Center for Health Care Rights

ADVOCACY FOR HEALTH CARE CONSUMERS

Important Medi-Cal Changes for Seniors and Persons with Disabilities

- In 2011, California's Dept. of Health Care Services will begin to move most Medi-Cal only beneficiaries who are elderly (age 65 and older) and younger persons with disabilities into Medi-Cal health plans.
- This new policy is part of California's efforts to restructure publicly funded health programs under the 1115 waiver that was approved by the federal government.

Who Is Required to Enroll into a Medi-Cal Health Plan?

Most individuals who have Supplemental Security (SSI) and only Medi-Cal as their health insurance will be required to join a Medi-Cal Health 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.

For more information,
call the Center for Health Care Rights at (800) 824-0780.

The Center for Health Care Rights (CHCR) is a California non-profit organization that provides free information and help with Medicare. CHCR is funded by government and private foundation grants. Funding for this flyer is provided by Los Angeles City Department of Aging HICAP/SHIP grant.

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Who is Exempt from the Mandatory Medi-Cal Health 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
- 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)

What is the Timeframe for the Enrollment Process?

- 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 health plan when they apply for Medi-Cal.

How Will People Be Informed that they Need to Enroll in a Medi-Cal Health Plan?

- 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 for the individual will be used to help select the plan.

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

- There are two Medi-Cal Health Plans in Los Angeles County: L.A. Care and Health Net. 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 Health Net include lists of providers for each plan.

- When a Medi-Cal beneficiary enrolls in a Medi-Cal Health Plan s/he must 1) choose a plan and 2) choose a primary care provider using the Medi-Cal Choice Form in the enrollment packet. If a primary care provider is not selected, the plan will assign the individual to a provider.

- The Health Information Form in the enrollment packet is designed to collect medical information. Completing the form is voluntary and will not affect the selection of a particular plan.

Can People Change their Medi-Cal Health Plan?

- 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.

Can Persons Required to Enroll in a Medi-Cal Health Plan Request a Medical Exemption to Stay in Fee For Service Medi-Cal?

- 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.

- 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.

- The Medical Exemption Form is mailed to Health Care Options (HCO).

- If the medical exemption request is denied, the Medi-Cal beneficiary can appeal the denial by requesting a State Fair Hearing.

- Pending the appeal, the individual must continue to use his/her Medi-Cal Health Plan.

Do Medi-Cal Health Plans Provide the Same Benefits as Fee For Service Medi-Cal?

- 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.

Are Mental Health Care Services Covered by Medi-Cal Health Plans?

- No, mental health services are not covered by Medi-Cal Health Plans.
- 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).
- New Medi-Cal Health Plan members will continue to use the DMH providers that they have previously used.

How are Member Problems and Complaints Resolved in a Medi-Cal Health Plan?

If a Medi-Cal plan member has a problem or complaint, s/he should contact the plan member services department for assistance.

Once the plan member has contacted the plan, s/he also has the right to request an Independent Medical Review 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.

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Center for Health Care Rights
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The California Dept. of Health Care Services, has proposed making the following changes in Medi-Cal benefits and cost sharing:

Mandatory Medi-Cal Beneficiary Copayments

- All persons with full Medi-Cal benefits will be required to pay copayments when they use Medi-Cal covered medical services.
- Implementation of this change is targeted for October 2011. Federal approval of this policy change is still pending approval. Beneficiaries and providers will receive advance notice prior to implementation.
- New Copayments –
  - $5 co-pay for doctor and dental visits.
  - $3 co-pay for generic drugs and $5 co-pay for brand name drugs.
  - $50 co-pay for emergency room visits.
  - $100 co-pay for hospital stays, with a $200 maximum per hospital stay.

Utilization Caps on Medi-Cal Benefits

- 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.
- Implementation of this change is targeted for October 2011. Federal approval of this policy change is still pending approval. Beneficiaries and providers will receive advance notice prior to implementation.

Elimination of Specific Medi-Cal Benefits TO BE IMPLEMENTED IN OCT/NOV

- Elimination of Medi-Cal coverage for over- the-counter cough and cold medicine and nutritional supplements (e.g., Ensure) except for tube feeding.
- Target implementation date is unclear at this time.

Elimination of Medi-Cal Adult Day Health Care Services

The California Dept. of Health Care Services has obtained federal approval to eliminate Adult Day Health Care Services as a Medi-Cal covered benefit.

- Implementation has been set for December 1, 2011.
- The California Dept. of Health Care Services has developed an ADHC transition plan to help ADHC participants access alternative community based services to help them remain in the community and prevent institutionalization.
- In Los Angeles County, 22,000 ADHC participants will be affected.
- The ADHC transition plan calls for enrolling ADHC participants into Medi-Cal health plans in October 2011. The Medi-Cal plans will have a 45 day period to evaluate these persons to provide appropriate care coordination and care management services.