Medi-Cal Fee-for-Service & Medi-Cal Managed Care

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Medi-Cal Service Delivery Models

- Fee-for-Service
- Managed Care

  An organized network of health care providers. The managed care plan can be public or private.

  The managed care is paid a flat fee for each member. Fixed per-member, per-month “capitated” fee, regardless of how many services a member may actually need.

Over 83% of Medi-Cal beneficiaries are enrolled in a managed care plan.

Medi-Cal Service Delivery Models

Coordinated Care Initiative (CCI)

- Counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.
  - CalAim: plan to make this a statewide model
- People who had FFS Medi-Cal moved into Managed care
- People who have Medicare and Medi-Cal – can have Medi-Cal Managed Care take over Medicare – "**Cal MediConnect**."
- Long Term Support Services: nursing facility care, In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), were the Multi-Purpose Senior Services Program (MSSP) were provided through managed care plans. As of January 1, 2018, IHSS is no longer a Medi-Cal managed care benefit.

More on CCI: https://calduals.org/wp-content/uploads/2017/12/Advocates-Guide-to-Californias-Coordinated-Care-Initiative-Version-6.pdf

Medi-Cal Managed care

- Governed by both state and federal law. Regulated CMS and DHCS.
- The DHCS and the Department of Managed Health Care (DMHC) share oversight responsibility for most Medi-Cal Managed Care plans.
- The DHCS administers the contracts with Medi-Cal Managed Care plans and is responsible for monitoring plan compliance with Medi-Cal requirements.
- The DMHC regulates the licensed health care service plans pursuant to the consumer protection laws called the Knox-Keene Act. It oversees the operational and financial solvency requirements of licensed plans.
  - COHS Medi-Cal plans are exempt from DMHC licensure, except Health Plan of San Mateo, is Knox-Keene licensed. COHS plans are regulated by DHCS.

    - Knox Keene: https://www.dmhc.ca.gov/AbouttheDMHC/LawsRegulations.aspx

Managed Care Provider Network Adequacy

Managed care plans must have adequate provider networks to provide all of their members with services. This means:

- Having enough hospitals
- Primary care physicians
- Specialists and
- Other Health Care Providers

Includes having providers in the geographical area where the managed care plan provides services and where the members of the plan live.

Providers have to be located in different places around that geographical area so that the members won't have to travel too far to get services.

As a rule, primary care providers should not be more than 30 minutes away.

Managed care plans are supposed to have adequate provider networks, but sometimes, there are gaps.

Managed Care: Non-discrimination & language access

Managed care plans must be able to deliver services to each member without discrimination.

This includes:

- having facilities that are physically accessible to people with disabilities such as mobility impairments,
- providing culturally competent services, and
- ensuring language access, including access to people who are limited-English-proficient or who need sign language interpreters or materials in alternative formats.

Are there any advantages to managed care?

- Help coordinating your care
- Help finding primary care doctors and specialists
- Help finding a pharmacy
- Ongoing referrals to specialists
- Telephone advice nurses
- Customer service centers
- Support groups
- Health education programs to help you. Examples:
  - Quit smoking
  - Prevent and deal with drug and alcohol problems
  - Manage chronic pain
  - Eat well and exercise safely
- Help getting to and from medical appointments (transportation assistance)

Are there any disadvantages to managed care?

- When switching to managed care, your treating professionals may not be in-network providers.
- There may not be enough providers in the network to provide with you with all of the services you need at a time or a location that is convenient to you.
- Asking for out-of-network providers when in a managed care plan: See: https://www.disabilityrightsca.org/system/files/file-attachments/555901.pdf

What kinds of managed care plan models are available under Medi-Cal?

There are two basic models of Medi-Cal managed care plans:

- COHS (County-Organized Health Systems) model plans, and
- non-COHS model plans.

General information about Medi-Cal managed care can be found on the DHCS website here: Medi-Cal Managed Care.

To find plans in counties:
https://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

County-Organized Health Systems

Only one managed care plan available in the county where the beneficiary lives.

Run by the county.

- **CalOptima:** Orange
- **CenCal Health:** Santa Barbara, San Luis Obispo
- **Central California Alliance for Health:** Santa Cruz, Monterey, Merced
- **Gold Coast Health Plan:** Ventura
- **Health Plan of San Mateo:** San Mateo
- **Partnership HealthPlan of California:** Solano, Napa, Yolo, Sonoma, Mendocino, Marin, Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, Trinity

Non-COHS Models

- There are at least two plans available in each county (except that San Benito County has only one plan). The Non-COHS plans fall into the following three categories:

- Two-plan model
- GMC (Geographic Managed Care) model
- Regional model

NON-COHS Two-Plan Model

There is a county organized plan called the Local Initiative (a prepaid health plan) and a commercial plan.

Local initiatives are publicly operated partnerships that include county health systems, other safety net providers, and private providers (except for Tulare County where the LI is operated by a commercial plan, Anthem Blue Cross).

Alameda: Alameda Alliance for Health (LI), Anthem Blue Cross Partnership Plan (CP)
Contra Costa: Contra Costa Health Plan (LI), Anthem Blue Cross (CP)
Fresno/Kings/Madera: CalViva Health (LI), Anthem Blue Cross (CP)
Kern: Kern Family Health Care (LI), Health Net (CP)
Los Angeles: LA Care (LI), Health Net (CP)
Riverside/San Bernardino: Inland Empire Health Plan (LI), Molina Healthcare (CP)
San Francisco: San Francisco Health Plan (LI), Anthem Blue Cross (CP)
San Joaquin/Stanislaus: Health Plan of San Joaquin (LI), Health Net (CP)
Santa Clara: Santa Clara Family Health Plan (LI), Anthem Blue Cross (CP)
Tulare: Anthem Blue Cross (LI), Health Net (CP)

Non-COHS GMC

In a GMC Model DHCS contracts with multiple commercial health plans within a single county.

- **Sacramento (GMC):** Anthem Blue Cross (CP), Health Net (CP), Kaiser Permanente (CP), Molina Healthcare (CP)
- **San Diego (GMC):** Care 1st (CP), Community Health Group (CP), Health Net (CP), Kaiser Permanente (CP), Molina Healthcare (CP)

Regional Managed Care Counties and Plans

The Regional Model developed for the rural expansion.

Consists of two commercial health plans wanting to serve two or more contiguous counties in the designated Expansion Region.

- **Anthem Blue Cross (CP), California Health and Wellness (CP):** Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba.
- **Molina Healthcare (CP), California Health and Wellness (CP):** Imperial
- **Anthem Blue Cross (CP), Medi-Cal fee-for-service (Regular Medi-Cal):** San Benito (one plan only).

Do I have to enroll in Medi-Cal managed care?

Who must enroll

- You get CalWorks benefits
- You get Medi-Cal only and you do not have a share of cost
- To find out if you must enroll, call Health Care Options (HCO) Medi-Cal Managed Care at **1-800-430-4263**

Who cannot enroll

- You are a member of a commercial medical plan through private insurance

Do I have to enroll? (cont.)

You may not have to enroll if:

- You get health services from an Indian Health Provider
- You have Medicare
- You request an exemption if you are being treated for a complex medical condition such as:
  - Pregnancy
  - Cancer
  - Organ transplant, or are scheduled for a transplant
  - Renal disease and have dialysis at least two times a week
  - A disease that affects more than one organ system, such as diabetes
  - You are HIV positive
  - Other conditions that may qualify

  See https://www.disabilityrightsca.org/system/files/file-attachments/5595.01_0.pdf

Do the Medi-Cal managed care plans provide all Medi-Cal services?

NO.

Services that are not provided through Medi-Cal managed care are said to be "carved out" of managed care.

Most carved-out services are provided under FFS.

- Specialty Mental Health.
  - Outpatient mental health services managed care plans must provide are:
    - Individual and group mental health evaluation and treatment (psychotherapy);
    - Outpatient services to monitor drug therapy;
    - Outpatient laboratory, drug (there are excluded drugs), supplies and supplements;
    - Psychiatric consultation;
    - Psychological testing to evaluate a mental health condition
  - SEE https://www.disabilityrightsca.org/publications/medi-cal-managed-care-plans-and-mental-health-services
- In-Home Supportive Services (IHSS)
- Home and Community Based Services (HCBS) - Waivers
- Dental
- California Children Services – except the Whole Child Model program: https://www.disabilityrightsca.org/system/files/file-attachments/713201.pdf CenCal Health in San Luis Obispo and Santa Barbara counties, Health Plan of San Mateo in San Mateo County, Central California Alliance for Health in Merced, Monterey and Santa Cruz counties, Partnership HealthPlan of California in Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Siskiyou, Shasta, Solano, Sonoma, Trinity and Yolo counties. CalOptima in Orange County.
- Local Education Agency (LEA)
- Special Programs

Continuity of care –transitioning into managed care

Your doctor must be part of the managed care network. **But** managed care plan must provide you with “continuity of care.”

If you now have a doctor who is not part of the managed care network, you can keep that doctor for up to 12 months after you have been enrolled in a Medi-Cal managed care plan; but only if the doctor:

- is willing to keep seeing you and willing to accept either the managed care network’s payment rate or the Medi-Cal fee-for-service rate, whichever is higher.

The doctor becomes a part of the managed care network just for purposes of caring for you. The doctor will have access to network providers for purposes of referrals, etc. There may be other situations where your plan is required to provide you with “continuity of care,” too.

For more information about this important continuity of care right, go to the Medi-Cal managed care website: Continuity of Care for Medi-Cal Managed Care Beneficiaries

How do I choose a health plan?

In COHS counties:

You will be enrolled in the COHS plan when you apply for Medi-Cal. If you move into a COHS county, you will be enrolled in the COHS plan when you notify the county Medi-Cal office of your change of address.

In two-plan, GMC, and regional model counties:

You enroll in a plan by sending a choice enrollment form HCO.

> You will then need to choose a plan and send the enrollment choice form to HCO. You will receive a reminder notice at least 30 days before you are required to enroll. If you do not enroll, you will be enrolled automatically by default in one of the plans.

For more information see: Enroll | Medi-Cal Managed Care Health Care Options

Changing to a different Medi-Cal Managed Care Plan

- You can change to a different Medi-Cal managed care plan once per month (except in COHS plan counties). You change plans by submitting a choice enrollment form to HCO. The change is effective the first of the month after HCO receives the form.

- You can get general information about changing plans on the HCO website here: Health Care Options.

- You can get a choice enrollment form on the HCO website here: Download forms.

I am dissatisfied with a decision of the managed care plan. What can I do?

Starting July 1, 2017, the rules for grievances and appeals changed. For detailed information see:

- All Plan Letter 17-006 at All Plan Letter 17-006.
- You can also read our publication on this subject at: Medi-Cal Managed Care: Appeals and Grievances.
- Also see our publication on Independent Medical Reviews at Medi-Cal Managed Care: An Independent Medical review (IMR) Can Change a Plan's No to Yes.

California Advancing and Innovating Medi-Cal: CalAIM

Guiding principles:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize toward common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

CalAIM: Managed Care:

Managed Care Enrollment

- DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. Exception: those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled.

Standardize Managed Care Benefits

- DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

CalAIM: Managed Care:

Transition to Statewide Managed Long-Term Services and Supports

- DHCS is proposing to discontinue the **Cal MediConnect** pilot program at the end of calendar year 2022. CCI will not longer be a pilot project - mandatory enrollment of **dual eligibles** into managed care.
- The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and **to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs)**. This will be done in phases:
  - January 2022: The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care.
  - January 2023: Full transition to mandatory enrollment of **dual eligibles** into managed care. Further, all dual and non-dual fee-for-service (FFS) Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023.
    - Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.
    - January 2025: Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.
- The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and are not statewide.
- https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-Proposal-03-23-2021.pdf

How can I find out more about the managed care plans in my area and pick the best one for me?

- You can find information about all of the Medi-Cal managed care plans available in each county here: Medi-Cal Managed Care Health Plan Directory.
- You can find general information about two-plan, GMC and regional model Medi-Cal managed care plans on the Health Care Options (California Department of Health Care Services) website here: Learn.
- You can compare plans here: Choose.
- General enrollment information for two-plan, GMC and regional model Medi-Cal managed care plans can be found here: Enroll.
- Specific enrollment information, including enrollment notices and specific informing materials for each plan (such as evidence of coverage), can be found here: Health Plan Materials.
- Specific enrollment forms for two-plan, GMC and regional model Medi-Cal managed care plans can be found here: Enroll. Instructions for completing the form are here: Enroll.

Office of the Ombudsman

The Office of the Ombudsman:

- Serves as an objective resource to resolve issues between Medi-Cal managed care members and managed care health plans.
- Helps members with urgent enrollment and disenrollment problems.
- Offers information and referrals.
- Identifies ways to improve the effectiveness of the Medi-Cal managed care program.
- Educates members on how to effectively navigate through the Medi-Cal managed care system.
- Help you find information in order to access appropriate mental health services
- Connect you with the right person/department to help you resolve a problem
- Connect you with local resources in your county who can help you
- Connect you with patient's' rights services

How can I contact the Office of the Ombudsman?

- **Hours of Operation:** Monday through Friday, 8am to 5pm PST; excluding holidays
- **By Phone:** (888) 452-8609
- **By email*:** MMCDOmbudsmanOffice@dhcs.ca.gov

Above information from DHCS website: https://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx