Medi-Cal Managed Care: Basic Consumer Protections

Health Access California is California's consumer coalition on health care, and was the sponsor of the HMO Patient Bill of Rights enacted a decade ago. We have been an active participant in the regulatory process at the Department of Managed Health Care since its creation in 2000.

This paper looks at basic consumer protections in organized delivery systems. It focuses on key protections to assure that consumers who have coverage get the care they need when they need it and makes recommendations to ensure that basic consumer protections are in place and enforced in Medi-Cal managed care for seniors and people with disabilities.

Seniors and persons with disabilities on Medi-Cal: A more vulnerable population

Low-income seniors and persons with disabilities who rely on Medi-Cal are an inherently fragile population by virtue of age, disability and low income status. Because seniors and persons with disabilities are more medically fragile on average than the commercial population for which the Knox-Keene Act was designed, we consider whether the consumer protections in Knox-Keene are sufficient for this population.

Seniors and persons with disabilities are also more vulnerable than the working families who currently dominate Medi-Cal managed care.

Usual source of care

Unlike most of those who rely on Medi-Cal managed care, seniors and persons with disabilities on Medi-Cal overwhelming report a usual source of care. For Medi-Cal managed care, HEDIS data shows that about half of pregnant women (52%) and just over a third of adolescents (37%) have a usual source of care. For persons with disabilities covered by Medi-Cal, both fee-for-service and managed care, *93%* report a usual source of care to CHIS. (CHIS, 2009, exhibit 44, p. 67)

CHCF Performance Standards

In preparing this paper, we have reviewed the performance standards developed for the California HealthCare Foundation for Medi-Cal managed care organizations serving persons with disabilities and chronic conditions (November 2005). This paper is intended to be complementary to that effort: the recommendations made here provide greater specificity or address areas not addressed by those performance standards. To assist the reader, we have made note where the CHCF performance standards address the same issue or a related issue.

Health Access supports the adoption of the performance standards recommended in that process. We are troubled that only some, but not all, are recommended for adoption in the 1115 waiver workgroup process currently underway.

Overview of Recommendations:

While better managing care in theory can provide better care at lower cost, in practice managed care can result in the denial and delay of needed care unless basic consumer protections are in place and enforced.

> *First, rate methodology must be sufficient to assure access to care;*
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> *Second, public oversight, including by affected consumers, improves quality;*
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> *Third, continuity of care or block transfers for more than three million seniors and persons with disabilities who will lose access to their current providers;*
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> *Fourth, network adequacy, including specialists willing to accept Medi-Cal reimbursement, must meet more stringent standards than those currently used by the Department of Managed Health Care;*
>
> *Fifth, fiscal solvency of risk bearing entities, including medical homes and accountable care organizations, must meet at a minimum the standards for risk bearing organizations under the Department of Managed Health Care;*
>
> *Sixth, other basic consumer protections provided under Knox-Keene Act, such as timely access, language access, and right to a second opinion must be assured; and*
>
> *Finally, persons with disabilities need to be assured full accessibility---and we must not repeat the history of language access in which laudable contract provisions fail to translate into documented language access.*

1. Continuity of Care or Block Transfers

DHCS director David Maxwell-Jolly has said publicly and unequivocally that in those counties where Medi-Cal managed care already exists, seniors and persons with disabilities would be enrolled into those managed care plans. If this is done, it will be one of the largest transfers of enrollment in California history.

Seniors and persons with disabilities are differently situated than moms and kids. CHIS shows that 93% of adults with disabilities on Medi-Cal already have a usual source of care while only 37% of adolescents in Medi-Cal *managed care* and only 52% of women in Medi-Cal *managed care* have a usual source of care.

Similar to persons with disabilities, seniors are likely to have usual sources of care. Many seniors and persons with disabilities will have five to ten providers already and some with more complex needs will have 15-20 providers.

Transitioning care for these individuals who already have multiple provider relationships will be very challenging. Existing law with respect to commercial managed care plans provides some guidance.

The requirements in Knox-Keene for continuity of care or block transfers were designed for largely healthy commercial populations covered by Knox-Keene when patient-provider relationships are disrupted in large numbers because of contract disputes.

Knox-Keene requires a health plan to arrange for completion of covered services for:

a. An acute condition
b. A serious chronic condition for as long as 12 months
c. Pregnancy, through the post-natal trimester
d. A terminal illness
e. Care of a newborn child to age 36 months
f. Performance of surgery previously authorized by the plan.
g. Additional requirements with respect to mental health services

These provisions are designed to allow consumers either to complete an episode or care or to have sufficient time to find an appropriate contracting provider. But remember: this is designed for an essentially healthy commercial population, most of whom have one or two conditions that need care, not for seniors or persons with disabilities who in most instances will have multiple providers. The Medi-Cal population of seniors and persons with disabilities also faces additional challenges, from the prevalence of serious mental conditions to limited English proficiency to the barriers inherent in poverty.

The medical exemption process that exists in Medi-Cal is inadequate for pregnant women. It works for children only because of the CCS carve-out.

The protections provided by Knox-Keene are substantially more consumer friendly than the Medi-Cal medical exemption process and are probably NOT sufficient for seniors and persons with disabilities who would be required to transition care of numerous providers.

While initial implementation poses the greatest challenge, the need for standards with regard to continuity of care will continue as long as seniors and persons with disabilities are expected to move into different care networks upon becoming enrolled in Medi-Cal. (Please note: CHCF recommendations provide only 60 days for transition, significantly less than provided to commercially insured populations under Knox-Keene.)

Recommendations: First, no consumer should be transferred until their needs are assessed and a plan of care developed. If the plan is not able to provide the care needed, the consumer should not be transferred. The patient assessment should include not only physical health but also assessment of cognitive and behavioral needs as well.

Second, any consumer with five or more providers should be assigned a case manager to assist with transition and be given no less than 24 months for the transition. (Under Knox-Keene, an individual managing a single chronic condition has 12 months to transition while a newborn has 36 months: 24 months is a mid-point between these requirements given the complexity of the needs facing a senior or person with disabilities with numerous providers.)

Third, for those with four or fewer providers, the managed care plan should be required to provide one-on-one assistance in transitioning care from existing providers.

Fourth, until the transition for that consumer is complete, the consumer should be

allowed to continue to receive care from providers with whom the consumer had a pre-existing provider-patient relationship.

2. Basic Consumer Protections: Knox-Keene Act

Under federal Medicaid law, Medi-Cal beneficiaries have the right to a fair hearing and other protections. These protections should be preserved.

Consumers in California enjoy a long list of consumer protections: these should apply to those enrolled in Medicaid managed care as well. In addition to standards for network adequacy and fiscal solvency, the Knox-Keene Act provides for many basic consumer protections. These protections should be provided in the context of an 1115 waiver so that those Medi-Cal beneficiaries in organized delivery systems have consumer protections at least as good as those available to other Californians.

A partial list of consumer protections in the Knox-Keene Act:

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

All of these consumer protections should be provided to those Medi-Cal beneficiaries in organized delivery systems in the context of an 1115 waiver. (Please note: not addressed in CHCF performance standards for SPDs in managed care.)

Recommendation: Any organized delivery system should be held to these basic consumer protections by statute. The agency charged with enforcing these consumer protections should not be DHCS which has a financial interest in reducing Medi-Cal spending even at the expense of access to care.

3. Network Adequacy: Part One: Physical Health

We know from our recent work on timely access regulations under the Knox-Keene Act that the Department of Managed Health Care is unable to determine adequacy of networks on an ongoing basis in any systematic way. Instead, DMHC determines whether there is an adequate network when a plan is initially licensed or when it expands into a new geographic area.

The requirement in Knox-Keene for managed care plans that there is one primary care provider for 1200 enrollees is meaningless since an individual physician can agree to cover 1200 consumers each for Blue Shield, Anthem, Healthnet, Medi-Cal and Medicare---leaving an individual physician responsible for 6,000 consumers.

The Department of Managed Health Care does not have a systematic means of measuring access to specialists and specialty care which will be essential in providing adequate care for seniors and persons with disabilities.

And we are talking about Medi-Cal here, not just managed care: we all know that many physicians, especially specialists, are reluctant to accept Medi-Cal patients. Network adequacy is more challenging in Medi-Cal managed care than in commercial managed care—and more challenging for seniors and persons with disabilities than for moms and kids on Medi-Cal managed care.

The existing Medi-Cal managed care contract requirement of one primary care provider for two thousand enrollees is in direct violation of the Knox-Keene Act. We assume that plans are complying with Knox-Keene and that both departments are enforcing the law rather than the Medi-Cal contract requirement.

Further, the needs of seniors require different specialty networks than the existing Medi-Cal managed care population of children and mothers. Similarly persons with disabilities may require a broad array of specialty. Knox-Keene requires that if a plan lacks adequate capacity within the network, consumers are referred out of network. This is routine in Knox-Keene where highly specialized care such as organ transplants or specialized cardiac care are routinely provided out of network.

What is the Department's plan to assure adequacy of networks? How will they assure timely access to specialists?

Please note: CHCF performance standards for SPDs in managed care are less consumer-friendly than Knox-Keene for consumers in block transfers resulting from provider-plan disputes. Health Access has adapted the Knox-Keene protections to the needs of consumers with multiple providers and a pre-existing source of care.

Recommendations: First, contracting Medi-Cal managed care plans should be required to demonstrate network adequacy annually by county, including access to specialists required for the covered population.

Second, contracting primary care providers should accept no more than 1200 patients from any source, including commercial carriers as well as Medicare.

Third, if a consumer requires a panoply of specialists that are not available in any network of managed care, then the consumer should have the opportunity to remain in fee for service.

4. Network Adequacy: Part Two: Social and Community Systems, including long term care plus mental health and substance abuse

The needs of seniors and persons with disabilities for services extend beyond traditional physical health. For instance, those with mental health issues are likely to need mental health and substance abuse treatment for extended periods. Similarly care for those with significant disabilities must be coordinated with services offered by regional centers as well as long term care. What little remains of services for seniors must also be coordinated to provide appropriate care and services that maximizes the ability of seniors to live active lives in the community.

A memorandum of understanding alone is not sufficient: coordination of care and services, particularly for those with multiple conditions and those who are newly diagnosed, requires active management by multiple service providers familiar with the services available in each community. Those entities that appear to engage in best practices in this area engage in regular case management and case conferences as well as quickly engaging newly diagnosed persons with disabilities. This approach is different than a shell agreement that is used to slough services off onto another payer: it is a genuine, ongoing engagement with other entities that provide care and services needed by low-income seniors and persons with disabilities. (Please note: CHCF performance standards less detailed. Health Access recommendations build on best practices.)

Recommendations: First, develop standards for active care coordination and management with providers of other care and services, including long term care, mental health, substance, and other services for persons with disabilities such as the regional center.

Second, at least annually and preferably quarterly case conferences.

5. Access for Persons with Disabilities: Compliance

An area of considerable concern to us is accountability for consumer protections.

Since the creation of Medi-Cal managed care, the contracts have specified that managed care plans must provide language access for covered services. The contractual language is very good but the ability to monitor whether consumers receive care in the language they speak has been very problematic. HEDIS does not bother to measure language access. While it appears that some Medi-Cal managed care plans do an exemplary job of providing language access, others do not.

As recently as 2007, representatives of Medi-Cal managed care plans and Medi-Cal providers complained to the Department of Managed Health Care about language access in Medi-Cal managed care. It is our hope that DMHC shared these complaints with DHCS so that the Medi-Cal program could take appropriate action through contract enforcement.

Access for persons with disabilities has been the subject of considerable policy work that has included standards developed, requirements contemplated, thoughtful policy work completed. But if after fifteen years, DHCS cannot tell us whether people are getting care in the language they speak, why should we have faith that persons with disabilities

will get care in a manner that provides access to those with disabilities?

Recommendations: (Please note: first and second recommendations are addressed by CHCF, the third and fourth are not.)

First, DHCS develop measurable, replicable access standards for access for those with disabilities and language access. DHCS require plans to update annually provider directors that list which providers are accessible for which types of disabilities and which providers provide care in languages other than English.

Second, DHCS should provide plain-language information to enrollees about their right to accessible care and care in the language spoken.

Third, consumer quality committees at both the state and local levels should assure accountability and compliance with contract requirements on an ongoing basis.

Fourth, all audits regarding access for persons with disabilities should be made public.

6. Fiscal Solvency: Organized Delivery Systems

California has a long sad history of entities accepting financial risk for providing care without adequate reserves, then going belly up after denying and delaying care while someone pockets the profits.

A few examples include:

a. Medi-Cal HMOs under the jurisdiction of the Department of Health Services in the early 1970s: these entities lacked financial reserves, lacked networks, and went broke while sending capitation payments to offshore entities in the Caribbean. It was these scandals that led to the enactment of the Knox-Keene Act in 1975.
b. Delegated model medical groups in the 1990s: many went bankrupt, some lacked even the most basic financial protections such as audited financials, some of the largest testified to denials and delays in care in order to minimize spending on care. Financial solvency requirements imposed in 1999-2003 seemed to have resolved these problems.

DHCS has said that they may rely on unregulated entities to be at risk. Whatever our qualms about HMOs, the long, sad experience of unregulated entities accepting financial risk is far more worrisome. (Please note: not addressed in CHCF performance standards for SPDs in managed care.)

Recommendation: No entity should be allowed to accept financial risk without demonstrating adequate financial reserves to provide contracted care. Adequate reserves should at a minimum be those required of risk-bearing organizations or health care service plans.

7. Fiscal Solvency: Rate Methodology Responsive to the Needs of Seniors and Persons with Disabilities

Medi-Cal managed care for working parents and children has long been characterized by inadequate reimbursement which undermines access to care. This was also true in the past of reimbursement for County Organized Health Systems, the only entities which provide mandatory managed care for seniors and persons with disabilities.

Seniors and persons with disabilities have a broader range of health needs than working parents and children. The materials assembled by DHCS indicate that a high proportion of seniors and persons with disabilities have multiple chronic conditions and that nearly a nearly third face mental health issues. In addition, carve-outs for California Children's Services and mental health needs for children simplify the rate methodology used for children. For these reasons, the rate methodology currently used for working parents and children should be carefully examined to see how it needs to be adapted for seniors and persons with disabilities.

Earlier proposals by this Administration relied on paying capitation payments at 95% of fee for service payments: that is a crude methodology that does nothing to assure the right incentives or the right care. It incentivizes denials and delays in care rather than appropriate care management.

We are also mindful that Medicare Advantage is considerably more expensive than Medicare fee-for-service—and that it appears to be more expensive than the additional benefits provided warrant.

Developing a rate methodology that pays for adequate and appropriate access to care, including access to tertiary and quaternary specialty care needed by some persons with disabilities, is a considerable exercise. Yet none of the workgroups convened by DHCS is tasked with focusing on rate methodology. (Please note: not addressed in CHCF performance standards for SPDs in managed care.)

Recommendations: First, convene a taskforce dedicated to rate methodology development.

Second, contract with Mercer or other experts to develop rate methodology that will assure adequate access to care and appropriate incentives.

Third, both the rates paid and the methodology for setting rates must be reviewed and updated, preferably annually.

Fourth, the cost effectiveness of the organized delivery system models should be compared among themselves and to fee-for-service delivery approaches.

Fifth, we urge consideration of different rates for different populations, depending on complexity and acuity.

8. Public Accountability: Public Oversight and Consumer Input

Managing care in a manner that improves access while reducing costs should be an ongoing process, not a one-time event. Doing so in a manner that is responsive to the needs of seniors and persons with disabilities requires input from those communities. We have also come to a strong preference for public oversight as well as input from the affected communities.

In its early days, Cal-Optima faced significant challenges in providing adequate access to care for seniors and persons with disabilities—complaints were frequent and loud enough to reach Sacramento. An important element in correcting the problems was involving advocates for seniors and persons with disabilities in ongoing public oversight of the provision of care. Similarly, the Inland Empire Health Plan has reached out to engage these communities in its successful effort to increase voluntary enrollment of seniors and persons with disabilities.

In contrast, commercial HMOs, many of which are large, multi-state companies, lack a history of public oversight, especially at the local level where care is delivered. A board of directors of a commercial HMO is focused on shareholder results, not on delivering the right care at the right time.

Recommendations: First, our review of existing practice in California lead us to a strong preference for organized delivery systems with boards that are either publicly elected or appointed by those who are publicly elected. Boards that are publicly elected or appointed by those who are have a degree of public accountability and oversight that has made those entities more responsive to the needs of persons with disabilities. (Please note: not addressed in CHCF performance standards for SPDs in managed care.)

Second, any organized delivery system tasked with organizing care for seniors and persons with disabilities should have local advisory committees familiar with the delivery of care and community resources in the local area. In most counties, county-level or even regional committees may be appropriate. In Los Angeles County we question whether that is sufficient county-level oversight is sufficient. In Los Angeles County with a population of 9.9 million, roughly comparable to the population of Sweden (9.2 million) or New Jersey (8.7 million), committees for the regions within LA may be more appropriate. (Please note: partially addressed in CHCF performance standards for SPDs in managed care.)

Third, local advisory committee should include affected seniors and persons with disabilities.

Fourth, how would organized delivery systems operated by for-profit entities accountable to shareholders rather than local constituencies assure that those for-profit entities are accountable to local Medi-Cal consumers?

9. Enrollment process: Default enrollment as well as education and outreach

Default enrollment is inherently distasteful because it means that the consumer is given no choice. It can literally be life-threatening for seniors and persons with disabilities whose health is dependent on timely care by physicians familiar with their particular situation. It is for that reason that we have separately addressed the need for good standards for block transfers or continuity of care.

California has a long, sad history of marketing abuses in Medi-Cal managed care, dating back to the 1970s with another round of problems in 1990s. Marketing abuses have included steering, in which providers are paid more by managed care plans if the provider steers a consumer to that plan. Marketing abuses have included managed care plans signing up consumers in geographic areas in which the plan had no capacity to deliver care or in languages in which the plan lacked the capacity to deliver care.

Any default enrollment algorithm should take into account not only contracting arrangements with safety net providers but also public oversight and accountability. It should also take into account compliance with contract requirements and demonstration of quality.

Education and outreach are an important part of the enrollment process. DHCS must be responsible for education of seniors and persons with disabilities. The materials prepared by DHCS must be in plain language.

Marketing by organized delivery systems and managed care plans is inherently problematic: all marketing materials should be subject to prior approval by both DHCS and DMHC in order to assure that organized delivery systems do not engage in cherry-picking or other forms of seeking to minimize risk. (Please note: not addressed in CHCF performance standards for SPDs in managed care.)

Recommendations: First, consumers that are unable to arrange an adequate network of providers, particularly specialists, or are unable to transition care successfully, should be allowed to remain with existing providers in fee-for-service Medi-Cal. Given that virtually every person with disabilities on Medi-Cal already has a usual source of care, their needs are very different than those of working families covered by Medi-Cal managed care.

Second, the default mechanism should take into account the public accountability and oversight of the organized delivery system as well as the degree of reliance of the organized delivery system on the safety net.

Third, outreach and enrollment should be done primarily by the State of California.

Fourth, marketing materials by an organized delivery system should be subject to prior review and approval by both DHCS and DMHC so that risk selection by the organized delivery system is minimized.

Fifth, stakeholder input on materials is essential

Sixth, literacy as well as language access must be taken into account in developing materials.

10. Safety net providers

Today there are almost seven million uninsured in California. They rely on county health systems and community clinics to obtain a range of care. While some private doctors and hospitals provide some care to the uninsured, most of the care for the uninsured is provided by county health systems and community clinics. These safety net providers rely on Medi-Cal funding as well as state and local funds to provide that care for the uninsured as well as for those on Medi-Cal.

The coverage initiatives attempt to create medical homes or organized systems of care for the uninsured that rely on county health systems. County health systems have made significant progress though it has been more uneven than was hoped.

Many seniors and persons with disabilities who are covered by Medi-Cal obtain their care from county health systems and community clinics as well. In some counties such as Los Angeles, few of those covered by Medi-Cal managed care receive care from the county health system: this has undermined the viability of the Los Angeles County health system. If this is replicated with seniors and persons with disabilities, it is unlikely that county hospitals will survive in many counties, leaving the uninsured with nowhere to turn. (Please note: not addressed in CHCF performance standards for SPDs in managed care.)

Recommendation: Assure the continued viability of county health systems and community clinics by using these providers as the anchor for any organized system of care.

11. Statute, not contracts

Finally, consumer protections should be in statute, not in the contract between the organized delivery system and the State of California. The basic consumer protections for those of us with commercial managed care are detailed in statute.

The parties to the contract between an organized delivery system and the State of California do not include the consumer who needs care but the organized delivery system which has agreed to a specific price and the Medi-Cal program which has consistently underpaid providers and plans. (Please note: CHCF performance standards for SPDs in managed care do not address this.)

This factsheet was prepared by Health Access, a statewide coalition of consumer, labor, ethnic, senior, faith, and other organizations that has been dedicated to achieving quality, affordable health care for all Californians for over 20 years. Please visit our website and read our daily blog at www.health-access.org