Plan Readiness Report

Coordinated Care Initiative

April 2014

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Executive Summary

Governor Brown signed Senate Bill (SB) 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012) and SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), as part of the Budget Act of 2012, which established the Coordinated Care Initiative (CCI). Further updates and clarifications to this initiative were enacted in June 2013 through SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013). This legislation requires the California Department of Health Care Services (DHCS) to submit a readiness report describing the process used to assure that health plans are prepared to participate in California's Duals Demonstration Project, referred to as Cal MediConnect, pursuant to Welfare and Institutions (W&I) Code Section (§) 14182.17(e)(4)(D).

CCI will become effective in the counties of Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo and Santa Clara according to the implementation schedule titled, "CCI Enrollment Timeline by Population and County," that can be found on the calduals website under the heading Enrollment Chart at the following link: http://www.calduals.org/implementation/cci-documents/enrollment-charts-timelines/.

As part of the Medicare-Medicaid Capitated Financial Alignment Demonstration, CMS and California developed a multi-step process to ensure that every selected Cal MediConnect plan is fully ready to accept enrollment.

In February 2014, DHCS announced a revised enrollment strategy for Los Angeles County. For Cal MediConnect only, there will be five Cal MediConnect plans, instead of two (LA Care and Health Net) as previously scheduled, in Los Angeles County. This means beneficiaries will have more options when selecting a Cal MediConnect plan in this county. The three additional plans, CareMore, Care 1st, and Molina are in the process of readiness reviews for Los Angeles County; however, these three plans have undergone extensive readiness reviews in other counties.

There are seven plans Cal Optima, CareMore, Care 1st, Alameda Alliance for Health, LA Care, Molina and Santa Clara Family Health Plan currently still under readiness review. DHCS will continue to work with these plans to ensure that they can begin enrollment as scheduled.

The Cal MediConnect Readiness Review Tool, a 58-page document, contains wide-ranging areas and criteria within each functional area that cover the broad range of plan requirements related to Cal MediConnect. To ensure a complete review, CMS engaged an external contractor, National Opinion Research Center (NORC) at the University of Chicago, to assist in the readiness review process. The readiness review was conducted in addition to other review steps (e.g., Medicare application, National Committee for Quality Assurance (NCQA) review of each Cal MediConnect plan model of care). The readiness review consists of four main components:

- Desk Review;
- Site Visit and Systems Testing;

- Network Validation; and
- Pre-Enrollment Validation.

For a plan to participate in Cal MediConnect, it must have successfully completed all components of the readiness review, including other important reviews, such as Medicare's application process and an NCQA review of each Cal MediConnect plan's Medicare model of care.

Introduction

In January 2012, Governor Brown announced the Coordinated Care Initiative (CCI) with the goals of enhancing health outcomes and beneficiary satisfaction for low-income Seniors and Persons with Disabilities (SPDs), including dual-eligibles (individuals eligible for Medicaid and Medicare), while achieving savings from rebalancing service delivery away from institutional care and into the home and community. Working in partnership with the Legislature and stakeholders, the Governor enacted the CCI through SB 1008 (Committee on Budget and Fiscal Review, Chapter 33, Statutes of 2012), SB 1036 (Committee on Budget and Fiscal Review, Chapter 45, Statutes of 2012), and SB 94 (Committee on Budget and Fiscal Review, Chapter 37, Statutes of 2013). This legislation requires the California Department of Health Care Services (DHCS) to submit a readiness report describing the process used to assure that health plans are prepared to participate in California's Duals Demonstration Project, referred to as Cal MediConnect, pursuant to Welfare and Institutions (W&I) Code Section (§) 14182.17(e)(4)(D).

The three major components of the CCI to be implemented in 2014 are:[1]

1. A three-year Demonstration Project (Cal MediConnect) for dual-eligibles that combines the full continuum of acute, primary, institutional, and home- and community-based services into a single benefit package, delivered through an organized service delivery system;
2. Mandatory Medi-Cal managed care enrollment for dual-eligibles; and
3. The inclusion of Long-Term Services and Supports (LTSS) as a Medi-Cal managed care benefit for SPD beneficiaries who are eligible for Medi-Cal only, and for SPD dual-eligibles.

This report explains the process used to assure plan readiness, as required by W&I Code §14182.17(e)(4)(D). As part of the Medicare-Medicaid Capitated Financial Alignment Demonstration, Centers for Medicare and Medicaid Services (CMS) and DHCS developed a multi-step process to ensure that every selected Cal MediConnect plan is fully ready to accept enrollment. This document explains the comprehensive joint CMS/State readiness review that every selected Cal MediConnect plan must pass in order to participate in Cal MediConnect.

[1] SB 1036 also authorizes the creation of a Statewide Public Authority for In Home Supportive Services (IHSS) collective bargaining and a county Maintenance of Effort for funding IHSS. However, statute does not require that these provisions be included in the scope of this report.

I. Readiness Review: Overview

The Cal MediConnect Readiness Review Tool was posted on the CMS website March 29, 2013.[2] This readiness review tool developed by CMS and DHCS for Cal MediConnect, California's Duals Demonstration Project, is the product of:

- Key requirements outlined in the CMS/California Memorandum of Understanding signed on March 27, 2013;
- The California Request for Solutions;
- Duals Plan Letters, which articulate key policy for the Cal MediConnect program;
- Key Medicaid and Medicare regulations; and,
- Stakeholder input received through letters and public meetings.

Systems-related criteria included in the readiness review tool reflect standard health care Information Technology practices. Particular attention was also paid to criteria for pharmacy and claims processing and payment that align with Medicare and Medicaid requirements. The readiness review tool contains functional areas and criteria within each functional area that cover the broad range of plan requirements related to Cal MediConnect. The functional areas reviewed that plans were required to meet are:

- Assessment;
- Care Coordination;
- Confidentiality;
- Enrollee and Provider Communications;
- Enrollee Protections;
- Monitoring of First-Tier, Downstream, and Related Entities;
- Organizational Structure and Staffing;
- Performance and Quality Improvement;
- Provider Credentialing;
- Provider Network;
- Systems; and,
- Utilization Management.

To ensure a complete review, CMS engaged an external contractor, National Opinion Research Center (NORC) at the University of Chicago, to assist in the readiness review process. The readiness review was conducted in addition to other review steps (e.g., Medicare application, National Committee for Quality Assurance (NCQA) review of each Cal MediConnect plan model of care). The readiness review consists of four main components:

- Desk Review;
- Site Visit and Systems Testing;
- Network Validation; and,
- Pre-Enrollment Validation.

[2] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf

Desk Reviews

On March 28, 2013, NORC sent a letter to each prospective plan (including subcontracted plans in Los Angeles County) to initiate the readiness review process, notify them of the documents they would be required to submit as part of the desk review, and inform them of the other phases of the readiness review process (e.g., site review, network validation, systems testing). Each plan was provided a list of the functional areas and related criteria, and was required to submit documents to demonstrate compliance with all criteria. Additionally, each plan was required to submit documents to rectify outstanding deficiencies. Plans were also required to submit a detailed project plan for the enhancement, development, and implementation of the information systems architecture required by Cal MediConnect. Between April and June 2013, the NORC team conducted extensive analysis of all the materials received from each plan.

Site Visit and System Testing

In July and August 2013, NORC, accompanied by CMS and DHCS staff, visited each plan, including subcontracted plans in Los Angeles County, at its place of business to further assess its understanding of Cal MediConnect requirements. During each site visit, the team reviewed all key areas of the readiness review tool.

Two teams participated in each site visit: one team interviewed plan staff about key operational areas; the other reviewed the plan's systems and systems-related functions. Additionally, each plan was provided with comprehensive care coordination systems testing scenarios that required the plan to simulate a "day in the life" of an enrollee and care manager within its systems. The functional areas evaluated included:

- Enrollment Processing;
- New Enrollee Intake and Outreach;
- Conducting the Health Risk Assessment (HRA);
- Enrollee Stratification;
- Care Manager Assignment;
- Creation of an Interdisciplinary Care Team (ICT);
- Development of a Care Plan;
- Documentation of the ICT Team Meeting Outcomes;
- Acute and Ambulatory Care Transitions; and,
- Process for Securing Long Term Care Support and Behavioral Health Services.

Pharmacy and non-pharmacy claims system testing was also conducted using a series of claims scenarios designed to address Medicare and Medicaid benefits along with continuity of care requirements. NORC developed 25 – 35 pharmacy and non-pharmacy test claim scenarios that each plan had to run through its claims processing system to test whether the system was configured properly for Cal MediConnect (i.e., testing if continuity of care requirements are programmed correctly). NORC conducted additional systems testing remotely in mid-October, as necessary, on a plan-specific basis.

Network Validation

On May 17, 2013, each plan received a letter from NORC asking them to submit Medicare facility and provider health services delivery tables, and DHCS Medi-Cal provider network tables. Based on a sample of providers, facilities and pharmacy networks pulled by NORC from the Health Plan Management System (HPMS), CMS and DHCS conducted a network validation review to confirm that each Cal MediConnect plan has fully contracted provider, facility, and pharmacy networks that meet Medicare and Medi-Cal network adequacy standards. On July 3, 2013 NORC sent each plan the sample of providers, facilities and pharmacies, and asked the plan to submit contract signature pages for this sample. Plans were also asked to provide contact information for each provider/facility/pharmacy by July 11, 2013. NORC then checked that all signature pages were submitted and signed. NORC pulled an additional sample of providers, facilities and pharmacies from each table and placed calls to verify that the provider/facility/pharmacy had a current contract with the plan for the Cal MediConnect.

Pre-Enrollment Validation

CMS conducted a pre-enrollment validation process to confirm that the policies and procedures reviewed during the desk review or discussed as part of the site visit are being operationalized prior to the start of Cal MediConnect plan marketing. This includes making sure that staff are being hired in accordance with staffing plans, staff are being trained on the topics required by Cal MediConnect prior to marketing, and key call center and customer service center scripts contain accurate and sufficient information.

Cal MediConnect plans received the request for information on November 7, 2013 and were required to submit the requested information the week of November 18, 2013. The request for information included five parts (beyond the items already submitted in the readiness review process):

- Call Center Information: Telephone numbers for each call line (e.g., language line, customer service line, coverage determination line, nurse advice line, behavioral health line, provider hotline, accompanying TTA/TTY lines).
- Staffing Information: Number of staff expected for key functions, including assessment, care coordination, member services, Minimum Data Set-Home Care assessments, and coverage line determinations; staff trainings to date and planned for future.
- Scripts: Five key scripts (benefits, formulary, continuity of care, formulary transition, and grievances and appeals) to ensure the unique requirements of Cal MediConnect, are explained correctly.
- Attestations: Attestations were obtained to the following statements:
  - The consumer governance board will be established by or on the effective date of Cal MediConnect and will comply with all contractual requirements, including composition and frequency of meetings;
  - The CMS HPMS is current and all plan points of contact are up to date; and
  - All call center scripts required through the Medicare marketing guidelines that were not collected as part of the pre-enrollment validation appropriately incorporate Cal MediConnect.

II. Readiness Review: Specific Analyses

This section lists the specific standard, process or tools that were used to analyze the readiness of the 17 separate items enumerated in W&I Code §14182.17(e)(4)(D). This section is intended to be read in conjunction with the California Readiness Review Tool[3] which was used to evaluate the readiness of plans for certain items listed below.

There are seven plans Cal Optima, CareMore, Care 1st, Alameda Alliance for Health, LA Care, Molina and Santa Clara Family Health Plan currently still under readiness review. DHCS will continue to work with these plans to ensure that they can begin enrollment as scheduled.

1. Data Sharing:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(1) utilizing the California Readiness Review Tool. The California Readiness Review Tool sections relevant to Data Sharing include Table 11. Systems, Points A-F: Pages 42-50.

2. Provider Networks and Access:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(2) utilizing the California Readiness Review Tool. The following sections of the California Readiness Review Tool are relevant to Provider Networks and Access:

- Table 7. Organizational Structure and Staffing, Point A, Bullet 5: Page 24.
- Table 9. Provider Credentialing: Page 35.
- Table 10. Provider Network, Point A: Page 36-38.
- Table 10. Provider Network, Point F, Bullets 1-4: Pages 40-41.

3. Monitoring and Quality Improvements:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(3) utilizing the California Readiness Review Tool. The following sections of the California Readiness Review Tool are relevant to Monitoring and Quality Improvements:

- Table 7. Organizational Structure and Staffing, Point A, Bullet 4: Page 24.
- Table 7. Organizational Structure and Staffing, Point B, Bullet 6: Page 26.
- Table 11. Systems, Point G: Pages 50-52.
- Table 12. Utilization Management, Points A-B: Pages 53-55.

[3] https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CARRTool.pdf

4. Accessibility:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(4) utilizing the California Readiness Review Tool. The following sections of the California Readiness Review Tool are relevant to Accessibility:

- Table 10. Provider Network, Point E: Page 39.
- Table 10. Provider Network, Point H: Page 41.

5. Readiness Standards:

Per the requirements of W&I Code §14087.48(b)(5), DHCS is to report on, "The extent to which the Medi-Cal managed care plan has met all standards and guidelines established by the department that demonstrate readiness to provide services to enrollees."

DHCS will only allow plans to implement Cal MediConnect if all readiness standards have been met. There are seven plans Cal Optima, CareMore, Care 1st, Alameda Alliance for Health, LA Care, Molina and Santa Clara Family Health Plan currently still under readiness review. DHCS will continue to work with these plans to ensure that they can begin enrollment as scheduled.

6. Contract Deliverables:

Per the requirements of W&I Code §14087.48(b)(6), DHCS is to report on, "The extent to which the Medi-Cal managed care plan has submitted all required contract deliverables to the department, including, but not limited to, quality improvement systems, utilization management, access and availability, member services, member grievance systems, and enrollment and disenrollments."

DHCS will only allow plans to implement Cal MediConnect if all needed contract deliverables have been provided. DHCS will continue to work with all plans to ensure that materials are received timely.

7. Health Plans Informational Materials:

Per the requirements of W&I Code §14087.48(b)(7), DHCS is to report on, "The extent to which the Medi-Cal managed care plan's Evidence of Coverage, Member Services Guide, or both, conforms to federal and state statutes and regulations, is accurate, and is easily understood."

Medicare sets strict marketing rules and marketing materials can only be used in Cal MediConnect once approved through that process. Medi-Cal notices are drafted by DHCS, who then oversees the work done by the plans. Taken together, this process ensures that Cal MediConnect plans have accurate and easily understood documents for beneficiaries.

8. Facility Site Reviews:

DHCS conducted a readiness review of all the requirements in W&I Code §14087.48(b)(8). The Facility Site Review was completed separately from the California Readiness Tool. The review procedures are provided in Duals Plan Letter 13-003 "Facility Site Review/Physical Accessibility Reviews" released July 17, 2013. (see: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-003.pdf)

9. Enrollee Communications:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(1) to ensure timely and appropriate communications with beneficiaries through the following:

- Outreach Plan: DHCS released for comment an outreach and communications plan in 2013. That outreach plan has been revised per stakeholder comment and will be re-released in the near future. The document is part of an iterative process where the outreach plan is improved and reformed over the enrollment period.
- Plan Communications: As part of existing Medicare and Medi-Cal requirements, plans have met requirements on communicating in alternative formats that are culturally, linguistically, and physically appropriate through means, including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations. This includes information on grievance and appeals. This also includes ensuring that plan policies and procedures address the effective transition of beneficiaries from Medicare Part D plans not participating in Cal MediConnect; as Medicare plans, Medicare ensures that Cal MediConnect plans are in compliance with all Medicare Managed Care Manual provisions.
- Contracting with Community-Based Groups: DHCS will contract with one community based organization in each county. SCAN Foundation is facilitating the selection of that individual who will then be supported by DHCS for 25 of the percent time.
- Enrollment Notice Development: DHCS continues to develop notices in compliance with all relevant statutory provisions and with stakeholder input. Each notice is made available publicly for stakeholder comment, and typically results in 20 or so letters being received. Notices are available in all threshold languages and alternative formats. Each notice includes information on how to obtain assistance on enrollment from both the Health Insurance Counseling & Advocacy Program and Medi-Cal's Health Care Options.
- Choice Guide: DHCS has vetted with stakeholders and will make available a booklet explaining plan choices and continuity of care provisions.

The California Readiness Review Tool sections that are relevant to Enrollee Communications include Table 5. Enrollee and Provider Communications, Point A, Bullets 1-5: Pages 19-20.

10. HRAs:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(2) utilizing the California Readiness Review Tool to ensure the managed care health plans perform an assessment process. The following sections of the California Readiness Review Tool are relevant to HRAs:

- Table 1. Assessment Processes, Point B: Pages 2-5.
- Table 7. Organizational Structure and Staffing, Point B, Bullets 2-5: Pages 25-26.

In addition, Cal MediConnect plans must comply with Duals Plan Letter 13-002 on "Health Risk Assessment and Risk Stratification Requirements" released June 24, 2013. (see: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-002.pdf)

11. Primary Care:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(3) utilizing the California Readiness Review Tool to ensure the managed care plans arrange for primary care. The California Readiness Review Tool sections relevant to Primary Care include Table 4. Enrollee Protections, Point C: Page 18.

Partial duals, as discussed in W&I Code §14182.17(d)(3)(B) and (C), cannot participate in Cal MediConnect. Existing Medi-Cal contract provisions apply to the partial duals population that offer protections on access to primary and specialty care physicians.

12. Care Coordination:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(4) utilizing the California Readiness Review Tool to ensure the managed care plans perform care coordination and care management activities. The following sections of the California Readiness Review Tool are relevant to Care Coordination and Interdisciplinary Care Team:

- Table 2. Care Coordination, Points A-C: Pages 6-12.
- Table 3. Confidentiality: Page 13.
- Table 7. Organizational Structure and Staffing, Point C, Bullets 2-3: Page 28.
- Table 7. Organizational Structure and Staffing, Point C, Bullets 9-11: Pages 31-32.

In addition, Cal MediConnect plans must comply with Duals Plan Letter 13-005 on "Continuity of Care" released November 27, 2013. (see: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-005.pdf)

13. Network Directory, Long-Term Care Supports and Services, and Out of Network Care:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(5) utilizing the California Readiness Review Tool to ensure the managed care plans comply with network adequacy requirements. The following sections of the California Readiness Review Tool are relevant to Network Directory, LTSS, and Out-of-Network Care:

- Table 5. Enrollee and Provider Communications, Point A, Bullet 6: Page 21.
- Table 5. Enrollee and Provider Communications, Point B: Page 22.
- Table 7. Organizational Structure and Staffing, Point C, Bullet 8: Page 30.
- Table 7. Organizational Structure and Staffing, Point C, Bullet 12: Page 32.
- Table 10. Provider Network, Point A, Bullets 6-13: Page 37.
- Table 10. Provider Network, Point G: Page 41.

14. Care Management:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(6) utilizing the California Readiness Review Tool to ensure the managed care health plans address medical and social care management needs. The following sections of the California Readiness Review Tool are relevant to Care Management:

- Table 7. Organizational Structure and Staffing, Point C, Bullet 1: Page 28.
- Table 7. Organizational Structure and Staffing, Point C, Bullets 4, 6-7: Page 29.

In addition, Cal MediConnect plans must comply with Duals Plan Letter 13-006 on "Care Plan Option Services" released December 6, 2013. (see: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/DPL2013/DPL13-006.pdf)

15. Grievance and Appeals Processes:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(d)(7) utilizing the California Readiness Review Tool to ensure the managed care health plans provide a grievance and appeal process. The following sections of the California Readiness Review Tool are relevant to Grievance and Appeals Processes:

- Table 4. Enrollee Protections, Points A-B: Pages 14-17.
- Table 7. Organizational Structure and Staffing, Point B, Bullets 7-8: Page 27.
- Table 7. Organizational Structure and Staffing, Point C, Bullet 5: Page 29.

16. Set and Implement Quality Measures:

DHCS conducted a readiness review of all the requirements in W&I Code §14182.17(e)(1) utilizing the California Readiness Review Tool to monitor the managed care health plans' performance and accountability for provision of services. The following

sections of the California Readiness Review Tool are relevant to Set and Implement Quality Measures:

- Table 6. Monitoring of First-Tier, Downstream, and Related Entities: Page 23.
- Table 7. Organizational Structure and Staffing, Point B, Bullet 9: Page 27.
- Table 8. Performance and Quality Improvement: Pages 33-34.

DHCS will continue to work with CMS and their contractor, Research Triangle Institute, to develop a plan for plan oversight. The stakeholder process on quality, which included four meetings between May and August 2012, continues.[4]

17. Stakeholder Outreach:

DHCS conducted a readiness review of all the requirements at W&I Code §14182.17(e)(3) utilizing the California Readiness Review Tool to solicit stakeholder and member participation in advisory groups for the planning and development activities relating to the provision of services for dual-eligible beneficiaries. The following sections of the California Readiness Review Tool are relevant to Stakeholder Outreach:

- Table 5. Enrollee and Provider Communications, Point A, Bullets 7-9: Page 21.
- Table 7. Organizational Structure and Staffing, Point A, Bullet 3: Page 24.

[4] For more information, please see: http://www.calduals.org/implementation/workgroup/quality/

APPENDIX A: State Plan Readiness Reporting Requirement Statute

Welfare and Institutions Code Section 14182.17

(d) Before the department contracts with managed care health plans or Medi-Cal providers to furnish Medi-Cal benefits and services pursuant to subdivision (b), the department shall do all of the following:

(1) Ensure timely and appropriate communications with beneficiaries as follows:

(A) At least 90 days prior to enrollment, inform dual eligible beneficiaries through a notice written at not more than a sixth-grade reading level that includes, at a minimum, how the Medi-Cal system of care will change, when the changes will occur, and who they can contact for assistance with choosing a managed care health plan or with problems they encounter.

(B) Develop and implement an outreach and education program for beneficiaries to inform them of their enrollment options and rights, including specific steps to work with consumer and beneficiary community groups.

(C) Develop, in consultation with consumers, beneficiaries, and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices.

(D) Ensure that managed care health plans and their provider networks are able to provide communication and services to dual eligible beneficiaries in alternative formats that are culturally, linguistically, and physically appropriate through means, including, but not limited to, assistive listening systems, sign language interpreters, captioning, written communication, plain language, and written translations.

(E) Ensure that managed care health plans have prepared materials to inform beneficiaries of procedures for obtaining Medi-Cal benefits, including grievance and appeals procedures, that are offered by the plan or are available through the Medi-Cal program.

(F) Ensure that managed care health plans have policies and procedures in effect to address the effective transition of beneficiaries from Medicare Part D plans not participating in the demonstration project. These policies shall include, but not be limited to, the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS, including a determination of which beneficiaries require information about their transition supply, and, within the first 90 days of coverage under a new plan, provide for a temporary fill when the beneficiary requests a refill of a nonformulary drug.

(G) Contingent upon available private or public funds other than moneys from the General Fund, contract with community-based, nonprofit consumer, or health insurance

assistance organizations with expertise and experience in assisting dual eligible beneficiaries in understanding their health care coverage options.

(H) Develop, with stakeholder input, informing and enrollment materials and an enrollment process in the demonstration site counties. The department shall ensure all of the following prior to implementing enrollment:

(i) Enrollment materials shall be made public at least 60 days prior to the first mailing of notices to dual eligible beneficiaries, and the department shall work with stakeholders to incorporate public comment into the materials.

(ii) The materials shall be in a not more than sixth grade reading level and shall be available in all the Medi-Cal threshold languages, as well as in alternative formats that are culturally, linguistically, and physically appropriate. For in-person enrollment assistance, disability accommodation shall be provided, when appropriate, through means including, but not limited to, assistive listening systems, sign language interpreters, captioning, and written communication.

(iii) The materials shall plainly state that the beneficiary may choose fee-for-service Medicare or Medicare Advantage, but must return the form to indicate this choice, and that if the beneficiary does not return the form, the state shall assign the beneficiary to a plan and all Medicare and Medi-Cal benefits shall only be available through that plan.

(iv) The materials shall plainly state that the beneficiary shall be enrolled in a Medi-Cal managed care health plan even if he or she chooses to stay in fee-for-service Medicare.

(v) The materials shall plainly explain all of the following:

(I) The plan choices.

(II) Continuity of care provisions.

(III) How to determine which providers are enrolled in each plan.

(IV) How to obtain assistance with the choice forms.

(vi) The enrollment contractor recognizes, in compliance with existing statutes and regulations, authorized representatives, including, but not limited to, a caregiver, family member, conservator, or a legal services advocate, who is recognized by any of the services or programs that the person is already receiving or participating in.

(I) Make available to the public and to all Medi-Cal providers copies of all beneficiary notices in advance of the date the notices are sent to beneficiaries. These copies shall be available on the department’s Internet Web site.

(2) Require that managed care health plans perform an assessment process that, at a minimum, does all of the following:

(A) Assesses each new enrollee's risk level and needs by performing a risk assessment process using means such as telephonic, Web-based, or in-person communication, or review of utilization and claims processing data, or by other means as determined by the department, with a particular focus on identifying those enrollees who may need long-term services and supports. The risk assessment process shall be performed in accordance with all applicable federal and state laws.

(B) Assesses the care needs of dual eligible beneficiaries and coordinates their Medi-Cal benefits across all settings, including coordination of necessary services within, and, when necessary, outside of the managed care health plan's provider network.

(C) Uses a mechanism or algorithm developed by the managed care health plan pursuant to paragraph (7) of subdivision (b) of Section 14182 for risk stratification of members.

(D) At the time of enrollment, applies the risk stratification mechanism or algorithm approved by the department to determine the health risk level of members.

(E) Reviews historical Medi-Cal fee-for-service utilization data and Medicare data, to the extent either is accessible to and provided by the department, for dual eligible beneficiaries upon enrollment in a managed care health plan so that the managed care health plans are better able to assist dual eligible beneficiaries and prioritize assessment and care planning.

(F) Analyzes Medicare claims data for dual eligible beneficiaries upon enrollment in a demonstration site pursuant to Section 14132.275 to provide an appropriate transition process for newly enrolled beneficiaries who are prescribed Medicare Part D drugs that are not on the demonstration site's formulary, as required under the transition of care requirements for Medicare Part D benefits as described in Chapters 6 and 14 of the Medicare Managed Care Manual, published by CMS.

(G) Assesses each new enrollee's behavioral health needs and historical utilization, including mental health and substance use disorder treatment services.

(H) Follows timeframes for reassessment and, if necessary, circumstances or conditions that require redetermination of risk level, which shall be set by the department.

(3) Ensure that the managed care health plans arrange for primary care by doing all of the following:

(A) Except for beneficiaries enrolled in the demonstration project pursuant to Section 14132.275, forgo interference with a beneficiary's choice of primary care physician under Medicare, and not assign a full-benefit dual eligible beneficiary to a primary care physician unless it is determined through the risk stratification and assessment process

that assignment is necessary, in order to properly coordinate the care of the beneficiary or upon the beneficiary's request.

(B) Assign a primary care physician to a partial-benefit dual eligible beneficiary receiving primary or specialty care through the Medi-Cal managed care plan.

(C) Provide a mechanism for partial-benefit dual eligible enrollees to request a specialist or clinic as a primary care provider if these services are being provided through the Medi-Cal managed care health plan. A specialist or clinic may serve as a primary care provider if the specialist or clinic agrees to serve in a primary care provider role and is qualified to treat the required range of conditions of the enrollees.

(4) Ensure that the managed care health plans perform, at a minimum, and in addition to, other statutory and contractual requirements, care coordination, and care management activities as follows:

(A) Reflect a member-centered, outcome-based approach to care planning, consistent with the CMS model of care approach and with federal Medicare requirements and guidance.

(B) Adhere to a beneficiary's determination about the appropriate involvement of his or her medical providers and caregivers, according to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(C) Develop care management and care coordination for the beneficiary across the medical and long-term services and supports care system, including transitions among levels of care and between service locations.

(D) Develop individual care plans for higher risk beneficiaries based on the results of the risk assessment process with a particular focus on long-term services and supports.

(E) Use nurses, social workers, the beneficiary's primary care physician, if appropriate, and other medical professionals to provide care management and enhanced care management, as applicable, particularly for beneficiaries in need of or receiving long-term services and supports.

(F) Consider behavioral health needs of beneficiaries and coordinate those services with the county mental health department as part of the beneficiary's care management plan when appropriate.

(G) Facilitate a beneficiary's ability to access appropriate community resources and other agencies, including referrals as necessary and appropriate for behavioral services, such as mental health and substance use disorders treatment services.

(H) Monitor skilled nursing facility utilization and develop care transition plans and programs that move beneficiaries back into the community to the extent possible. Plans

shall monitor and support beneficiaries in the community to avoid further institutionalization.

(5) Ensure that the managed care health plans comply with, at a minimum, and in addition to other statutory and contractual requirements, network adequacy requirements as follows:

(A) Provide access to providers that comply with applicable state and federal law, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.

(B) Meet provider network adequacy standards for long-term services and supports that the department shall develop.

(C) Maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients, which shall be made available to beneficiaries, at a minimum, by phone, written material, and the Internet, and in accessible formats, upon request.

(D) Monitor an appropriate provider network that includes an adequate number of accessible facilities within each service area.

(E) Contract with and assign patients to safety net and traditional providers as defined in subdivisions (hh) and (jj), respectively, of Section 53810 of Title 22 of the California Code of Regulations, including small and private practice providers who have traditionally treated dual eligible patients, based on available medical history to ensure access to care and services. A managed care health plan shall establish participation standards to ensure participation and broad representation of traditional and safety net providers within a service area.

(F) Maintain a liaison to coordinate with each regional center operating within the plan's service area to assist dual eligible beneficiaries 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.

(G) Maintain a liaison and provide access to out-of-network providers, for up to 12 months, for new members enrolled under Sections 14132.275 and 14182.16 who have an ongoing relationship with a provider, if the provider will accept the health plan's rate for the service offered, or for nursing facilities and Community-Based Adult Services, or the applicable Medi-Cal fee-for-service rate, whichever is higher, and the managed care health plan determines that the provider meets applicable professional standards and has no disqualifying quality of care issues in accordance with guidance from the department, including all-plan letters. A partial-benefit dual eligible beneficiary enrolled in Medicare Part A who only receives primary and specialty care services through a Medi-Cal managed care health plan shall be able to receive these Medi-Cal services from an out-of-network Medi-Cal provider for 12 months after enrollment. This subparagraph shall not apply to out-of-network providers that furnish ancillary services.

(H) Assign a primary care physician who is the primary clinician for the beneficiary and who provides core clinical management functions for partial-benefit dual eligible beneficiaries who are receiving primary and specialty care through the Medi-Cal managed care health plan.

(I) Employ care managers directly or contract with nonprofit or proprietary organizations in sufficient numbers to provide coordinated care services for long-term services and supports as needed for all members.

(6) Ensure that the managed care health plans address medical and social needs as follows:

(A) Offer services beyond those required by Medicare and Medi-Cal at the managed care health plan's discretion.

(B) Refer beneficiaries to community resources or other agencies for needed medical or social services or items outside the managed care health plan's responsibilities.

(C) Facilitate communication among a beneficiary's health care and personal care providers, including long-term services and supports and behavioral health providers when appropriate.

(D) Engage in other activities or services needed to assist beneficiaries in optimizing their health status, including assisting with self-management skills or techniques, health education, and other modalities to improve health status.

(E) Facilitate timely access to primary care, specialty care, medications, and other health services needed by the beneficiary, including referrals to address any physical or cognitive barriers to access.

(F) Utilize the most recent common procedure terminology (CPT) codes, modifiers, and correct coding initiative edits.

(7) (A) Ensure that the managed care health plans provide, at a minimum, and in addition to other statutory and contractual requirements, a grievance and appeal process that does both of the following:

(i) Provides a clear, timely, and fair process for accepting and acting upon complaints, grievances, and disenrollment requests, including procedures for appealing decisions regarding coverage or benefits, as specified by the department. Each managed care health plan shall have a grievance process that complies with Section 14450, and Sections 1368 and 1368.01 of the Health and Safety Code.

(ii) Complies with a Medicare and Medi-Cal grievance and appeal process, as applicable. The appeals process shall not diminish the grievance and appeals rights of IHSS recipients pursuant to Section 10950.

(B) In no circumstance shall the process for appeals be more restrictive than what is required under the Medi-Cal program.

(e) The department shall do all of the following:

(1) Monitor the managed care health plans' performance and accountability for provision of services, in addition to all other statutory and contractual monitoring and oversight requirements, by doing all of the following:

(A) Develop performance measures that are required as part of the contract to provide quality indicators for the Medi-Cal population enrolled in a managed care health plan and for the dual eligible subset of enrollees. These performance measures may include measures from the Healthcare Effectiveness Data and Information Set or measures indicative of performance in serving special needs populations, such as the National Committee for Quality Assurance structure and process measures, or other performance measures identified or developed by the department.

(B) Implement performance measures that are required as part of the contract to provide quality assurance indicators for long-term services and supports in quality assurance plans required under the plans' contracts. These indicators shall include factors such as affirmative member choice, increased independence, avoidance of institutional care, and positive health outcomes. The department shall develop these quality assurance indicators in consultation with stakeholder groups.

(C) Effective January 10, 2014, and for each subsequent year of the demonstration project authorized under Section 14132.275, provide a report to the Legislature describing the degree to which Medi-Cal managed care health plans in counties participating in the demonstration project have fulfilled the quality requirements, as set forth in the health plan contracts.

(D) Effective June 1, 2014, and for each subsequent year of the demonstration project authorized by Section 14132.275, provide a joint report, from the department and from the Department of Managed Health Care, to the Legislature summarizing information from both of the following:

(i) The independent audit report required to be submitted annually to the Department of Managed Health Care by managed care health plans participating in the demonstration project authorized by Section 14132.275.

(ii) Any routine financial examinations of managed care health plans operating in the demonstration project authorized by Section 14132.275 that have been conducted and

completed for the previous calendar year by the Department of Managed Health Care and the department.

(2) Monitor on a quarterly basis the utilization of covered services of beneficiaries enrolled in the demonstration project pursuant to Section 14132.275 or receiving long-term services and supports pursuant to Article 5.7 (commencing with Section 14186).

(3) Develop requirements for managed care health plans to solicit stakeholder and member participation in advisory groups for the planning and development activities relating to the provision of services for dual eligible beneficiaries.

(4) Submit to the Legislature the following information:

(A) Provide, to the fiscal and appropriate policy committees of the Legislature, a copy of any report submitted to CMS pursuant to the approved federal waiver described in Section 14180.

(B) Together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, in consultation with stakeholders, develop a programmatic transition plan, and submit that plan to the Legislature within 90 days of the effective date of this section. The plan shall include, but is not limited to, the following components:

(i) A description of how access and quality of service shall be maintained during and immediately after implementation of these provisions, in order to prevent unnecessary disruption of services to beneficiaries.

(ii) Explanations of the operational steps, timelines, and key milestones for determining when and how the components of paragraphs (1) to (9), inclusive, shall be implemented.

(iii) The process for addressing consumer complaints, including the roles and responsibilities of the departments and health plans and how those roles and responsibilities shall be coordinated. The process shall outline required response times and the method for tracking the disposition of complaint cases. The process shall include the use of an ombudsman, liaison, and 24-hour hotline dedicated to assisting Medi-Cal beneficiaries navigate among the departments and health plans to help ensure timely resolution of complaints.

(iv) A description of how stakeholders were included in the various phases of the planning process to formulate the transition plan, and how their feedback shall be taken into consideration after transition activities begin.

(C) The department, together with the State Department of Social Services, the California Department of Aging, and the Department of Managed Health Care, convene and consult with stakeholders at least twice during the period following production of a draft of the implementation plan and before submission of the plan to the Legislature. Continued

consultation with stakeholders shall occur on an ongoing basis for the implementation of the provisions of this section.

(D) No later than 90 days prior to the initial plan enrollment date of the demonstration project pursuant to the provisions of Sections 14132.275, 14182.16, and of Article 5.7 (commencing with Section 14186), assess and report to the fiscal and appropriate policy committees of the Legislature on the readiness of the managed care health plans to address the unique needs of dual eligible beneficiaries and Medi-Cal only seniors and persons with disabilities pursuant to the applicable readiness evaluation criteria and requirements set forth in paragraphs (1) to (8), inclusive, of subdivision (b) of Section 14087.48. The report shall also include an assessment of the readiness of the managed care health plans in each county participating in the demonstration project to have met the requirements set forth in paragraphs (1) to (9), inclusive. **(Note: 14182.17 (e)(1) and (3) in existing statute, were previously in statute as 14182.17 (d)(8) and (9)**.

Welfare and Institutions Code 14087.48:

14087.48. (a) For purposes of this section "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089), or pursuant to Article 1 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8.

(b) Before a Medi-Cal managed care plan commences operations based upon an action of the director that expands the geographic area of Medi-Cal managed care, the department shall perform an evaluation to determine the readiness of any affected Medi-Cal managed care plan to commence operations. The evaluation shall include, at a minimum, all of the following:

(1) The extent to which the Medi-Cal managed care plan demonstrates the ability to provide reliable service utilization and cost data, including, but not limited to, quarterly financial reports, audited annual reports, utilization reports of medical services, and encounter data.

(2) The extent to which the Medi-Cal managed care plan has an adequate provider network, including, but not limited to, the location, office hours, and language capabilities of primary care physicians, specialists, pharmacies, and hospitals, that the types of specialists in the provider network are based on the population makeup and particular geographic needs, and that whether requirements will be met for availability of services and travel distance standards, as set forth in Sections 53852 and 53885, respectively, of Title 22 of the California Code of Regulations.

(3) The extent to which the Medi-Cal managed care plan has developed procedures for the monitoring and improvement of quality of care, including, but not limited to,

procedures for retrospective reviews which include patterns of practice reviews and drug prescribing practice reviews, utilization management mechanisms to detect both under- and over-utilization of health care services, and procedures that specify timeframes for medical authorization.

(4) The extent to which the Medi-Cal managed care plan has demonstrated the ability to meet accessibility standards in accordance with Section 1300.67.2 of Title 28 of the California Code of Regulations, including, but not limited to, procedures for appointments, waiting times, telephone procedures, after hours calls, urgent care, and arrangement for the provision of unusual specialty services.

(5) The extent to which the Medi-Cal managed care plan has met all standards and guidelines established by the department that demonstrate readiness to provide services to enrollees.

(6) The extent to which the Medi-Cal managed care plan has submitted all required contract deliverables to the department, including, but not limited to, quality improvement systems, utilization management, access and availability, member services, member grievance systems, and enrollment and disenrollments.

(7) The extent to which the Medi-Cal managed care plan's Evidence of Coverage, Member Services Guide, or both, conforms to federal and state statutes and regulations, is accurate, and is easily understood.

(8) The extent to which the Medi-Cal managed care plan's primary care and facility sites have been reviewed and evaluated by the department.