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Achieving "Readiness" in Medi-Cal's Managed Care Expansion for Persons with Disabilities: Issues and Process

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Introduction

This Policy Brief examines issues that can be expected to arise as California moves to significantly expand the use of mandatory managed care arrangements for Medi-Cal enrollees with disabilities. This analysis is based on information gleaned from more than a decade of Medicaid managed care specification analyses for the federal government and private funders, focusing on both the general beneficiary population and persons with chronic illnesses and disabilities. [1] This Policy Brief also reflects experiences in furnishing technical assistance to state purchasers and in developing model managed care purchasing specifications for both general and special needs managed care populations for both public and private funders.[2]

The Policy Brief begins with a brief overview of the California Redesign Initiative, which has been drawn from numerous sources of information. This overview focuses on both the scope of the initiative and the process of development to date. The Brief then describes the federal and state legal framework in which California's managed care system will operate and identifies a series of process-related and topical issues that can be expected to arise as the state moves from broad concept stage to actual operationalization of a much expanded compulsory managed care system for children and adults with disabilities. Both sets of issues are common to all Medicaid managed care systems but take on particular importance in the context of compulsory managed care arrangements for beneficiaries with disabilities.

[1] S. Rosenbaum et. al, Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (1st through 4th editions, George Washington University, Washington D.C., 1997-2002). S. Rosenbaum et. al., Negotiating the New Health System: A Nationwide Study of Managed Behavioral Health Contracts (George Washington University, Washington D.C. 1997, 2001. All purchasing specifications as well as the Negotiating studies can be viewed online at http://www.gwumc.edu/sphhs/healthpolicy/chsrp/managed_care.html.

[2] See http://www.gwumc.edu/sphhs/healthpolicy/chsrp/managed_care.html.

Background and Overview

California's experience with mandatory managed care for persons with disabilities dates back to 1983, when the first County Operated Health System (COHS) in Santa Barbara went into effect.[3] As of 2005, five COHS plans operate in eight counties;[4] together they enroll approximately 166,000 aged, blind, and disabled beneficiaries for whom enrollment is compulsory.[5] Beyond these COHS arrangements, enrollment by persons with disabilities is spotty in the other two types of managed care systems in California – the Two-Plan Model which is active in two counties and the Geographic Managed Care system which has plans in twelve counties. In these systems, managed care enrollment is voluntary for persons with disabilities, but mandatory for some other eligibility groups, such as families and children. Together, they serve an additional 124,000 aged, blind, and disabled beneficiaries through managed care plans.[6]

For some time, the possibility of expanded managed care enrollment for beneficiaries with disabilities has been under discussion. On several occasions proposals to mandate such enrollment were included in state budget proposals put forth by both Governor Schwarzenegger as well as by his predecessor, Governor Gray Davis.[7] The legislature consistently rejected these proposals.

In his 2004-2005 budget, Governor Schwarzenegger announced his intention to seek broad §1115 waiver authority from the Bush Administration to support a "redesign" of the Medi-Cal program.[8] Certain elements of this redesign effort dealt with benefits and cost sharing for non-disabled adult enrollees, as well as the state's financial support to public hospitals. A centerpiece of the proposal however, ultimately became a more than trebling of compulsory managed care for persons with disabilities.

As part of the Administration's effort, the California Department of Health and Human Services worked with two major foundations[9] to develop a "stakeholder process" for promoting public input. A 2004 analysis of the process suggests that compulsory managed care for persons with disabilities was not a clearly stated element of the stakeholder process and became evident only as the process unfolded. Furthermore, this analysis suggests that when the issue ultimately emerged as a major element of the Administration's plans, it did so as a broad "concept" rather

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[3] State of California. Medi-Cal Redesign. January 2005 Available at http://www.dhs.ca.gov/mcs/mcpd/MCReform/PDFs/MC%20Redesign%201-12-05%20final%20updated.pdf

[4] The five COHS plans are: Cal Optima (Orange), Central Coast Alliance Health (Santa Cruz, Monterey), Partnership Health Plan of California (Solano, Napa, Yolo), Santa Barbara Regional Health Authority (Santa Barbara), Health Plan of San Mateo (San Mateo).

[5] California Association of Health Plans. Medicaid Managed Care – the impact of enrolling aged, blind, and disabled beneficiaries: A national review of programs. March 2005 at p.44.

[6] California Association of Health Plans, 44.

[7] DHHS Medi-Cal Redesign; Conversation on August 17, 2005 with Angela Gilliard, Health Advocate, Western Center on Law and Poverty.

[8] See materials at Medi-Cal Redesign. http://www.medi-calredesign.org/overview.aspx (Accessed August 22, 2005)

[9] Letter from Kim Belshe, Secretary of The California Department of Health and Human Services (March 4 2005) naming the California Health Care Foundation and the California Endowment as collaborators. Accessed at http://www.medi-calredesign.org/overview.aspx (August 22, 2005). Among other things, the initiative set up a website titled www.medi-calredesign.org ,which does not appear to have been updated and no longer seems active. The site is a useful archive for documents.

than as a detailed plan for which public reaction was sought.[10] The report also noted that in stakeholders' view, effective comment was not possible because of the absence of detailed plans to which they could react. [11]

In January 2005, the state issued its formal redesign proposal, which served as the basis for the Administration's submission to the Bush Administration of a formal waiver request proposal for waivers under §1115 of the Social Security Act to carry out a large-scale demonstration involving, among other matters, compulsory managed care enrollment of non-dual-eligible Medi-Cal beneficiaries with disabilities in any county with an operational managed care system.[12]

The Proposal, entitled "Medi-Cal Redesign"[13] ran twenty-six pages in length, devoting approximately three pages *in toto* to compulsory managed care enrollment of persons with disabilities. In proposing to virtually treble compulsory managed care enrollment for Medi-Cal only beneficiaries with disabilities,[14] the Proposal made no mention of the 2004 stakeholder process, nor did it identify the concerns raised in the 2004 Stakeholder report regarding the lack of information available to the process. Acknowledging the need to ensure health plan readiness for persons with disabilities, the Administration identified the COHS experience as evidence of its qualification to broaden its compulsory program. Yet, the document did not offer (or suggest the existence of) evidence from comprehensive studies of its eight-county mandatory enrollment system that might have provided the type of detail that would have illuminated the issues for stakeholders.[15]

The Administration did identify some of the issues that would be relevant to the question of managed care readiness for persons with disabilities: analysis of "available" utilization and cost data; network "adequacy;" care coordination and carve-outs; quality monitoring and improvement; linkages with non-Medi-Cal services; accessibility and availability of new treatment modalities; community and provider input into the planning process; and health plan compliance with the Americans with Disabilities Act (ADA).[16] At the same time, the list was not exhaustive and omitted three of the most central issues, benefit design, utilization management, and appeals rights.

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[10] Pacific Health Consulting Group, Medi-Cal Redesign Stakeholder Report (May 7 2004) at p.7.
[11] Medi-Cal Redesign Stakeholder Report at 23.
[12] Medi-Cal Redesign, *supra*
[13] The proposal can be found at http://www.medi-calredesign.org/ (Accessed August 22, 2005)
[14] DHHS, Medi-Cal Redesign (January 10, 2005). P. 7-8.
[15] The California Health Care Foundation analysis similarly notes a lack of comprehensive and systematic evidence from the COHS initiative.
[16] Medi-Cal Redesign, p. 11

In July 2005, the Centers for Medicare and Medicaid Services (CMS) approved the proposal and issued Special Terms and Conditions.[17] CMS conditioned a significant proportion of the state's requested public hospital financing to a specific 17-month timeline for the phase-in of an expanded compulsory managed care program for beneficiaries with disabilities. The CMS timeline specified as follows:

- By September 30, 2005: enactment of authorizing legislation to permit expanded managed care;
- By May 31, 2006: the state must submit its state plan amendments and additional waiver requests associated with expanded managed care for Medi-Cal only persons with disabilities;
- July 1, 2006 - June 30 2007: continued development of managed care waivers and state plan amendments, as well as plan contracts;
- January 2007: Expanded managed care enrollment to begin.

Nothing in the version of the terms and conditions used for this analysis suggests CMS waiver of federal Medicaid standards governing managed care arrangements.[18] Indeed, as discussed at greater length below, the Special Terms and Conditions contemplate that the state will prepare and submit separate materials related to the managed care expansion, in the form of state plan amendments (SPAs) or additional §1115 waiver requests.[19]

Critical Issues in Managed Care Design and Administration for Persons with Disabilities

In our experience, certain issues emerge in virtually all states that seek to implement or expand the use of compulsory managed care. Over the years, many of these issues also have become the focus of federal statutory managed care standards, as codified in the Balanced Budget Act of 1997 and implementing regulations.

Auto-enrollment: Any compulsory managed care system requires an auto-enrollment mechanism to ensure that non-selecting beneficiaries are enrolled in a plan, since compulsory managed care arrangements condition virtually all contractual coverage on plan enrollment. Obviously, auto-enrollment can be disruptive depending on whether the member's providers are in the network and how the plan elects to administer its contract. Auto-enrollment when poorly done carries health care access and quality implications as a result of disruption in care, lack of knowledge regarding coverage, serious under-use of care and excessive profits generated by this under-use. A number of issues arise in auto-enrollment involving persons with disabilities: the process for auto-enrolling (i.e., the assignment of individuals to plans whose network includes the individual's primary care provider); the qualifications of plans allowed to accept auto-enrolled persons; the level of information on health status and special needs that must

[17] Draft Terms and Conditions were issued in July and they were finalized in August.
[18] These standards can be found at 42 CFR § 438.
[19] CMS, Special Terms and Conditions (July 20, 2005) p.2

accompany auto-enrollment; the timeframes given to plans to assign patients to physicians and make initial contact; and the opportunity for plan switching post-auto-enrollment. As Table 1 suggests, auto-enrollment is currently not a focus of formal standards under the three sources of law examined.

Retention of existing provider relationships: In the case of persons with disabilities, the extent to which plans will be required to honor existing relationships with primary and specialty care providers is critical, particularly since some health plans may elect to re-assign members to primary care providers based on network discounts and volume agreements. Treatment of existing provider relationships is also not an issue currently addressed.

Involuntary disenrollment for "cause" and involving institutionalized enrollees: Compulsory enrollment of persons with disabilities can raise certain distinct involuntary disenrollment issues. One such issue involves the institutionalization of a plan member, with the question being whether the plan will be required to re-accept the member upon release. The other issue is the extent to which California will recognize the right of a plan to disenroll a "disruptive" plan member. The issue of disenrollment for disruption most typically arises in the context of patients with serious mental illness but obviously can arise in the case of persons with disabilities who are strong advocates for their health care needs. California law addresses these issues to varying degrees, generally not permitting disenrollment of disruptive persons.

Primary and specialty care distance and travel times: Discounted and managed health care is the ultimate product sold in Medicaid managed care. Specifications related to time and distance are of particular importance because of the shortage of specialty care services. Inevitably Medicaid beneficiaries experience serious shortages in gaining access to certain specialty services (including primary specialties such as dental care in the case of persons with disabilities because of dentists' unwillingness to treat patients with complex physical and mental disabilities). Determining the affirmative steps that plans will be expected to take to make services accessible in terms of geographic conditions and waiting times will be an essential aspect of readiness.

Plan and provider ability to communicate with members and patients: Communication with members and patients with disabilities in all aspect of plan operations is a fundamental feature, not only for clinical services but also for member services, consumer call lines, and all other forms of oral and written plan communication. The technology for patient communication has advanced over the years, and the standards to which plans will be held in both their own operations and those of their network providers constitute a key consideration generally and as a matter of ADA compliance. In addition, plan and provider compliance with Title VI standards related to members with Limited English Proficiency (LEP) would be relevant.

Physical and adaptive access throughout the plan and its network: The extent to which plans can assure that their service sites have been adapted to be accessible to persons with disabilities is central to this expansion. As with communications capabilities, the task is to find operational standards and use those standards to fashion benchmarks that plans and networks will be expected to meet. This issue does not appear to be addressed under existing laws.

Out of network coverage and payment: Medicaid is closer to a classic HMO model than commercial products, which tend to offer incentivized coverage through networks of providers that heavily discount their care. In Medicaid's case, out of network care for contractual benefits and services typically is not covered at all, except in the case of family planning services and supplies. For a member population of persons with disabilities, the question arises as to whether plans should be obligated to permit out-of-network coverage under certain conditions (i.e., where no in-network provider of contractual services has the qualifications and relevant expertise that might be needed for particular conditions). In this context, the COHS contract offers an example of an approach that extends beyond out of network provision of contract services in medical emergencies.

Relevant provider expertise: Relevant expertise is a significant issue for persons with serious and chronic conditions, particularly individuals who suffer from co-morbidities, who in turn make up a substantial proportion of all enrollees with disabilities. Whether plans will be required to broaden their networks of specialists or permit out of network access in specific cases is an issue that has not yet been addressed under California law.

Treatment of the health care safety net and other essential providers: Beneficiaries with disabilities rely on certain safety net providers such as health centers, children's hospitals, and specialty programs and services maintained by or operating in close collaboration with schools, child welfare agencies, early intervention programs, state and community agencies specializing in the treatment and management of adults with disabilities, and other specialized providers. In general, California law generally confines its standards to certain classes of safety net providers such as disproportionate share hospitals and federally qualified health centers. Issues relating to safety net providers are addressed infrequently in California law. COHS contracts simply encourage plans to include safety net providers in their networks and require that safety net providers to be paid a rate similar to other subcontractors that provide a similar scope of services. Medi-Cal ensures that Children's hospitals are paid according to their case severity.

Benefit design and extra-contractual coverage: A particularly complex issue may be benefit design and access to extra-contractual benefits. One of the central findings of our research in managed care has focused on the failure of contracts to set forth with clarity which Medicaid benefits either completely or partially fall within the scope of an agreement and which are extra-contractual and thus covered through another contract or directly by the Medi-Cal program. Enormous coverage disputes over coverage can arise. Numerous examples of ambiguous coverage exist. Where the terms of coverage are not well defined, beneficiaries can discover that every payer – their primary health plan, their behavioral plan (if one is used) and the state Medicaid program – all deny treatment on the grounds that another payer is responsible. The simplest means for avoiding this outcome is to make managed care contractors responsible for coverage up to federally required limits under the terms of the state's Medicaid plan, but most states opt to limit or exclude contractor responsibility, if only because they are unable to find contractors willing to accept such broad coverage and management duties. How coverage duties and limits are expressed and who holds authority for resolving coverage disputes among payers is a critical issue for this population because of its higher rates of use of costly services.

EPSDT: The EPSDT program represents a subset of the entire coverage challenge, since the breadth of the program sweeps in all services and benefits required under the federal

definition of "medical assistance." EPSDT's treatment mandate is of special importance to children with disabilities, who comprise an estimated 20% of any state's high cost Medicaid cases. Special attention needs to be devoted to the approach the state will take to allocating EPSDT diagnosis and treatment responsibilities among plan products as well as between the state agency and its plans. Furthermore, EPSDT requires the provision of support services needed to gain access to non-Medicaid services important to children (such as early intervention, educational, social services, and nutritional service). Whether these access enhancing activities are the function of plans or a separate contractor is a decision that needs to be addressed.

Medical Necessity (children and adults) and utilization review: The process and standards used to determine the necessity of care in any particular case requires attention, since health plans may be accustomed to the use of commercial norms that may be inapplicable in a Medicaid context. For example, Medicaid's rules against discrimination presumably would prohibit a plan from denying needed therapy to a person with disability on the grounds that a "recovery" is not possible. This type of distinction is common in the commercial market. Similarly, in the case of children, the standard of medical necessity under EPSDT focuses on growth and development, not simply the curative nature of a particular intervention. Again, this is a departure from commercial norms, and these distinctions are especially critical where the patient is a child with a disability whose need for the care may be for attainment and development of functioning, not to correct an acute condition. These issues are unique to Medicaid.

The process of utilization review is also important, not only because of the need for skilled reviewers with experience in assessing need in the case of a low income population with serious conditions, but also because of beneficiaries' federal right to continued coverage of services whose cessation or reduction is recommended during the pendency of an appeal. This right to coverage during the timely appeal of a recommended reduction or termination in care is unique to Medicaid and of particular importance in a disability context.

Grievance System and Appeals Process: Persons with serious and chronic conditions and disabilities often have a consistent and extensive need for sustained health care. For this group, access to a clear, highly transparent, supported, and when necessary expedited grievance and appeals system is essential. Of critical importance is the inclusion of special Medi-Cal protections that prevent the reduction or loss of benefits in the case of persons receiving ongoing care when a timely appeal is made. While each source of law considered here contains a grievance system, they vary greatly in level of detail and protection. The Knox-Keene statute has extensive regulations regarding notification of decisions, ability to appeal, expedited decision making, and other matters. Conversely, the Medi-Cal regulations are quite sparse and do not sufficiently explain the link between the grievance and appeal system and special Medicaid protections designed to ensure continued benefits.

Quality measurement and improvement markers and public reporting: The population whose enrollment is targeted in this expansion is one for whom health care quality measurement cannot stop at primary and acute care. There is an enormous need to establish common, relevant, timely, reliable and valid measures of health care quality and to insist on the public reporting of intermediate and ultimate outcome measures in a timely manner, based on current data. The lack

of such a system is a notable omission in the current COHS program although individual plans may produce data.

Risk financing and stop-loss: Persons with disabilities obviously present a much greater potential for financial losses, especially if a broad array of services and management responsibilities are encompassed within the contract. Establishing a limit to contractual responsibilities and ensuring financial safeguards up to federally allowed maximums will be a central issue in development of this market, just as has proven to be the case in the development of other markets such as Medicare Part D, which uses controlled levels of risk in its plans. How much risk the state attempts to "downstream" in order to ensure scorable savings will end up driving the design and operation of plans in their relationship to their population of members with disabilities. This is an issue that has received specific attention under the California sources of law shown below, and consideration of these standards against plan growth will be a central aspect of planning.

California's Legal Framework

The legal framework relating to Medicaid managed care in California is complex. In addition to the federal regulations that govern managed care arrangements in all states (unless waived as part of a §1115 demonstration), California has three main sources of regulations: 1) Medi-Cal regulations and associated codes, 2) Knox-Keene Health Care Services Plan Act of 1975[20] and associated Department of Managed Health Care regulations, and 3) the actual provisions of the managed care contractual arrangements which govern the relationship between the public purchasers on one hand and the managed care systems on the other. For this analysis we have elected to use the COHS boilerplate contract in view of its direct relevance to compulsory managed care for persons with disabilities. Table 1 also includes provisions from the CalOptima COHS contract. The contract developed by CalOptima includes extensive protections for enrollees with disabilities and offers a valuable beginning point for further standards development.

Table 1 sets forth a series of issues that we have identified over the years through our Medicaid managed care research and technical support involving compulsory Medicaid managed care arrangements. Table 1 and the accompanying footnotes indicate the extent to which one or more sources of California law related to managed care currently address a particular issue. Thus, the Table both identifies the issues that will be of particular importance during the developmental phase of the expansion and also links each issue to existing state law.

While Table 1 shows which areas of law have provisions related to these critical issues, it does not indicate whether the current protections are adequate. In fact, there is evidence that many of the provisions could be strengthened. Generally speaking, the Knox-Keene Act and implementing regulations potentially offer significant protections to managed care enrollees. However, even the structure of the Knox-Keene Act contains gaps in critical safeguard areas such as auto-enrollment and physical and adaptive access throughout the network. Furthermore, existing Medi-Cal managed care arrangements that are offered through COHS plans are exempt

[20] California Health and Safety Code Chapter 2.2.

from Knox-Keene requirements even though these plans represent the benchmark experience for persons with disabilities who currently are enrolled in compulsory managed care.[21] Medi-Cal regulations also have numerous gaps and some covered areas, such as the grievance procedure requirements, are quite sparse.

Table 1. Member and Patient Safeguards in Health Plan Expansion Development for Medi-Cal Enrollees with Disabilities

ISSUE	KNOX KEENE	MEDI-CAL[22] RULES	COHS MEDI-CAL CONTRACT[23]	CAL-OPTIMA NETWORK CONTRACT[24]
Enrollment				
Auto-enrollment safeguards				
Treatment of existing provider relationships for new enrollees				
Involuntary disenrollment by health plans	§§1365, 1348.8[25]	WI[26] §§14412 & 14466[27]	6.3[28]	Art. 3, L[29]
Involuntary disenrollment/ reenrollment of institutionalized persons		See note 26		
Voluntary disenrollment by members		§§ 53440, 53442; WI § 14413[30]		Art.3, M[31]
Access				
Primary care time and distance/travel times	§1367.03; DR[32] 1300.67.2[33]		7.2.2[34]	Art.5, D.1, D.3., Art.5,L[35]

[21] Health and Safety Code, §1343(c). COHS plans received a waiver from meeting Knox-Keene requirements since they were not engaged in competition as Medi-Cal only products and were publicly operated. Four of the five COHS plans (all except Partnership Health Plan) have Knox-Keene licenses which are required for their non-Medi-Cal lines of business, such as participation in Healthy Families, California's SCHIP program. However, this does not mean that their Medi-Cal beneficiaries receive Knox-Keene protection unless the provisions are embedded in the Medicaid managed care contract with the state.

[22] Medi-Cal Rules refer to Title 22 of California Code of Regulations, unless otherwise noted. The rules reported here relate to the Prepaid Health Plans generally and do no cover the Two-Plan model or the Geographic Managed Care plans.

[23] Information in this column is from the boilerplate County Operated Health Systems contract from 1999, but still used in 2005.

[24] This contract covers CalOptima Networks from 1/1/03-12/31/05

[25] Enrollment may be terminated only in limited circumstances – failure to pay, fraud, deception, "good cause."

[26] WI refers to Welfare and Institutions Code

[27] Legislative intent was that enrollment not be terminated except for loss of eligibility, good cause, or request of beneficiary. In Los Angeles County only, plan may disenroll any member for month(s) patient is hospitalized and stable but refuses to be transferred from non-plan facility to plan facility when it is medically safe to do so.

[28] Member will be disenrolled if no longer eligible for Medi-Cal or if the member moves out of the plan's service area.

[29] Physician may request and CalOptima may approve disenrollment for specific members according to CalOptima policies.

[30] Disenrollments due to eligibility terminated, marketing fraud, misrepresentation, move out of service areas, or plan merger/reorganization do not need to go through grievance process. Requests may be made to plan or Department. Plan must furnish form immediately upon request.

[31] Members have the right to disenroll from a Health Network.

[32] DR refers to regulations issued by the Department of Managed Health Care (DMHC)

[33] Facilities must be located so as not to create barriers to accessibility. Hours of operation and after hours care needs to be reasonable. Plan must have process to monitor access, including waiting and travel times.

ISSUE	KNOX KEENE	MEDI-CAL[22] RULES	COHS MEDI-CAL CONTRACT[23]	CAL-OPTIMA NETWORK CONTRACT[24]
Specialty care appointment and distance/travel times	§1367.03; DR 1300.67.2[36]			Art.5, D.2, Art.5, M[37]
Plan member communications capacity for members with special language or comprehension needs[38]				Art. 3. EE[39]
Physical and adaptive access throughout plan and network			7.5.8[40]	Art.6,P; Art.6,T, Art.12,F[41]
Provider networks and competencies				
Communications capability				Art. 3. EE[39]
Out of network coverage and payment	§ 1371.4(b), (j), 1262.8[42]	Title 22, Ch. 7[43]	7.5.9, 7.7 generally, 7.7.7[44]	Art.4, B[45]
Relevant Specialty				Art.6,P.6[46]
Treatment of safety net providers		WI §§14083(k), 14085.5, 14085.9, 10487.21[47]	2.26, 2.35, 2.74, 7.25, 7.7.12, 9.51[48]	Art.1, EE & QQQ, Art.2, E.5 & E.6, Art.7, E[49]

[34] Primary care physicians must be located within 30 minutes or 10 miles of member's residence unless the state has approved a different time and distance standard.
[35] Physician must ensure that appointments for non-urgent primary care services are scheduled within 21 calendar days of a member's request. Health assessments and general physical examinations must be scheduled within in 30 calendar days of member's request. Primary care physicians must available be within 20 minutes or 10 miles of member's place of residence.
[36] Plan must provide accessibility to medically required specialists who are certified or eligible for certification by appropriate board. Plan must have process to monitor access, including waiting and travel times.
[37] Physician must ensure that appointments for specialist services are scheduled within 31 calendar days of referral. Specialist must be available within a "reasonable" driving distance from member's place of residence. Physicians must provide transportation if nearest available specialist is more than 30 minutes from member's residence.
[38] This refers to communication issues due to disability, not language barriers.
[39] Physicians must provide interpreter services for deaf or heard of hearing as necessary to ensure availability of effective communication.
[40] Plan facilities must comply with requirements of Title III of Americans with Disabilities Act.
[41] Physicians must comply with several requirements relating to ABD members, including participating in the Community Liaison program (helping ABD members navigate health system and improving their access to care), referring members to Seating Clinic as needed, making available medically necessary incontinence supplies (unrestricted by brand), authorizing other specified supplies for 6 months, allowing ABD members to select any participating and willing specialist as a primary care provider, creating a care plan fro ABD and members with special health care needs, conducting home assessments when appropriate, providing standing referrals when appropriate, and having facilities or sites capable of accommodating ABD members.
[42] Plan must reimburse provider for emergency care until patient is stabilized. Non-contracting hospital must contact enrollee's plan before admitting or transferring to a non-contracting hospital for care after patient is stabilized.
[43] Reimbursement is available for emergency service provided out-of-network.
[44] Plan will arrange for provision of "seldom used specialty services" from specialists outside the network when medically necessary. Contractors will refer enrollees with developmental disabilities to the regional centers for those non-medical services such as respite, out-of-home placement, and supportive living for persons with substantial disabilities if such services are needed. In addition, plan will pay for a variety of other out-of-network services such as emergency services, school-based services, family planning services, etc.
[45] Physicians must provide and pay for all emergency services, including those provided by out-of-network providers without prior authorization.
[46] Physicians must have participating providers possessing expertise in serving ABD members, including but not limited to endocrinology, neurology, genetics, and psychiatry.

ISSUE	KNOX KEENE	MEDI-CAL[22] RULES	COHS MEDI-CAL CONTRACT[23]	CAL-OPTIMA NETWORK CONTRACT[24]
Coverage and utilization management				
Benefit design issues and extra-contractual benefits and coverage		§ 53210(d), WI § 14304.5[50]		
Treatment of EPSDT benefits and services for children under 21				
Medical necessity standard for adults and children		WI § 14059.5[51]	2.49[52]	Art. 1, TT[53]
Utilization review procedures	§§ 1363, 1367, 1371.8[54]		8.10[55]	Art.6, L.2(b)[56]
Appeals procedures and timelines	§§ 1363, 1367.04, 1368, 1373, 1374, 1397.5[57]	§ 53260; WI 11450(a)(1)[58]	8.12.6, 8.12.7[59]	Art.3,D[60]
Quality measurement and reporting				
Cross-plan standardized performance measurement of quality in physical health, mental health and management of persons with co-morbidities	§ 1380; DR 1300.80[61]	§§ 53312, 53314 WI § 14309[62]	8.6[63]	Art.6,D[64]

[47] Special circumstances of DSH hospitals should be taken into account by Dept. when negotiating contracts and supplemental reimbursement is available to DSH hospitals. Children's hospitals will be reimbursed based on severity of pediatric diagnostic case types.
[48] Defines safety net provider as a provider of comprehensive primary care or hospital providing acute inpatient service to both medically indigent and eligible beneficiaries. Plans must promote broad participation by safety-net provider in their service area. Plan will meet federal requirements for access to and reimbursement of FQHCs. Reimbursement for FQHC and RHCs must be same as provided to other subcontractors providing similar services. Department has the right to review rates paid to FQHCs and RHCs.
[49] FQHCs must be reimbursed at a rate comparable to any other subcontract arrangement for similar services. Indian Health Service provider will be reimbursed at the approved Medi-Cal rate. CalOptima reserves the right to pay providers, including Safety Net Providers, additional sums of money that CalOptima deems beneficial to the provider.
[50] Plan needs prior approval of Director to provide extra services at a cost to member and plan must notify members of services available and cost.
[51] A service is medically necessary when it is "reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain."
[52] Medically necessary is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through diagnosis or treatment of disease, illness or injury."
[53] Medically necessary is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through diagnosis or treatment of disease, illness or injury."
[54] Knox-Keene Act contains extensive rules regarding criteria and process for utilization review.
[55] The contract contains rules regarding criteria and process for utilization review, though less specific than the rules found in the Knox-Keene act in some aspects.
[56] Physician must have a utilization management program that conforms to CalOptima guidelines.
[57] Knox-Keene Act contains extensive rules regarding process and timeline for appeals.
[58] Medi-Cal regulations and code require that each plan has a grievance procedure that is approved by the Department, but very few specifics provided. Enrollees have a right to a fair hearing if grievance is unresolved.
[59] Plan must implement a grievance system in accordance with 10 CCR 1300.68 and Health and Safety Code 1368.01 (outlining requirements of grievance system).
[60] Physician must implement and comply with grievance procedure described in CalOptima policies.
[61] Department will conduct periodic on-site medical survey of the health system delivery for each plan.
[62] Each plan must submit a variety of reports and the Department will provide for a continuing study of the quality of care and services from the plans.

ISSUE	KNOX KEENE	MEDI-CAL[22] RULES	COHS MEDI-CAL CONTRACT[23]	CAL-OPTIMA NETWORK CONTRACT[24]
Accessible public communication of findings	§ 1341.5, 1380(h)[65]	WI § 14459.5(c)		Art.10,I[66]
Financial Safeguards				
Actuarially Sound Rates		§ 53321, WI §§ 14262(a), 14301(a)[67]	11.1[68]	Art.2, E.2[69]
Stop Loss		§ 53251(b), 53252[70]	10.8, 10.9[71]	Art 3, HH[72]

The Process of Redesign: Transparency and Accountability in the Development Phase of the Managed Care Expansion

The process of managed care redesign is as important as the elements of the redesign effort, since no academic overview of the dimensions of redesign can substitute for the actual involvement in redesign of the people and entities directly affected: persons with disabilities and their family members where relevant, and the health professionals and specialty providers whose focus is the treatment and management of persons with disabilities. The Schwarzenegger Administration recognized the importance of involvement on a preliminary basis with its stakeholder process. In its special terms and conditions, CMS appears to assume that a new process of public input will commence, and the Redesign proposal anticipates a subsequent process as well.

Both state and federal law govern the process of managed care redesign for persons with disabilities. Federal guidelines issued by the Clinton Administration in 1994[73] and reaffirmed by

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[63] Plan will implement policies and protocols to systematically assess, monitor, evaluate, and take effective action to address any needed quality improvements. The plan must conduct quality improvement studies that reflect the population served in terms of age groups, disease categories, and special risk status.
[64] Physicians must maintain a quality improvement program which includes an annual work plan and evaluation. Quality improvement activities are available to CalOptima upon request.
[65] DMHC must make public information filed with or obtained by the agency unless contrary to law. Medical survey findings must be made public 180 days after completion of survey unless Director finds additional time is necessary. Plan may review findings before they are public. One copy of survey results free upon request.
[66] Physicians agree that CalOptima may release to providers, members, and others, data relating to performance of physician and hospital that CalOptima believes would contribute to evaluation of options and alternatives and making informed decisions regarding health care needs.
[67] Department will use "any reasonable and adequate method of computing or determining per capita rates of payments," based on various assumptions, including "experience data."
[68] State will pay the "appropriate" capitation payment and ensure such payments are "reasonable" and do not exceed the amount set forth in 42 CFR 447.361 (since repealed).
[69] Primary care provider covered services for ABD members will be reimbursed at least $30 per member per month.
[70] Department will bear the cost of providing medically necessary services to a member when the costs exceed the risk limited in the aggregate during a 12 month time period specified in the contract. The risk limit is determined annually. Plan may obtain reinsurance for the cost of providing services.
[71] Plan may obtain reinsurance through the State or other insurers or may self-insure with approval of the State. Reinsurance plan may cover the total cost of emergency services provided by a non-contractor and 90% of all costs exceeding 115% of its income during any fiscal year. The State may limit plan's liability to pay and provide for care to members which results from or is greatly aggravated by a catastrophic occurrence or disaster.
[72] CalOptima arranges for reinsurance. Physicians may also purchase, at their own expense, supplemental reinsurance from another source.

the current Administration in 2002[74] require transparency and public input into §1115 proposals, and the CMS expectation of a detailed managed care plan is an indication that the agency will treat this phase of the state's Redesign project as effectively a new waiver proposal. The following excerpt from the 1994 public transparency guidelines indicates the range of choices open to the state in terms of the next round of public input:

> The Department recognizes that people who may be affected by a demonstration project have a legitimate interest in learning about proposed projects and having input into the decision-making process prior to the time a proposal is submitted to the Department. A process that facilitates public involvement and input promotes sound decision-making. There are many ways that States can provide for such input. In order to allow for public input into the proposals, the Department expects States to ordinarily follow one (or more if the State desires) of the processes described in this section.
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> 1. At any time prior to submitting a section 1115 demonstration proposal to the Department of Health and Human Services, a State may provide to the Department a written description of the process the State will use for receipt of public input into the proposal prior to its submission to the Department. Within 15 days of receipt of such description, the Department will notify the State whether the described process provides adequate opportunity for public input. The Department will accept any process that--
>
> Includes the holding of one or more public hearings, at which the most recent working proposal is described and made available to the public, and time is provided during which comments can be received; or
>
> Uses a commission or other similar process, where meetings are open to members of the public, in the development of the proposal; or
>
> Results from enactment of a proposal by the State legislature prior to submission of the demonstration proposal, where the outline of such proposal is contained in the legislative enactment; or
>
> Provides for formal notice and comment in accordance with the State's administrative procedure act; provided that such notice must be given at least 30 days prior to submission; or
>
> Includes notice of the intent to submit a demonstration proposal in newspapers of general circulation, and provides a mechanism for receiving a copy of the working proposal and an opportunity, which shall not be less than 30 days, to comment on the proposal; or,
>
> Includes any other similar process for public input that would afford an interested party the opportunity to learn about the contents of the proposal, and to comment on its contents.
>
> The State shall include in the demonstration proposal it submits to the Department a statement (a narrative of several sentences) briefly describing the process that it followed in implementing the process previously presented to the Department. The Department may find a proposal incomplete if the process has not been followed.

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[73] 59 Fed. Reg. 49249 (Sept. 27, 1994)
[74] State Medicaid Directors Letter from Dennis Smith (SMD 02-007) (May 3, 2002)

> 2. A State that has not followed the procedures described in paragraph 1. must submit a description of the process that was used in the State to obtain public input, at the time it submits its demonstration proposal. The Department will notify the State if the process was adequate within 15 days after the application is submitted, applying the same criteria as in paragraph 1. If the process was not adequate, the State can cure the inadequacy by-- Posting a notice in the newspaper of widest circulation in each city with a population of 100,000 or more, or in the newspaper of widest circulation in the State if there is no city with a population of 100,000, indicating that a demonstration proposal has been submitted. Such notice shall describe the major elements of the proposed demonstration and any changes in benefits, payments, eligibility, responsibilities, or provider selection requested in the proposal. The notice shall indicate how interested persons can obtain copies of the proposal and shall specify that written comments will be accepted by the State for a period of thirty days. If a State follows such a procedure, the State should respond to requests for copies of the proposal within seven days. The State should maintain a record of all comments received through this process.[75]

In addition, it is important to note that the federal managed care standards themselves, which appear not to have been waived, require transparency in system development:

> The State plan must specify * * * ; the process the State uses to involve the public in both design and initial implementation of the [managed care] program and the methods it uses to ensure ongoing public involvement once the State plan has been implemented.[76]

Furthermore, as the 1994 Guidelines suggest, the federal government anticipates that states will follow their own Administrative Procedures Act. Amendments to California's APA suggest that particular attention has been paid to the public input process for Medi-Cal managed care, and an issue to be considered is the extent to which the APA will expressly require use of public notice and rulemaking in developing this extensive redesign.

A final consideration underscores the value of transparency during the developmental phase of this expansion: its sheer size. This proposal will more than triple the number of children and adults with disabilities enrolled in compulsory managed care arrangements. Experience to date is confined to five plans operating in eight counties, whose health care conditions may not be replicable to other parts of the state. It appears that no detailed analysis of the COHS has been undertaken to determine the transferability of the experience or to gain detailed insight as to the strengths and limitations of such an expansion. The expansion will involve not only counties with at least some managed care experience, but also counties that apparently have had no experience until now.

It is important to stress that while the CMS Special Terms and Conditions contemplate a planning and phase-in period, they do not appear to set a final completion date for expanded managed care enrollment. Put another way, enrollment must begin by a date certain but no date

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[75] 59 Fed. Reg. 49250
[76] 42 C.F.R. §438.50(b)(4)

certain is provided in terms of speed or completion. This leaves room for a careful expansion design in our view, with prioritization given to expansion sites whose health systems have certain attributes, expansion sites that will utilize plans operating under certain Knox-Keene safeguards, or an expansion plan that phases the enrollment expansion using another approach. This type of phased approach may emerge as a particularly important safeguard and one that is essential to ensuring that health plans participating in the expanded system are capable of ensuring services that are both non-discriminatory and of high quality.

Conclusion

The Medi-Cal redesign initiative has the potential to make far reaching changes in the quality and accessibility of health care for the state's poorest children and adults with disabilities. Unfortunately, the data from the state's experiences so far with managed care for this population are so limited that it is not possible to predict with more than limited accuracy what issues may arise as compulsory arrangements are extended to many more counties. The lack of documented experience and the health risks faced by the target population suggest a need to focus on a range of issues that arise in all states as compulsory managed care is phased in and that have particular relevance to persons with disabilities.

Furthermore, transparency in planning will be important to generating support for the effort. Unlike earlier public input efforts, this developmental phase should be expected to entail detailed planning documents that propose actual operational standards and procedures for contracting for, and measuring the quality of, managed care. Indeed, federal and state procedural standards contemplate transparency.

There is no question that the Special Terms and Conditions assume rapid efforts to begin the transformation. But the Terms and Conditions also appear to allow for deliberation in the structure of the new system, since they set no fixed timeline for completion of the process. For this reason, considerations of phasing and careful attention to readiness may be as vital to the success of redesign as the standards themselves.