Beneficiary Protections and the Coordinated Care Initiative

The Coordinated Care Initiative (CCI) includes comprehensive protections to ensure beneficiary health and safety along with high quality care delivery. The state received significant stakeholder feedback on the beneficiary protections needed to drive success and quality in the CCI's design and implementation. The following beneficiary protections enacted in SB 1008 (Chapter 33, Statutes of 2012) reflect stakeholder feedback, as well as lessons learned from the transition of Medi-Cal-only seniors and persons with disabilities (SPDs) into Medi-Cal managed care. This document provides a summary of these beneficiary protections under the CCI.

Continuity of Care. The state will require health plans to follow all continuity of care requirements established in current law. Dual eligible beneficiaries will not have a medical exemption request process because the duals demonstration for coordinated Medicare and Medi-Cal benefits is a voluntary program. A medical exemption request process will be available to Medi-Cal-only beneficiaries required to enroll in Medi-Cal managed care.

Specifically for continuity of care, the state shall:

- Develop materials that describe continuity of care rights in all threshold languages that will be distributed to beneficiaries through health plans and providers.

- For Medi-Cal services, require that health plans maintain a liaison and provide access to out-of-network providers, for up to 12 months, if the provider meets applicable professional standards; has no disqualifying quality of care issues; and will accept the health plan's rate, or for nursing facilities and Community-Based Adult Services, the applicable Medi-Cal fee-for-service rate, whichever is higher. This does not apply to ancillary service providers [WIC 14182.17(d)(1)(I)(5)(G)].

- For Medicare services, a beneficiary may continue receiving services from an out-of-network Medicare provider for primary and specialty care services for six months if all the following criteria are met: 1) the beneficiary has an existing relationship with the provider; 2) the provider accepts payment from the health plan based upon the current Medicare fee schedule; and 3) the health plan would not otherwise exclude the provider due to documented quality of care concerns [WIC 14132.275(k)(2)(A)].

Notification and Enrollment Processes. The state will ensure beneficiaries are meaningfully informed about their enrollment rights and care options [WIC 14182.17(d)(1)]. Specifically, the state will:

- 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.

- Develop, in consultation with beneficiaries and other stakeholders, an overall communications plan that includes all aspects of developing beneficiary notices.
- Ensure that 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.
- Ensure that health plans 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.
- Contingent upon available private or public dollars other than the state 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;
- Ensure its contracted enrollment broker, starting 90 days prior to enrollment, will inform dual eligible beneficiaries of their enrollment options through a series of mailings written at no more than a sixth-grade reading level in the language the beneficiary understands and available upon request in alternative formats. This information will include, at a minimum, how their system of care would change, when the changes will occur, and how to contact the state's enrollment broker for questions or assistance with choosing a health plan.
- Ensure its enrollment contractor recognizes, as under current state law, a caregiver, family member, conservator, or legal services advocate who is recognized as an authorized representative by any program the beneficiary is receiving.
- Only mail enrollment materials to beneficiaries required to make a choice or affirmatively opt out. [WIC14182.17(c)(2)]

Care Coordination. Health plans shall have care coordination and management activities that reflect a member-centered, outcome-based approach, and provides seamless access to the full continuum of necessary services [WIC 14182.17(d)(1)(I)(4)].

Specifically, this care coordination will:

- Be sensitive to the beneficiary's language and culture and be delivered in an appropriate care setting, including the home and community.
- Follow the beneficiary's direction about the level of involvement of his or her caregivers or medical providers.
- Span medical and long-term services and supports (LTSS) care systems, with a focus on transitions between service locations.
- Consider behavioral health needs and coordinate with county services.
- Provide individualized care plans for individuals deemed at higher risk through the assessment process.

- Be performed by nurses, social workers, primary care providers, and other medical professionals, as appropriate.
- Ensure access to appropriate community resources and monitor skilled nursing utilization, with a focus on transitions between the facilities and community.

Self-Directed Care. Beneficiaries will continue having the choice to self-direct their care [WIC 14186(b)(5)].

Specifically, when appropriate, beneficiaries will:

- Be able to hire, fire, and supervise their In-Home Support Services (IHSS) provider, as currently allowed in California's IHSS program.
- Decide whether, how, and, what LTSS to accept to maintain independence and quality of life.
- Select their health care providers within the health plan network and control care planning and coordination with their health care providers.
- Have access to services that are culturally, linguistically, and operationally sensitive to meet their needs and that improve their health outcomes, enhance independence, and promote living in home and community settings.

Health-Risk Assessment. The state will require that health plans perform an assessment process that, in accordance with all applicable federal and state laws, evaluates beneficiaries' medical, long-term care, and behavioral health needs [WIC14182.17(d)(1)(I)(2)].

Specifically, the state will require that the health plans' assessment processes:

- Use an interactive process, such as telephonic, web-based, or in-person communication, to assess each new enrollee's risk level and needs.
- Address the care needs of the beneficiary and coordinate their Medicare and Medi-Cal benefits across all settings.
- Incorporate the preferences of the beneficiary, including the preferred setting for delivery of LTSS.
- Review historical Medi-Cal and Medicare utilization data.
- Assess an individual's cognitive status and ability to make informed decisions.
- Assess an individual's behavioral health needs.
- Follow set timeframes for reassessment.

Network Adequacy. Health plans will be required to establish and maintain provider networks that meet Medi-Cal network readiness standards for LTSS and Medicare network adequacy standards for medical services and prescription drugs. In addition, beneficiaries will have a choice of providers among a broad network of primary care providers,

behavioral health providers, specialists, ancillary providers, hospitals, pharmacists, and providers of LTSS [WIC 14182.17(d)(1)(I)(5)].

Specifically, the state will require that health plans:

- Contract with health facilities and providers that comply with applicable state and federal laws, including, but not limited to, physical accessibility and the provision of health plan information in alternative formats.
- Maintain an appropriate provider network that includes an adequate number of specialists, primary care physicians, hospitals, long-term care providers, and accessible facilities within each service area.
- 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 Internet website, upon request.
- Contract with safetynet and traditional providers, as defined in state regulations, to ensure access to care and services.
- Employ care managers directly or contract with care management organizations in sufficient numbers to provide coordinated care services for LTSS as needed for all members. Care managers will assist with the continuity of care options, access to plan services, and plan authorization processes.
- Have non-emergency medical transportation available in sufficient supply and accessibility so that individuals have timely access for scheduled and unscheduled medical care appointments.
- Assign a primary care physician to provide 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.

Appeals and Grievances. The state requires that under no circumstance shall the process for appeals be more restrictive than what is required under the Medi-Cal program. The appeals process shall not diminish the grievance and appeals rights of IHSS consumers. Beneficiaries will receive notices of their appeals rights in a format and language understandable and accessible. On all notices that deny, reduce, or otherwise amend a request for services, demonstration health plans are required to notify the beneficiary of the right to appeal the decision [WIC 14182.17(d)(1)(I)(7)].

Specifically, the state will require that health plans provide a grievance and appeal process that:

- 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.

- Complies with the Medicare and Medi-Cal grievance and appeal processes, as applicable.

Quality Monitoring. The state shall monitor the health plans' performance and accountability for providing beneficiaries seamless access to medically necessary services. The state shall provide reports, at least annually, to the legislature regarding the health plan performance [WIC14182.17(d)(1)(I)(8)].

Specifically, the state will:

- Develop, in cooperation with stakeholders, performance measures that the health plans must achieve as part of their contracts to ensure quality care is provided to beneficiaries.

- Ensure performance measures include a subset focused on LTSS, such as member choice, increased independence, avoidance of institutional care, and improved health outcomes.

- Summarize the health plan performance annually to the legislature, including financial reviews and independent audits performed by the Department of Managed Health Care (DMHC).

- Monitor utilization of covered services on a quarterly basis.

- Develop requirements for managed care health plans to solicit stakeholder and member participation in advisory groups for the planning and development of the demonstration.