with any of the requirements listed in this document, the Department shall suspend enrollment in that plan until such time as the plan is able to demonstrate substantial compliance. If necessary to assure beneficiaries receive or maintain adequate and timely medically appropriate care when put at risk due to the plans' failure plans to comply with any of these requirements, the Department shall allow beneficiaries to disenroll from the plan and to be covered on a fee-for-service basis.

28. Available Exemptions From Plan Enrollment Should Be Broadened.

The Department must develop less onerous medical exemption standards[6] and procedures[7] 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. These standards would allow a Medi-Cal recipient to

[6] Such as, but not limited to, the standards listed in the regulations governing exemptions contained in 22 Cal. Code of Regulations § 53887(a)(2)(A).
[7] Such as those in 22 California Code of Regulations §§ 53887 and 53889.

switch to a plan provider without risk of adverse medical consequences. In addition, a medical exemption shall be granted if the beneficiary's access to care, continuity of care, or ability to live in the community would be jeopardized if he or she were not able to receive or maintain receipt of FFS Medi-Cal.

Once the SPD beneficiary has made a request for an exemption to plan enrollment, or to extend an exemption to enrollment, the Department must retain the SPD beneficiary in FFS Medi-Cal. This status will continue until the Department makes a final determination that the SPD beneficiary is ineligible for an exemption or an extension of the exemption, or indefinite exemption, to plan enrollment.

29. **Plans Must Clearly Explain the Process to Disenroll.**

Plans must clearly identify the process for members to disenroll by providing plain and accessible information to enrollees about that option separate and apart from the enrolment packet provided by the enrollment broker. Plans must also provide any necessary disenrollment forms to effectuate such disenrollment. Plans should be required to follow up with members who disenroll and determine the reason for disenrollment, and report this data to the Department on a monthly basis. That data report should also be publicly available on the Department's website.

30. **Enrollees Must Be Allowed to Maintain FFS Medi-Cal While Requesting an Exemption.**

An enrollee or potential enrollee will be retained in FFS Medi-Cal when requesting a medical exemption or renewal of a medical exemption. If the request is denied, the potential enrollee will be retained in FFS Medi-Cal until a plan has been selected and a service provided. Persons requesting a medical exemption – or indicating by their statements a need for a medical exemption – shall be referred to a local independent ombudsman program for assistance. The Department must ensure that there is no interruption in access to specialty providers and that payments for treatment are made.

Grievances and Appeals

31. Notices to Beneficiaries Must Be Standardized and Meet all Legal Requirements.

The Department must require plans to use model notices the Department develops, and advise all beneficiaries of their right to an accommodation under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act (Section 504). For persons who are determined to be persons with communications related disabilities, the Department also shall ensure that all notices are available in different formats and/or other languages consistent with the requirements of federal and state law, including the ADA, Section 504, and Title VI of the Civil Rights Act regarding non-English proficient persons with specific needs (for example, written notices in large print, Braille, audio, computer disc, and/or a copy provided to a designated representative) to enable persons with print-related disabilities to effectively challenge service and eligibility denials, terminations, delays, modifications in benefits, or administrative decisions regarding any of the foregoing adequately.

32. Plans Must Ensure Flexibility and Accommodations with Grievances and Appeals.

Any delivery system serving SPDs must demonstrate that SPDs have access to various means of submitting grievances and may receive assistance from the plan when a person with a physical or mental health disability requires an accommodation or policy modification to submit a grievance on his or her own behalf. All grievance and appeals procedures must be accessible based on the various needs and abilities of beneficiaries. Plans must make reasonable accommodations concerning grievance and appeal requirements, including, but not limited to, tolling the time in which to file for fair hearing requests or grievances.

33. Plans Must Track Grievances and Remedial Measures.

Plans must track grievances related to violations of ADA/Section 504 and related state disability access laws by individual providers within their network. For any such grievances reported to the plan, the plan must work with the provider to advise them of the requirements of federal and state disability access laws, tax credits available to provide accommodations and make architectural improvements, technical assistance provided by the plan or other third-party

entities to provide physical and programmatic access to plan members, and otherwise assist with problem solving related to issues raised by the grievance.

34. **Grievance and Appeals Procedures Must Comply with Medicaid and Knox-Keene Requirements.**

The plans' grievance and appeals process also must meet requirements enumerated in federal and state Medicaid statutes and regulations, as well as other state law consumer protections, under the Knox-Keene Act, the Welfare and Institutions Code, and state regulations related to due process and complaint/grievance procedures.

For more information contact:

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