Important Medi-Cal Changes Affecting Seniors and Persons with Disabilities

Presented by the

Center for Health Care Rights

February 2012

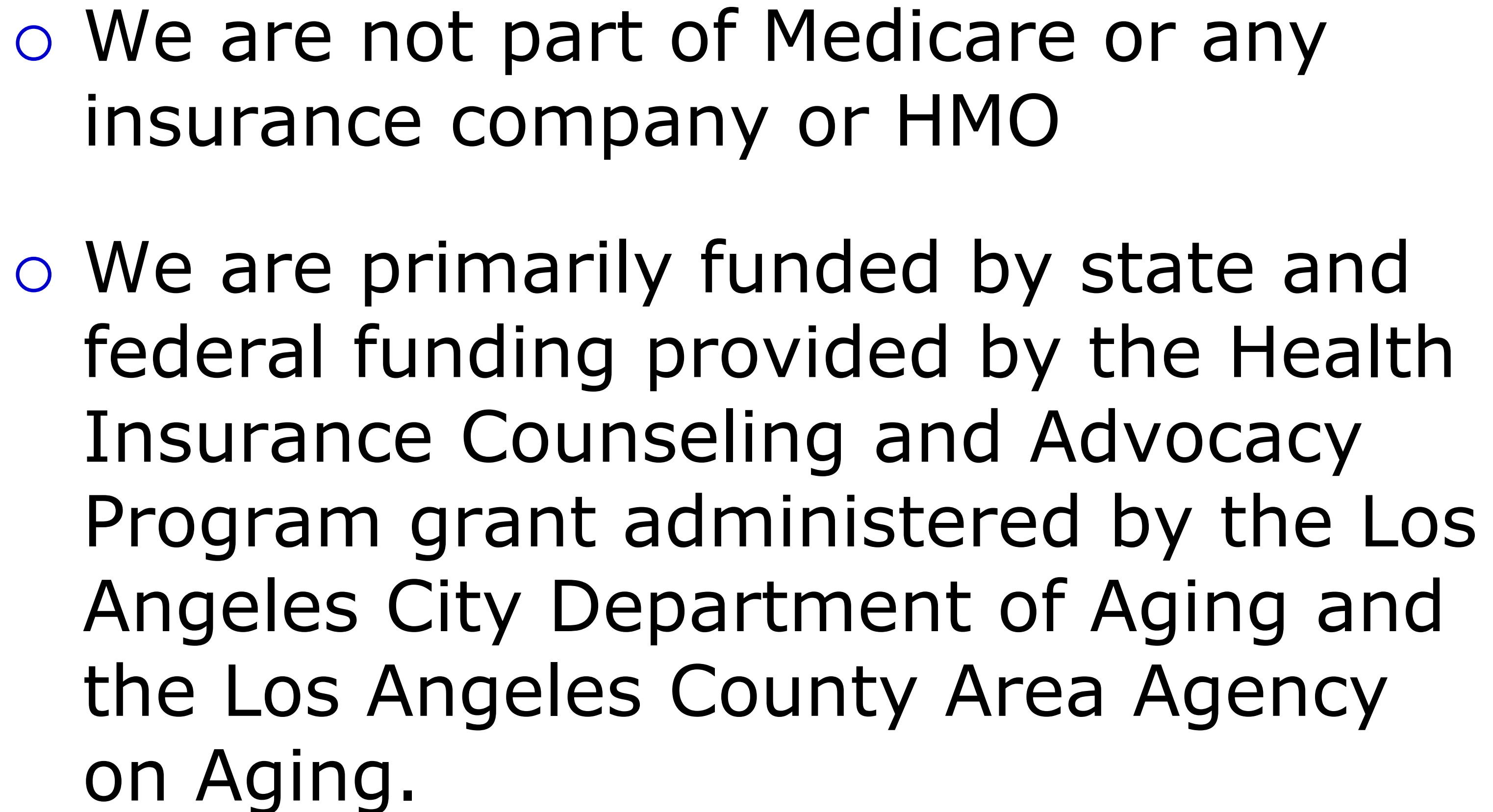
- Close all applications not related to training (i.e. emails, alerts, IM)
- Mute all lines (including your own)
- Turn off pagers/wireless devices
- Refrain from typing
- Raise hand if you have a question and type your question in the chat box
  - We will try to respond to as many questions as possible

Copyright (c) February 2012 by Center for Health Care Rights

Center for Health Care Rights (CHCR)

- A non-profit organization that provides free information and help with Medicare and health insurance questions.
- Our services are free for Los Angeles County residents

Copyright (c) February 2012 by Center for Health Care Rights



- We are not part of Medicare or any insurance company or HMO
- We are primarily funded by state and federal funding provided by the Health Insurance Counseling and Advocacy Program grant administered by the Los Angeles City Department of Aging and the Los Angeles County Area Agency on Aging.

Copyright (c) February 2012 by Center for Health Care Rights

- Some of these changes are directly related to efforts to reduce Medi-Cal spending.
- Other changes are related to new policies to restructure publicly funded health programs under California's 1115 waiver that was approved by the federal government.

- These changes will affect Medi-Cal eligible persons who are 65 and older and persons under the age of 65 who have Medi-Cal due to disability. These individuals are generally referred to as Seniors and Persons with Disabilities or SPDs.

Copyright (c) February 2012 by Center for Health Care Rights

- New requirements that seniors and persons with disabilities who only have Medi-Cal must enroll in Medi-Cal Managed Care Health plans.
- Changes in Medi-Cal benefits implemented in 2011 and changes in Medi-Cal benefits that may be implemented later this year if approved by the federal government
- The elimination of Medi-Cal adult day health care services (ADHC) effective **April 1, 2012** and plans for ADHC participants' transition to the new Community-Based Adult Services (CBAS).

Copyright (c) February 2012 by Center for Health Care Rights

- As of June 2011, California's Dept. of Health Care Services (DHCS) has begun to require most Medi-Cal only beneficiaries who are elderly (age 65 or older) and younger persons with disabilities to enroll into Medi-Cal managed care health plans.

Copyright (c) February 2012 by Center for Health Care Rights

- Most individuals who have Supplemental Security (SSI) and only Medi-Cal as their health insurance will be required to join a Medi-Cal Managed Care Plan. Persons affected include:
  - Elderly persons who are age 65 and older;
  - Blind individuals of any age who have been declared legally blind by the Social Security Administration; and,
  - Disabled individuals of any age who have been declared legally disabled by the Social Security Administration.

Copyright (c) February 2012 by Center for Health Care Rights

Who is Exempt from the Mandatory Medi-Cal Managed Care Plan Enrollment?

- Medi-Cal eligible persons who meet **any of** the following requirements **do not** have to join a Medi-Cal plan:
  - Have Medicare and Medi-Cal
  - Have Medi-Cal with a Share of Cost
  - Have restricted scope Medi-Cal for emergencies or pregnancy
  - Live in a nursing home and receiving Medi-Cal Long Term Care
  - California Children's Services CCS eligible children
  - Have private health insurance
  - Meet medical exemption guidelines
  - Participate in Medicaid home and community based waiver programs (does not include IHSS)

Copyright (c) February 2012 by Center for Health Care Rights

- Enrollment will be staggered over a 12 month period, starting June 1, 2011 and ending June 1, 2012. Enrollment for current Medi-Cal eligible persons will be based on their birthday month.
  - Example: Persons with a May birthday will be required to join a plan by June 1st.
- Starting in June 2011, most new Medi-Cal only applicants will be required to join a Medi-Cal plan when they apply for Medi-Cal.

Copyright (c) February 2012 by Center for Health Care Rights

- Medi-Cal (DHCS) will send letters and make phone calls to Medi-Cal beneficiaries starting 90 days before the beneficiary's enrollment date.
- Enrollment packets will be sent out 60 days before the enrollment date.
- In Los Angeles County, if a Medi-Cal beneficiary does not select a plan, s/he will be enrolled into either L. A. Care Health Plan or Health Net. If a Medi-Cal beneficiary is assigned to a plan, Medi-Cal claim data from the prior 12 month period for the individual will be used to help select the plan.

Copyright (c) February 2012 by Center for Health Care Rights

Notifications	Schedule Date
Letter regarding changes to Medi-Cal	11/2/2011 to 11/10/2011
Follow-up phone call	11/13/2011 to 11/21/2011
Health Plan Choice Packets	11/30/2011 to 12/8/2011
Follow-up phone call to health plan choice packets	12/13/2011 to 12/21/2011
Final letter reminding you to choose a health plan	1/19/2012 to 1/29/2012
Final date to choose a health plan (after this date a health plan will be chosen for you)	2/16/2012
Enrollment effective date	3/1/2012

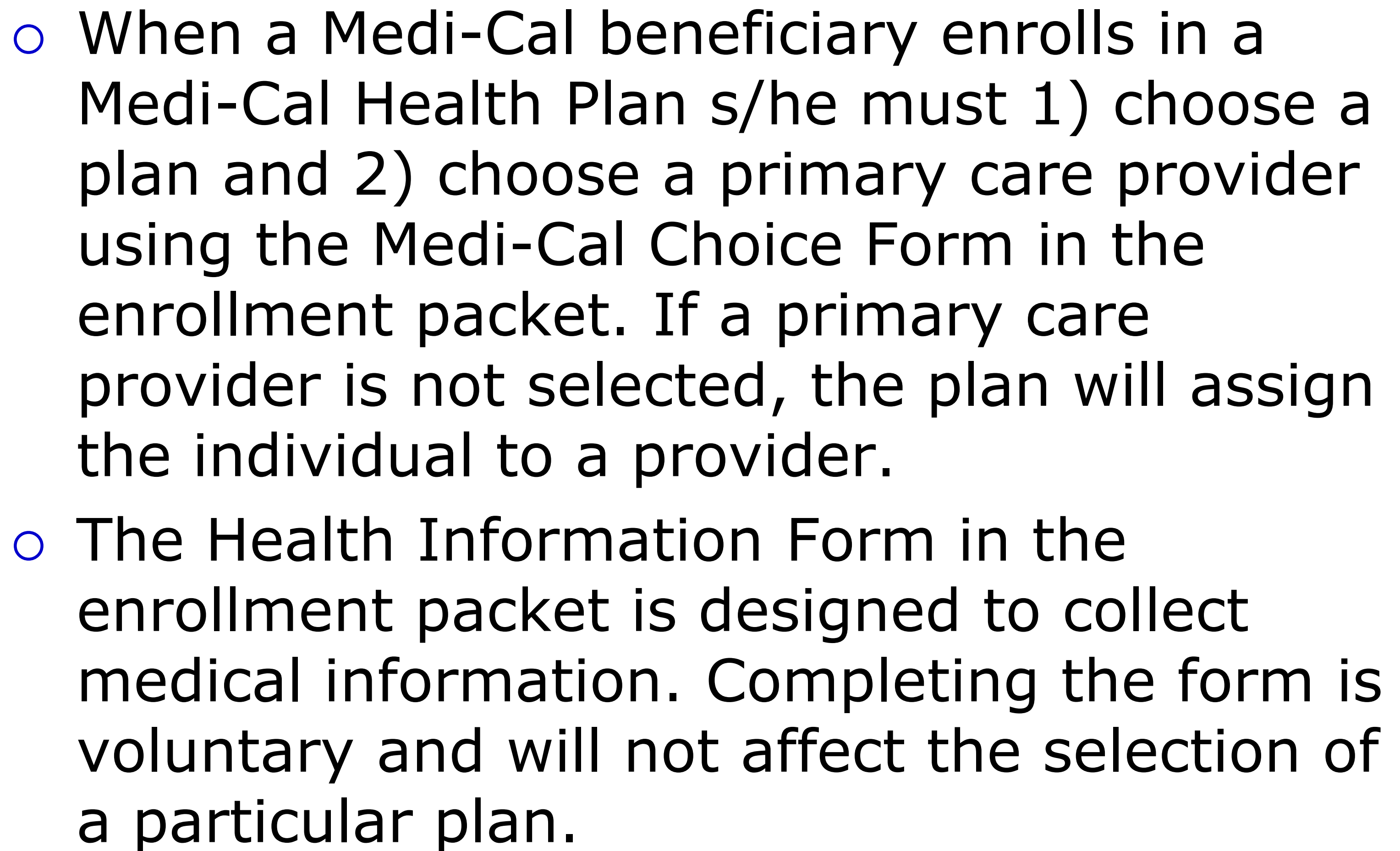
Copyright (c) February 2012 by Center for Health Care Rights

How Does A Person Enroll in a Medi-Cal Plan?

- There are two Medi-Cal Health Plans in Los Angeles County: L.A. Care and HealthNet. Both plans work with other partner plans and have health care provider networks.

- When choosing a plan, persons with Medi-Cal should select a plan that permits them to continue to see the doctors, pharmacies and vendors that contract with the plan. The enrollment packets for L.A. Care and HealthNet include lists of providers for each plan.

Copyright (c) February 2012 by Center for Health Care Rights



Copyright (c) February 2012 by Center for Health Care Rights

- Yes, Medi-Cal beneficiaries can change to another plan but cannot return to fee for service Medi-Cal unless they qualify for an exemption. To switch plan, call Health Care Options at:
  - **1-800-430-4263 English**
  - **1-800-430-3003 Spanish**
  - **1-800-430-7077 TDD**
- Additional phone numbers for other languages are on the Health Care Options web site: http://www.healthcareoptions.dhcs.ca.gov
- Persons who are already in a Medi-Cal Health Plan do not need to do anything. If they are happy with their plan, they can remain in the plan.

Copyright (c) February 2012 by Center for Health Care Rights

Medi-Cal Managed Care and Long Term Care

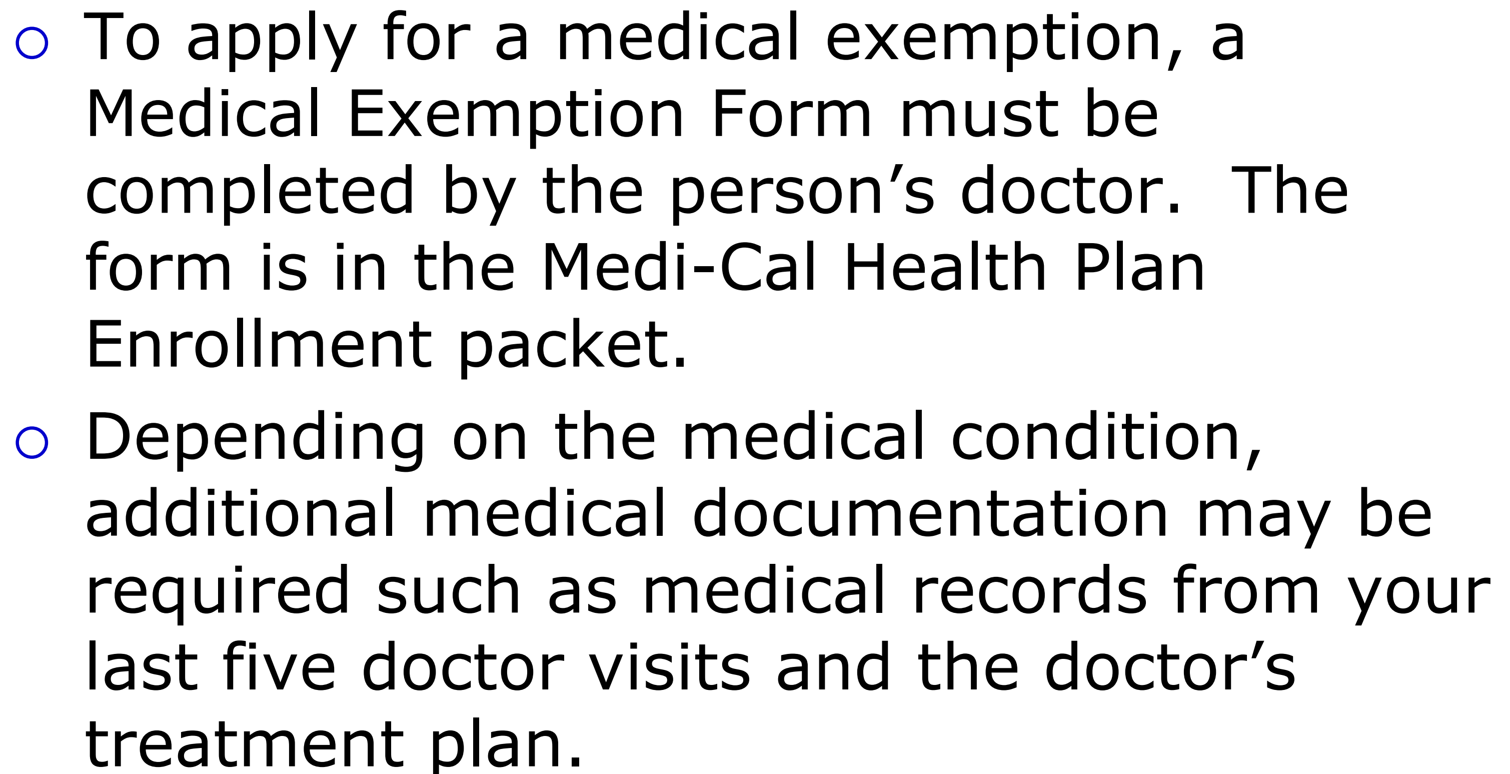
- Individuals in nursing homes that are eligible for Medi-Cal Long Term Care will not be mandatorily enrolled into a Medi-Cal health plan.
- Persons in a Medi-Cal health plan who enter a long term care facility will be covered by their Medi-Cal for the first two (2) months. In the third month, a long term care resident will be automatically disenrolled from the Medi-Cal managed care and returned to fee for service Medi-Cal.

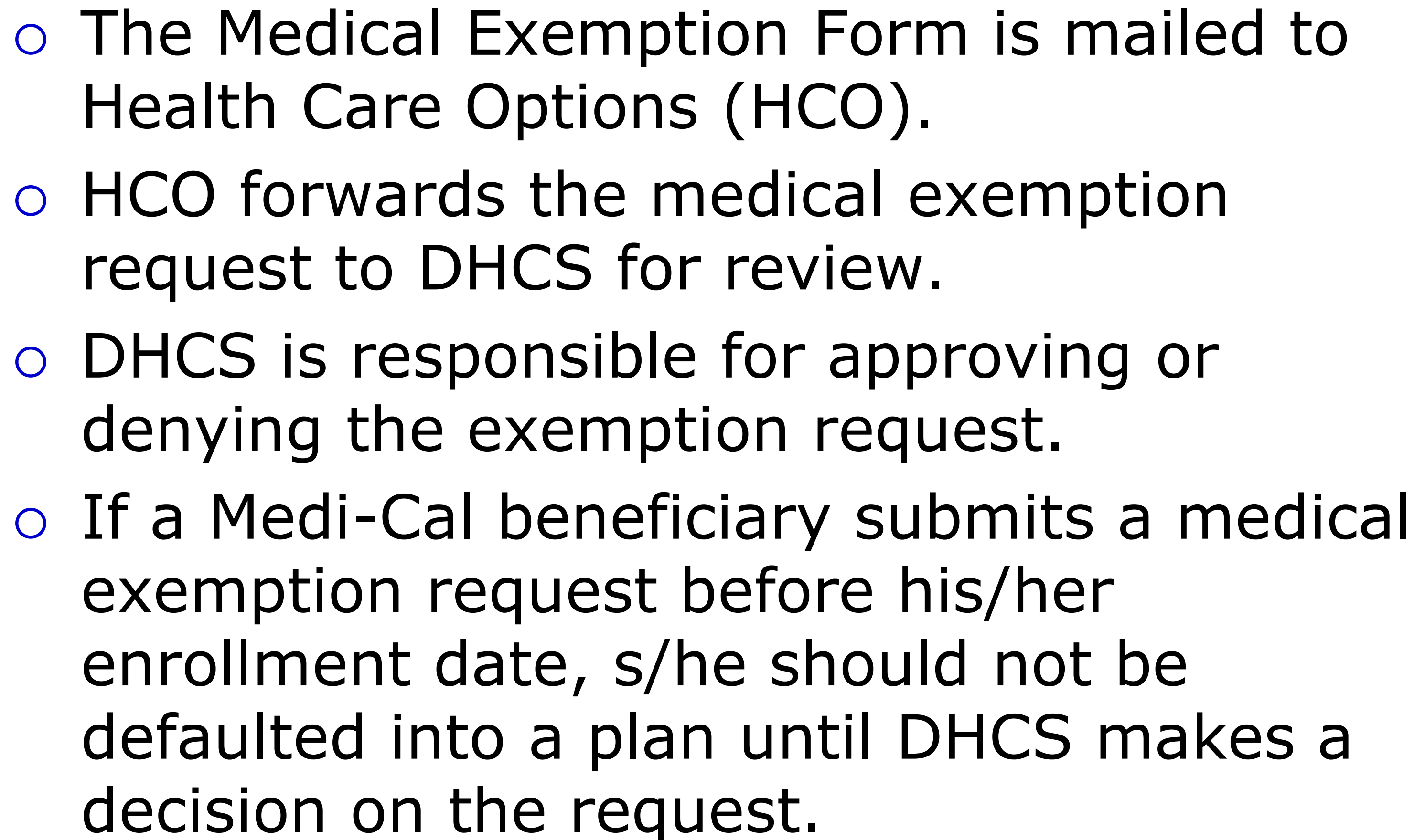
Copyright (c) February 2012 by Center for Health Care Rights

- To qualify for a medical exemption, the individual must have a high risk or complex medical condition **and** his medical provider does not contract with any Medi-Cal Health Plan.

  - Examples of high risk /complex medical conditions: HIV/AIDs, chronic renal dialysis, cancer, complex neurological disorder.

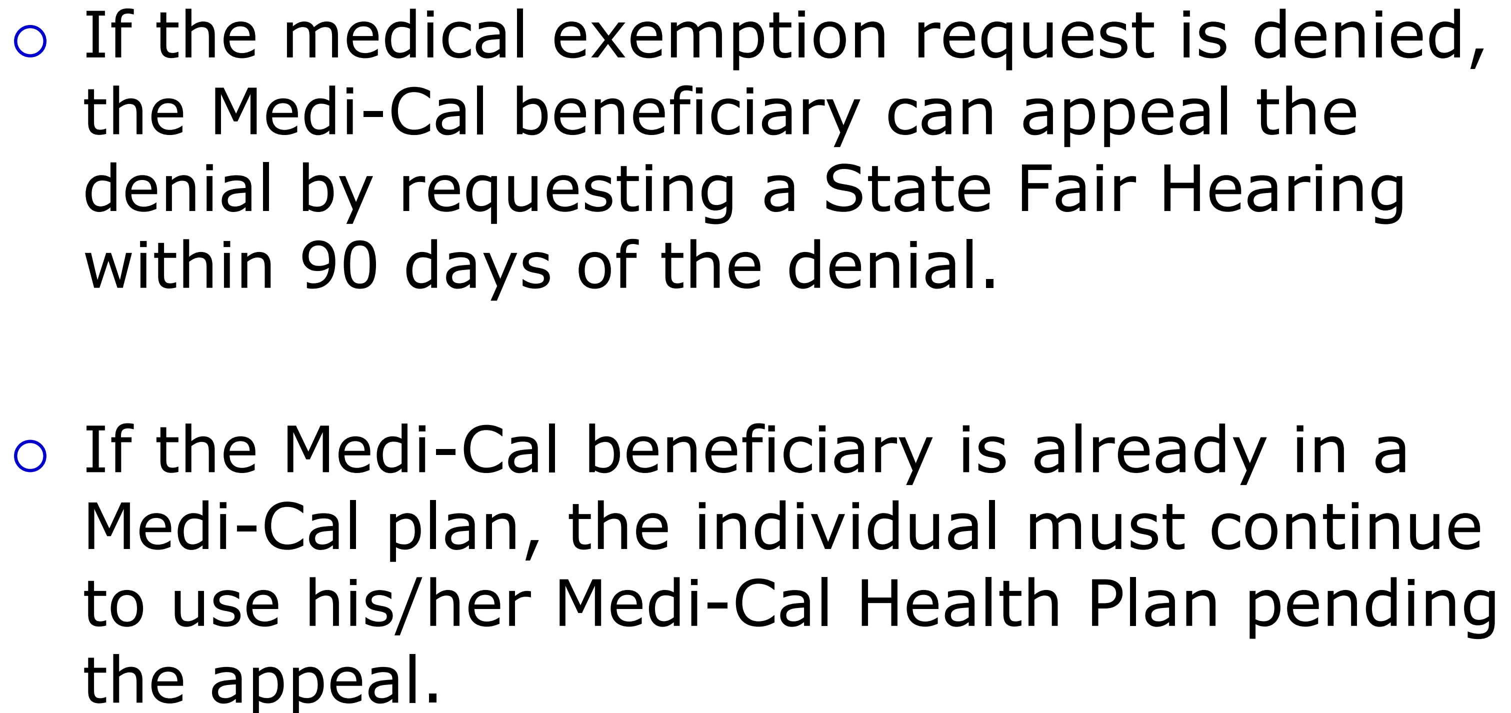
Copyright (c) February 2012 by Center for Health Care Rights


To apply for a medical exemption, a Medical Exemption Form must be completed by the person’s doctor. The form is in the Medi-Cal Health Plan Enrollment packet.
Depending on the medical condition, additional medical documentation may be required such as medical records from your last five doctor visits and the doctor’s treatment plan.



- The Medical Exemption Form is mailed to Health Care Options (HCO).
- HCO forwards the medical exemption request to DHCS for review.
- DHCS is responsible for approving or denying the exemption request.
- If a Medi-Cal beneficiary submits a medical exemption request before his/her enrollment date, s/he should not be defaulted into a plan until DHCS makes a decision on the request.

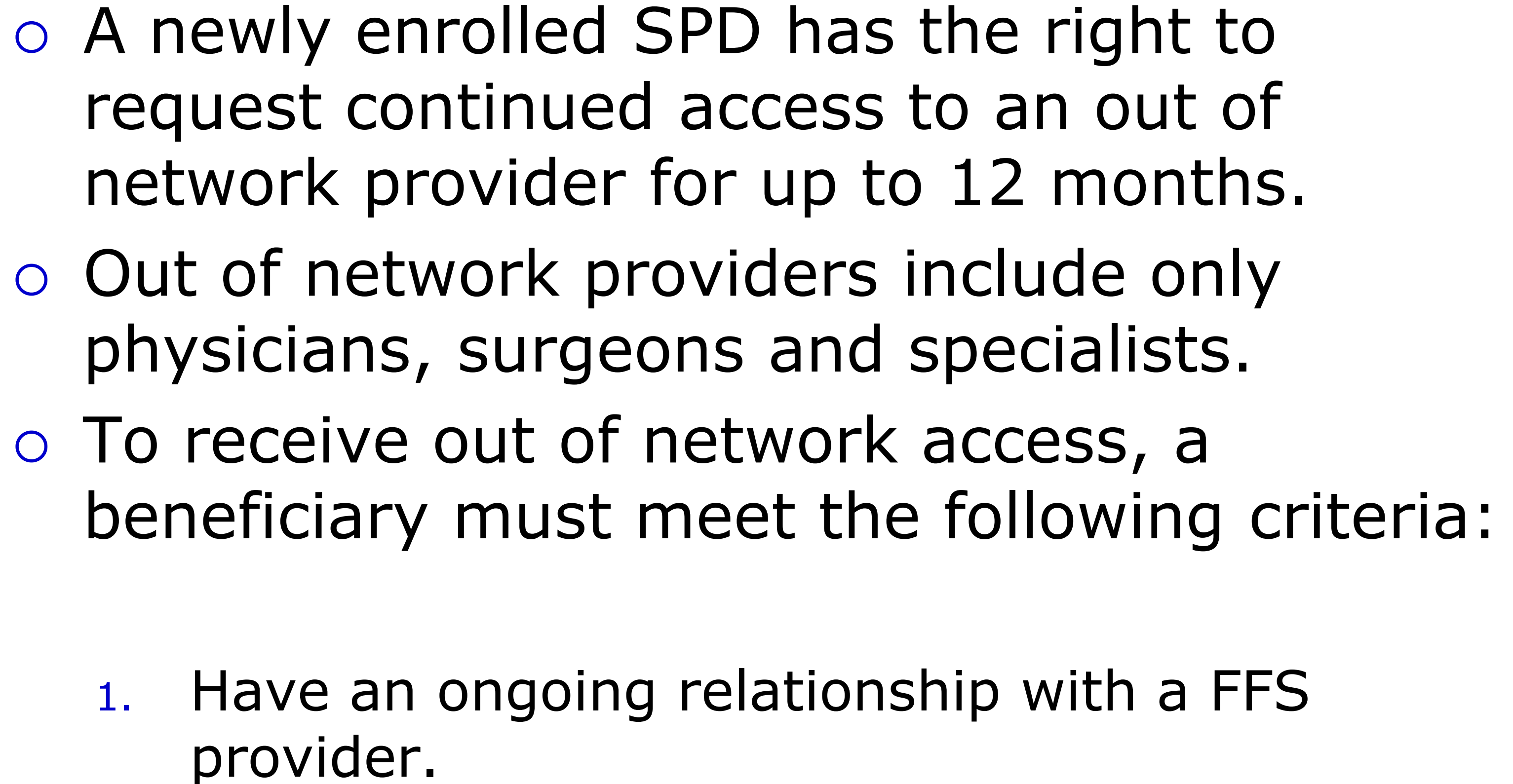
Copyright (c) February 2012 by Center for Health Care Rights



- If the medical exemption request is denied, the Medi-Cal beneficiary can appeal the denial by requesting a State Fair Hearing within 90 days of the denial.
- If the Medi-Cal beneficiary is already in a Medi-Cal plan, the individual must continue to use his/her Medi-Cal Health Plan pending the appeal.

- The 1115 Medi-Cal waiver approved by CMS requires that SPD beneficiaries be provided with access to care that is organized and coordinated as they transition to mandatory managed care.
- To ensure continuity of care, Medi-Cal plans must allow SPD beneficiaries to continue receiving treatment with their current fee for service (FFS) provider, even if the provider is not part of any managed care plan network.

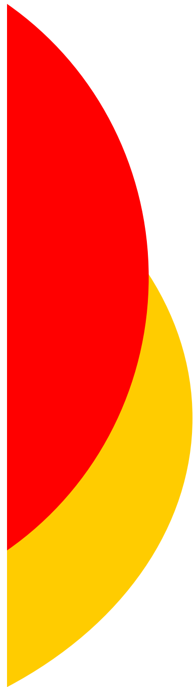
Copyright (c) February 2012 by Center for Health Care Rights



- A newly enrolled SPD has the right to request continued access to an out of network provider for up to 12 months.
- Out of network providers include only physicians, surgeons and specialists.
- To receive out of network access, a beneficiary must meet the following criteria:

    1. Have an ongoing relationship with a FFS provider.

Copyright (c) February 2012 by Center for Health Care Rights



2. The provider must be wiling to accept the health plan or Medi-Cal FFS rates, whichever is higher; and,

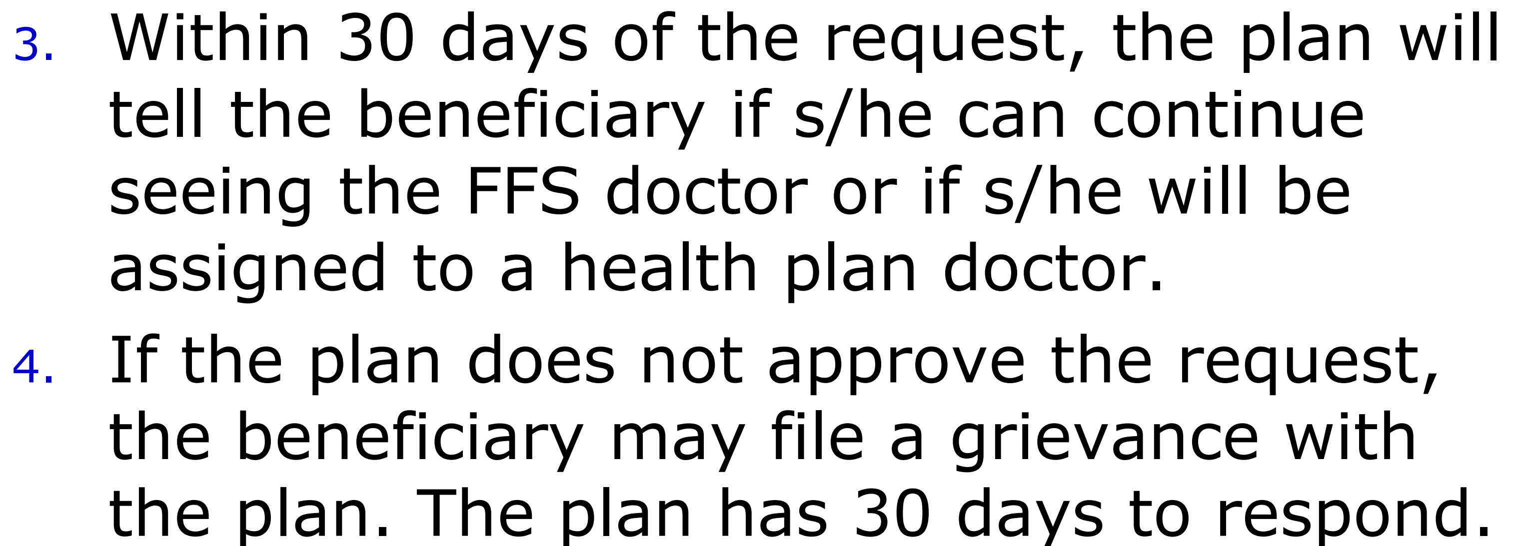
3. The plan must determine that there is no quality of care issues with the provider.

- The ongoing relationship between the beneficiary and the out of network provider will be verified by the plan using FFS utilization data provided by DHCS.

Steps to follow to continue seeing a current FFS Medi-Cal doctor:

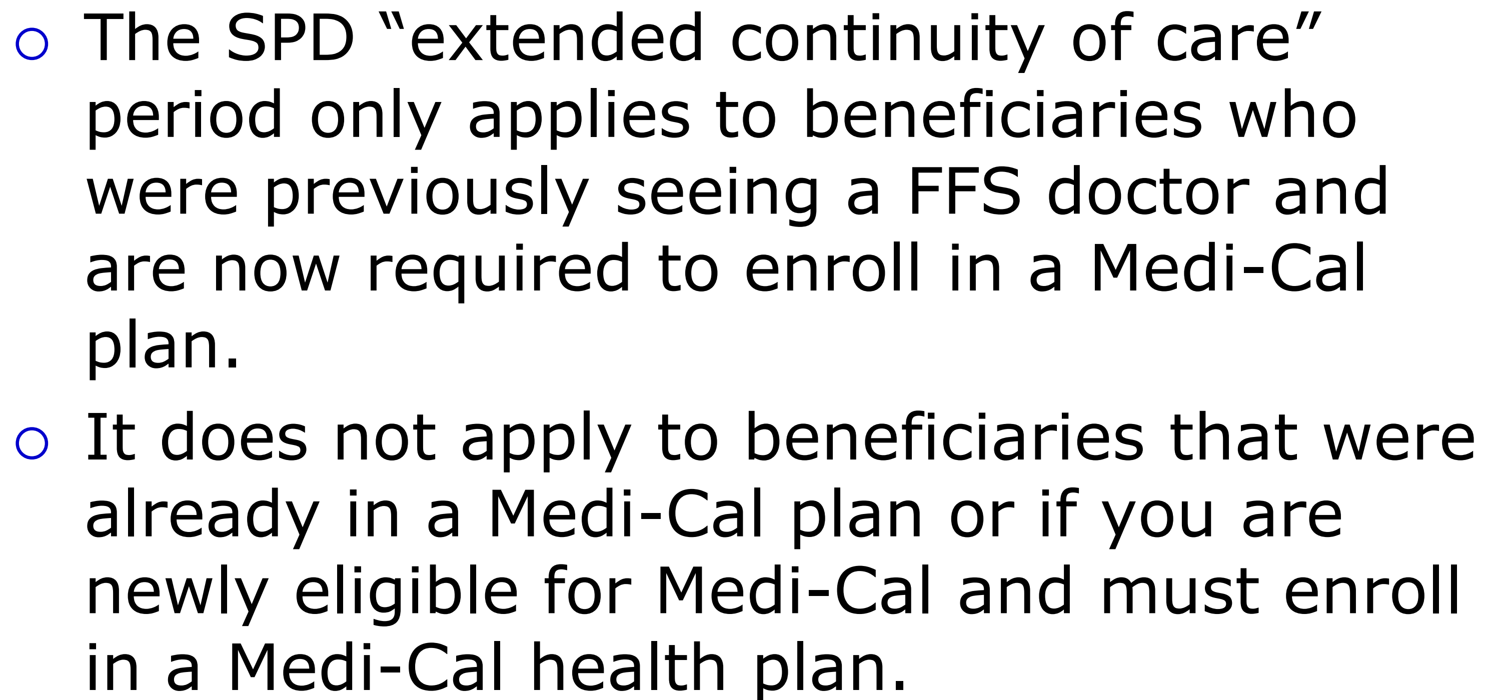
1. Call the new Medi-Cal plan and explain that you want to continue seeing your FFS Medi-Cal doctor
2. Provide the plan with the name and phone number for your FFS Medi-Cal doctor

Copyright (c) February 2012 by Center for Health Care Rights



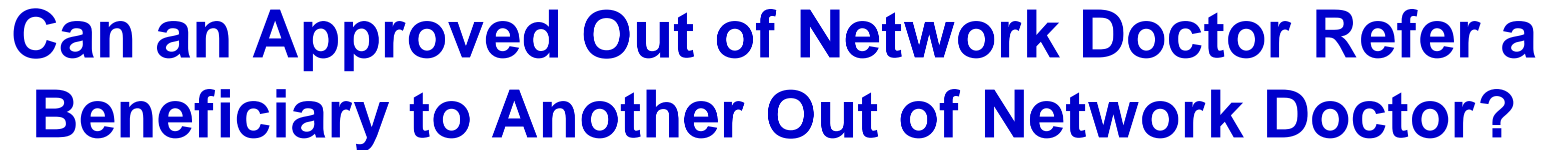
3. Within 30 days of the request, the plan will tell the beneficiary if s/he can continue seeing the FFS doctor or if s/he will be assigned to a health plan doctor.
4. If the plan does not approve the request, the beneficiary may file a grievance with the plan. The plan has 30 days to respond.

Copyright (c) February 2012 by Center for Health Care Rights



- The SPD “extended continuity of care” period only applies to beneficiaries who were previously seeing a FFS doctor and are now required to enroll in a Medi-Cal plan.
- It does not apply to beneficiaries that were already in a Medi-Cal plan or if you are newly eligible for Medi-Cal and must enroll in a Medi-Cal health plan.

Copyright (c) February 2012 by Center for Health Care Rights



Can an Approved Out of Network Doctor Refer a Beneficiary to Another Out of Network Doctor?

- No, the approved out of network doctor must work with the plan. If the plan does not have a specialist available in network, the plan must provide a medically necessary referral to an out of network doctor.

Copyright (c) February 2012 by Center for Health Care Rights

- The health plan is required to grant all requests by a transitioning SPD for extended continuity of care if:
  1. The doctor requested has provided the beneficiary with services in the last 12 months;
  2. The doctor agrees to accept payment from the plan; and
  3. The doctor has no quality of care issues (as determined by the plan).

Copyright (c) February 2012 by Center for Health Care Rights

- A new or refilled prescription ordered by a current out of network doctor will be filled only if it is on the plan formulary
- If it is not on the formulary, a prior authorization will be required. The plan must make a decision in 24 hours.
- A non-formulary medication refill that is part of ongoing treatment may be subject to review by the plan for up to 5 days. During this time, the medication must be covered.

Copyright (c) February 2012 by Center for Health Care Rights

- The Medi-Cal benefits provided in a Medi-Cal Health Plan are the same as fee for service Medi-Cal.
- The plan primary care provider is responsible for making patient referrals to plan specialty services. Plan members cannot see plan specialists without a primary care referral.
- Plan members will be responsible for paying for medical care provided by in plan or out of plan care that has not been authorized by the plan.
- Emergency room medical care is covered.

Copyright (c) February 2012 by Center for Health Care Rights

- No, mental health services are not covered by Medi-Cal Managed Care Health plans.
- These services are "carved out" and are billed to fee for service Medi-Cal.
- Medi-Cal beneficiaries in Medi-Cal Health Plans will continue to receive mental health services through the Los Angeles County Department of Mental Health (DMH) and DMH contracted private providers.

Copyright (c) February 2012 by Center for Health Care Rights

- New Medi-Cal Health Plan members will continue to use the DMH providers that they have previously used.
- Substance abuse treatment and methodone is also carved out as a Medi-Cal benefit.

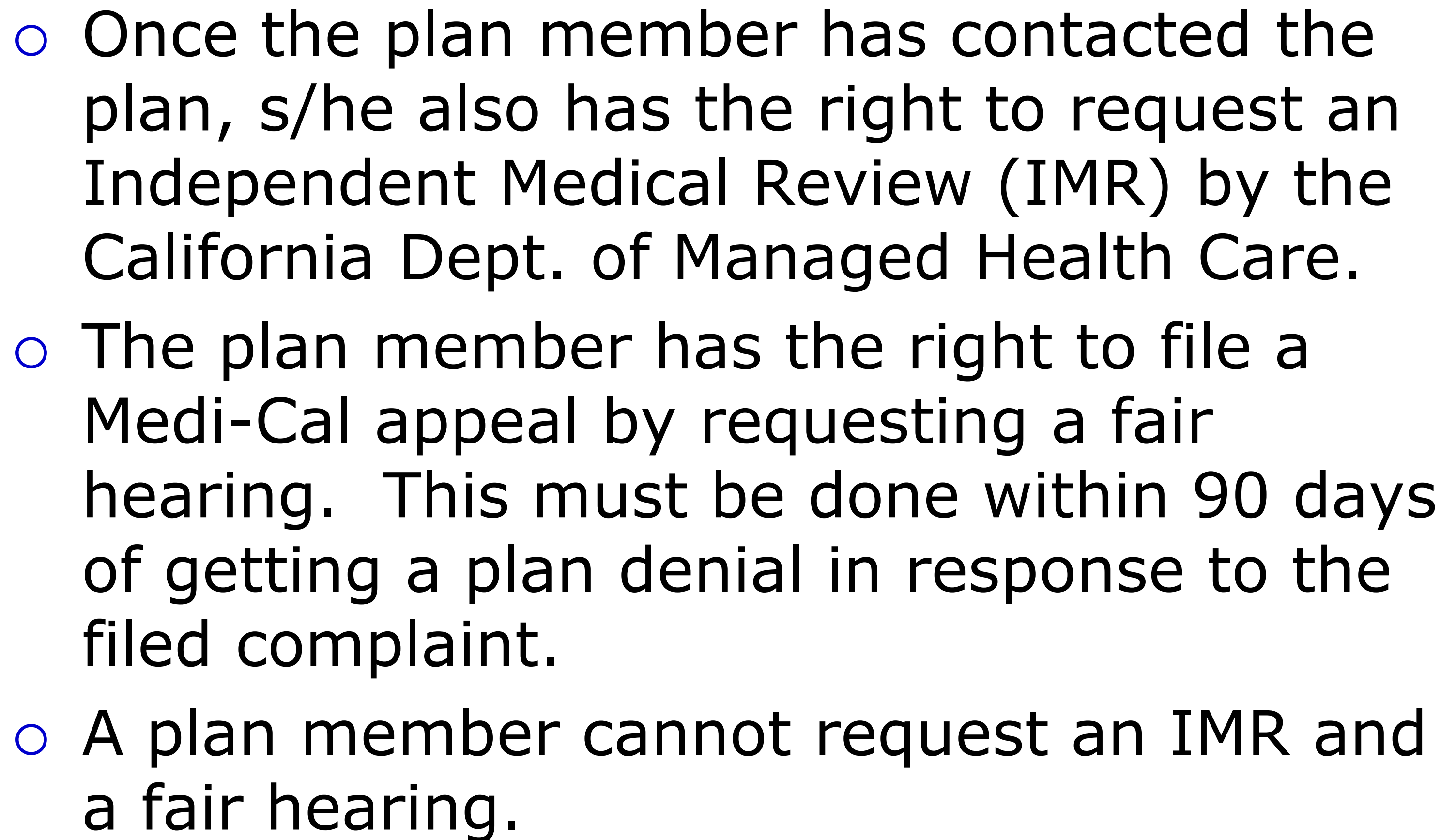
Copyright (c) February 2012 by Center for Health Care Rights

- The Medi-Cal Pharmacy Provider Manual identifies "non-capitated" psychiatric drugs that should be billed on a fee for service basis.
- If the drug is not on this list, it's the health plan's responsibility.
- Carved out psychiatric drugs that are billed to Medi-Cal on a fee for service basis must be filled at DMH contracting pharmacies.

Copyright (c) February 2012 by Center for Health Care Rights

- If a Medi-Cal plan member has a problem or complaint, s/he should contact the plan member services department for assistance.
- Plans have 30 days to resolve a grievance.
- The plan must have an expedited review process for serious health threats such as severe pain, loss of life, limb or major bodily functions, or termination of health care.

Copyright (c) February 2012 by Center for Health Care Rights



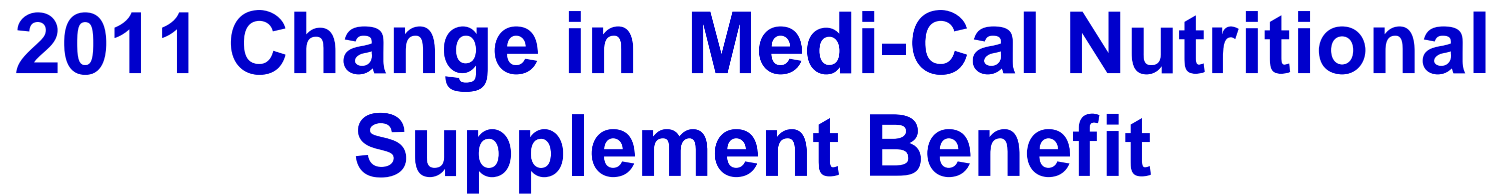
- Once the plan member has contacted the plan, s/he also has the right to request an Independent Medical Review (IMR) by the California Dept. of Managed Health Care.
- The plan member has the right to file a Medi-Cal appeal by requesting a fair hearing. This must be done within 90 days of getting a plan denial in response to the filed complaint.
- A plan member cannot request an IMR and a fair hearing.

Copyright (c) February 2012 by Center for Health Care Rights

- DHCS has received federal approval to cap Medi-Cal payment for hearing aid benefits at $1,510 per beneficiary.
- Hearing aid benefits include hearing aids, supplies and accessories.
- The cap does not apply to replacement of a hearing aid that is lost, stolen or damaged due to circumstances beyond the beneficiary's control.

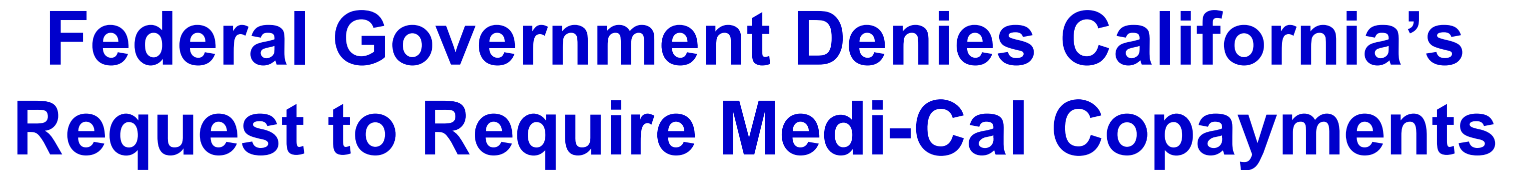
- Beneficiaries in the EPSDT Program
- Beneficiaries receiving long term care in a skilled nursing facility or intermediate care facility
- Beneficiaries in an intermediate care facility for the developmentally disabled (ICF/DD), including and ICF/DD Habiliatative.
- Beneficiaries in PACE
- Beneficiaries receiving contracted managed care with Senior Care Action Network (SCAN) or AIDS Healthcare Foundation.

Copyright (c) February 2012 by Center for Health Care Rights



- Effective October 2011, Medi-Cal will no longer cover enteral nutritional supplements (eg. Ensure, Gluserna) unless it is administered by tube feeding.
- Medi-Cal eligible persons in the Early and Periodic Screening, Diagnosis and Treatment Program are exempt.
- Persons with diagnosis of malabsorption and in born errors of metabolism may also qualify for exemption.

Copyright (c) February 2012 by Center for Health Care Rights



Federal Government Denies California's Request to Require Medi-Cal Copayments

- In 2011, California's DHCS submitted a request to amend the state's Medicaid 1115 Waiver to impose mandatory copayments on Medi-Cal beneficiaries.
- In early February 2012, CMS denied the request.

Copyright (c) February 2012 by Center for Health Care Rights

Proposed Medi-Cal Utilization Caps

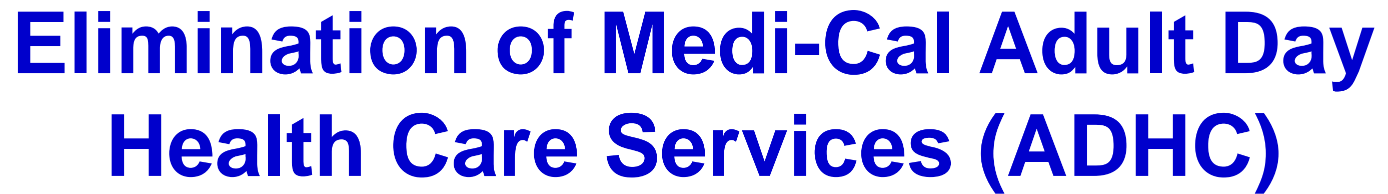
- The proposed utilization caps would limit doctor and clinic visits are limited to 7 per year. All visits above 7 would be subject to a physician certification that they are medically required. It is unclear if this service limit will apply to persons who are eligible for dually eligible for Medicare and Medi-Cal.

Copyright (c) February 2012 by Center for Health Care Rights

Elimination of Medi-Cal Adult Day Health Care Services (ADHC) as an Optional Medi-Cal Benefit

- January 2011, Governor Brown proposed a state budget that included the elimination of ADHC services as an optional Medi-Cal benefit.
- March 2011, legislation was passed by the California Legislature and signed into law to eliminate ADHC as a Medi-Cal benefit. ADHC services were to be eliminated effective Sept. 1, 2011.

Copyright (c) February 2012 by Center for Health Care Rights



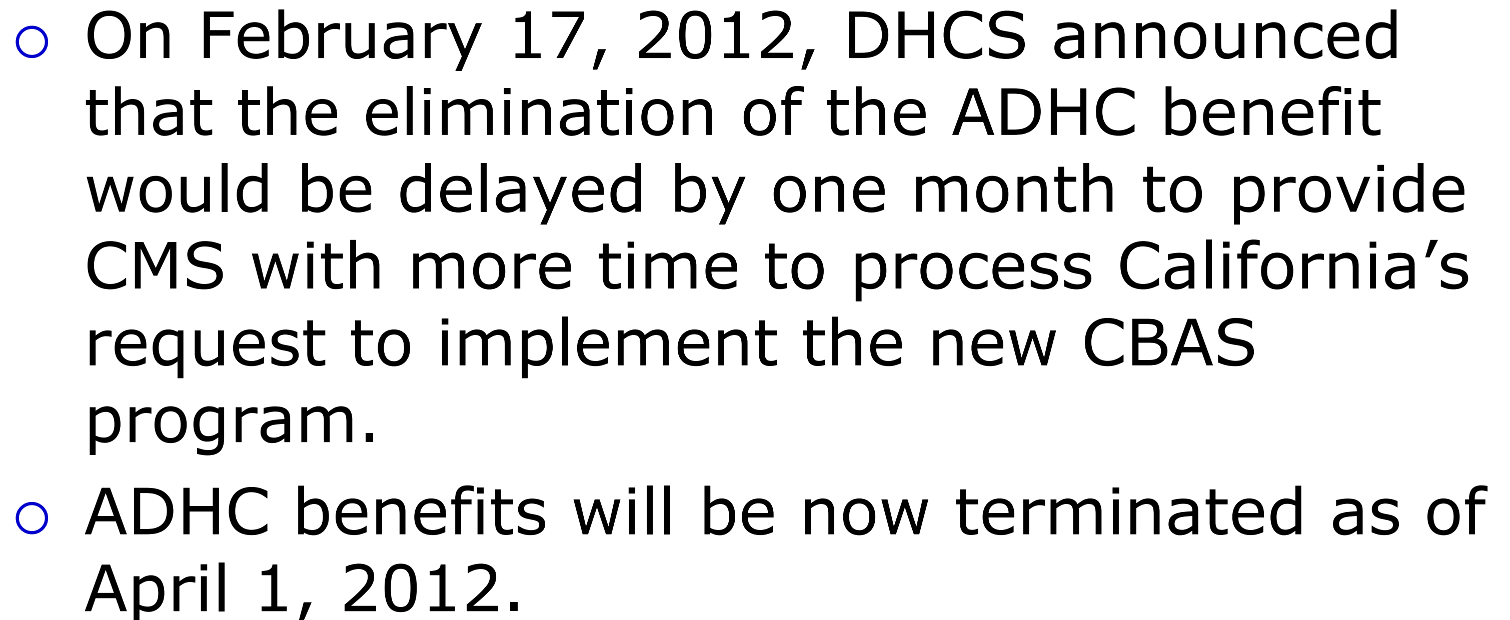
- In June 2011, a lawsuit (Darling vs. Douglas) was filed by Disability Rights California that challenged the elimination of Medi-Cal ADHC services.
- In July 2011, DHCS extended the ADHC date of elimination from Sept. 1 to December 1, 2011.

Copyright (c) February 2012 by Center for Health Care Rights

Settlement Agreement of the ADHC Lawsuit – Elimination of ADHC Is Delayed and New CBAS Program is Created to Replace ADHC

- On November 17, 2011, California and the lawsuit plaintiffs entered into a settlement agreement regarding the elimination of ADHC services.
- The agreement stated that the ADHC Program is extended to 2/29/12 but will be phased out and replaced by a new program called Community Based Adult Services (CBAS) effective March 1, 2012.

Copyright (c) February 2012 by Center for Health Care Rights



- On February 17, 2012, DHCS announced that the elimination of the ADHC benefit would be delayed by one month to provide CMS with more time to process California’s request to implement the new CBAS program.
- ADHC benefits will be now terminated as of April 1, 2012.

Copyright (c) February 2012 by Center for Health Care Rights

ADHC Transition to CBAS Program

- The state estimates that the elimination of the ADHC Program will save California $28 million in 2011-12 and $92 million in 2012-13.
- All ADHC participants will be evaluated for eligibility for the new CBAS Program.
- ADHC providers can apply to become CBAS providers.
- Between April 1, 2012 through June 30, 2012, CBAS services will be provided by CBAS services on a fee for service basis.

Copyright (c) February 2012 by Center for Health Care Rights

- By July 1, 2012, CBAS services will be provided by Medi-Cal managed care plans except in counties were managed care is not available. In these counties, the services will remain a fee for service Medi-Cal benefit.

Copyright (c) February 2012 by Center for Health Care Rights

New CBAS Program

- The Community Based Adult Services Program will be similar to the ADHC Program. It will be an outpatient, facility based program that provides the same services provided by ADHC.

Copyright (c) February 2012 by Center for Health Care Rights

Eligibility for the CBAS Program

- Current ADHC participants will be eligible for CBAS services if they meet certain medical necessity and eligibility criteria for ADHC and they:
  - Meet Nursing Facility Level of Care A (NF-A), or
  - Have a moderate to severe cognititve impairment, or
  - Have a brain injury, or

Copyright (c) February 2012 by Center for Health Care Rights

Eligibility for the CBAS Program

- Have a mild to moderate cognitive disability and need supervision with two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management or hygiene; or
- Have chronic mental illness or brain injury and need assistance or supervision with either:

Copyright (c) February 2012 by Center for Health Care Rights

- Two of the following: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management or hygiene; or
- One need from the above list and one of the following: money management, accessing resources, meal preparation, or transportation or,
- Are developmentally disabled.

Copyright (c) February 2012 by Center for Health Care Rights

Eligibility Assignment Process for the New CBAS Program

- During the period of December 2011 through February 2012, current ADHC participants will be assessed for CBAS eligibility by DHCS working with ADHC providers.
- Persons who are not currently ADHC participants can apply for ADHC until March 31, 2012. After April 1, 2012, they can apply for CBAS through their Medi-Cal managed care plan. If they are not in a Medi-Cal managed care plan or if there is no managed care plan in their county, they can apply for CBAS through DHCS.

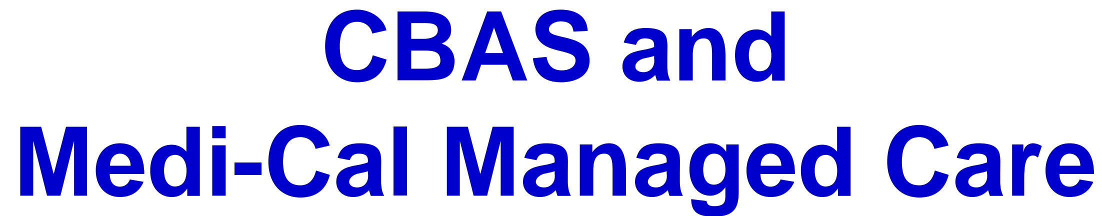
Copyright (c) February 2012 by Center for Health Care Rights

- In early February 2012, DHCS will begin to send notices to ADHC participants regarding their eligibility for the CBAS Program. Persons who are determined to be eligible will receive instructions for enrolling in a CBAS Program.
- ADHC participants who are notified that they are not eligible for the CBAS Program will receive information on their eligibility for Enhanced Care Management services and their right to appeal the denial of CBAS services.

Copyright (c) February 2012 by Center for Health Care Rights

- By July 2012, CBAS will become a Medi-Cal managed care benefit.
- In counties with Medi-Cal managed care plans, CBAS providers will be required to provide services through a contract with a Medi-Cal plan. To received CBAS services, participants must be in a Medi-Cal plan.
- If no Medi-Cal plans are available in a specific county, CBAS services will be available on a fee for service basis.

Copyright (c) February 2012 by Center for Health Care Rights



- Medi-Cal beneficiaries who receive CBAS services will not be charged any cost sharing.
- Medicare/Medi-Cal dual eligibles must be enrolled in a Medi-Cal plan to receive CBAS services unless there is no Medi-Cal managed care plan in their county.

Copyright (c) February 2012 by Center for Health Care Rights