California Department of Health Care Services

How California's Waiver Protects Vulnerable Populations

California's new comprehensive waiver will ensure more organized, accountable delivery models to improve care for seniors and persons with disabilities.

Key protections include:

1. Providing guaranteed access to medical care: Seniors and persons with disabilities (SPDs) will have an established, assigned medical home, either through a physician or clinic.
2. Monitoring system performance and outcomes: Organized delivery systems will be monitored to improve provider performance and health outcomes within their systems.
3. Ensuring beneficiaries have choice: Enrollment in organized systems of care will be modeled on the state's current process for mandatory enrollment of children and families. SPDs will have the opportunity to choose the system in which they will enroll. In counties where an alternative plan is developed, enrollees can choose existing plans or the county alternative option.
4. Enrollment into plans and alternative options will be based on plan performance, support for the local safety net and adherence to additional patient protection requirements: Compliance with all existing regulations under Knox-Keene contracting provisions will be required for existing managed care plans. County Alternative Options, depending on their structure, may be required to obtain and maintain Knox-Keene licensure as well. Both models will require compliance with all Department of Health Care Services (DHCS) Medi-Cal contracting provisions.

   Additionally, both models must fully address the following key elements:

   Access

   a) Network Adequacy – DHCS, working closely with the Department of Managed Health Care (DMHC), will ensure all provider networks are appropriate before enrollment takes place and will closely monitor networks as additional populations enroll to ensure capacity is appropriately maintained.
   b) Access to Information – Any plan or provider communication must be made available in alternative formats and in plain language, assuring that all members have access to communications that take into account hearing, visual, or other limitations.
   c) Physical Accessibility – DHCS will adopt an evaluation method to assess and monitor plans and network providers to ensure the physical accessibility needs of people with disabilities and chronic conditions are met.

   Transition

   a) Outreach and Education – DHCS will conduct outreach and education activities that provide eligible SPDs with information on Medi-Cal managed care, member choices and consumer protections.
   b) Phased-In Transition – A coordinated, phased-in transition over the course of 12 months with staggered enrollment will ensure adequate support for these beneficiaries.
   c) Access to Existing Providers – Members will have the opportunity to select a plan that includes their preferred providers in the network. DHCS will require plans to allow new enrollees who are under active treatment with an out-of-network provider to continue their treatment with that provider for a period of up to 60 days.

d) Assignment. Beneficiaries who do not make a plan choice, and for whom utilization data is available to DHCS, will be assigned to plans where there is a match between the plan's network and providers from whom the beneficiary has received treatment.

Care Management and Coordination

a) Early Identification of a Member's Health Care Needs – DHCS will develop information about health status and treatment history based on member-specific Fee for Service utilization data, so that after a beneficiary is enrolled, the enrolling organization can identify those who may require early initiation of assessment and care planning.
b) Care Management Assessment -- Based on information from the initial assessment, the plan or alternative county option may be required to develop a formal care plan with annual reassessments and/or reassessments based on a triggering event. Caregivers should be considered in assessing and determining care management needs. Current contract requirements allow plans up to 120-days to conduct the initial member assessment. Available utilization data and members' self-assessment at time of enrollment will assist plans and alternative options in identifying high risk members and in making the initial assessment as soon as possible, but not later than 90 days after enrollment.
c) Cultural Competency Training – Plans, alternative county options and providers will be trained in cultural competency and sensitivity to better serve the SPD and chronically ill populations.
d) Behavioral Health Coordination – DHCS will require its contracted delivery models to ensure coordination for the behavioral health needs of the SPD members and, when appropriate, make coordination with behavioral health services a specific component of the member's overall care management plan.
e) Coordination of Other Services – All delivery models will be required to provide specific protocols and strategies to demonstrate that care provided by the plan is coordinated with services that a beneficiary receives from other delivery systems, such as those provided through regional centers, in-home supportive services, and other community-based services. This includes the designation of a liaison with regional centers to assist in the coordination of care for persons with developmental disabilities.

Performance Monitoring and Improvement

Expand Required Performance Measures – DHCS will develop and publish results for existing and additional performance measures in ways that provide quality indicators not only for each plan's entire Medi-Cal managed care population, but also specifically for each plan's enrolled SPDs.

Augmented Audit Effort – DHCS will expand medical audit reviews of participating plans to include elements specifically related to care for the expanded populations. Additionally, DHCS will augment its financial audit reviews to ensure that an annual financial statement audit is performed on contracting plans.

Complaint and Grievance Procedures - DHCS will continue to provide beneficiaries with accessible methods to support the submission and resolution of member complaints and grievances.