

SHD Paraphrased Regulations - Medi-Cal

585 Managed Care Two Plan

585-1

The Two-Plan Model Managed Care Program exists, in the counties of Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. (§53800(a))

Each plan in such a designated region shall, in pertinent part:

1. Agree to provide or arrange for the provision of, to the extent allowed by federal and state law, the scope of Medi-Cal program benefits set forth by contract to eligible beneficiaries who select or are assigned to the plan.
2. Provide readily available and accessible health care services and utilize preventive health care programs.
3. Case manage members' utilization of health care services.
4. Inform eligible beneficiaries about nonmedical transportation services that may be available under the Medi-Cal program, including the conditions under which such services will be provided by the plan, and how to request those services which the plan opts to provide.

(§53840(a))

585-2

In those counties which have adopted the Two-Plan Model:

- (a) Enrollment in plans shall be mandatory for eligible beneficiaries who meet all of the following criteria:
 - (1) Are eligible to receive Medi-Cal services that are not limited in scope.
 - (2) Have been determined to have an SOC equal to zero.
 - (3) Do not meet the criteria for selecting an alternative to plan enrollment, specified in §53887.
 - (4) Are eligible for either of the following:
 - (A) Programs linked to the Aid to Families with Dependent Children (Aid to Families with Dependent Children) program, as described in §1931 of the Social Security Act (42 United States Code §1396) as amended by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996; or
 - (B) The Medically Indigent program for children under age 21, as specified in §50251(a).

(§53845(a))

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CDHS or the Health Care Options Program shall mail an enrollment form and plan information to each eligible beneficiary described in §53845(a) who does not attend a health care options presentation. The mailing shall include health care options information and instructions to enroll in a plan within thirty days of the postmark date on the mailing envelope. At a minimum, the mailing shall include instructions on how to enroll, how to request an exemption from mandatory enrollment for medical or nonmedical reasons, and how to request a medical exemption certification form. (§53882(c))

Each eligible beneficiary described in §53845(a) shall select a plan within thirty days of receipt of an enrollment form unless a request for an exemption to plan enrollment is submitted to the Health Care Options Program within 30 days of receipt as prescribed in §53887(b), or within thirty days of the postmark date of the health care options information if mailed.

(1) In the event the eligible beneficiary does not select a plan within thirty days, the Health Care Options Program shall assign the eligible beneficiary to a plan, in accord with §53883.

(§53882(d))

585-2B

State regulations regarding the Two-Plan model provide:

- (a) The Health Care Options Program shall assign an eligible beneficiary to a plan within a designated region, from which to receive health care services, in the following situations:
- (1) In the event the eligible beneficiary does not select a plan within thirty days of receiving an enrollment form.
 - (2) In the event a member requests and is granted disenrollment from either plan within that region, but does not enroll in the competing plan, unless that member was granted approval by the department or its designee to receive health care services through the fee-for-service Medi-Cal program.
 - (3) In the event the competing plan is at capacity, the fee-for-service Medi-Cal option shall be made available.
- (b) In carrying out (a), the Health care Options Program shall comply with the assignment requirements contained in §53884.

(§53883)

585-2C

In assigning an eligible beneficiary to a plan, in the Two-Plan Model, the Health Care Options Program shall consider the Plan's ability to render linguistically appropriate services and the eligible beneficiary's need for those services, if made known to the Program. (§53884(b)(3))

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In Two-Plan Model counties:

(b) Enrollment in a plan shall be voluntary for eligible beneficiaries who meet all of the following criteria:

(1) Are eligible to receive Medi-Cal services that are not limited in scope.

(2) Have been determined to have an SOC equal to zero.

and

(3) Are eligible for any of the following:

(A) The federal Supplemental Security Income program for the Aged, Blind, and Disabled.

(B) The Medically Indigent program for pregnant women, as specified in §50251(b)(3).

(C) The Foster Care Program as described in W&IC §11400 et seq.

(D) The Adoption Assistance Program as described in W&IC §16115 et seq.

(§53845)

585-4A

In a Two-Plan Model, certain eligible beneficiaries may receive fee-for-service Medi-Cal. State regulations provide that:

An eligible beneficiary meeting the criteria specified in §53845(a), who satisfies the requirements in (1) or (2) below, may request fee for service Medi-Cal for up to 12 months as an alternative to plan enrollment by submitting a request for exemption from plan enrollment to the Health Care Options Program as specified in (b) below.

(1) An eligible beneficiary who is an American Indian as specified in §55100(i), a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from an Indian Health Service facility for care on a fee-for-service basis.

(2) An eligible beneficiary who is receiving fee-for-service Medi-Cal treatment or services for a complex medical condition, from a physician, a certified nurse midwife, or a licensed midwife who is participating in the Medi-Cal program but is not a contracting provider of either plan in the eligible beneficiary's county of residence, may request a medical exemption to continue fee-for-service Medi-Cal for purposes of continuity of care.

(A) For purposes of this section, conditions meeting the criteria for a complex

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medical condition include, and are similar to, the following.

An eligible beneficiary:

1. Is pregnant.
2. Is under evaluation for the need for an organ transplant; has been approved for and is awaiting an organ transplant; or has received a transplant and is currently either immediately postoperative or exhibiting significant medical problems related to the transplant. Beneficiaries who are medically stable on post-transplant therapy are not eligible for exemption under this section.
3. Is receiving chronic renal dialysis treatment.
4. Has tested positive for HIV or has received a diagnosis of acquired immune deficiency syndrome (AIDS).
5. Has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer that will continue for up to 12 months or has been approved for such therapy.
6. Has been approved for a major surgical procedure by the Medi-Cal fee-for-service program and is awaiting surgery or is immediately postoperative.
7. Has a complex neurological disorder, such as multiple sclerosis, a complex hematological disorder, such as hemophilia or sickle cell diseases, or a complex and/or progressive disorder not covered in 1. through 6. above, such as cardiomyopathy or amyotrophic lateral sclerosis, that requires ongoing medical supervision and/or has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be interrupted.
8. Is enrolled in a Medi-Cal waiver program that allows the individual to receive sub-acute, acute, intermediate or skilled nursing care at home rather than in a sub-acute care facility, an acute care hospital, an intermediate care facility or a skilled nursing facility.
9. Is participating in a pilot project organized and operated pursuant to §§14087.3, 14094.3, or 14490 of the Welfare and Institutions Code.

(§53887(a), effective December 19, 2000)

585-4B

A request for exemption from plan enrollment (in a Two-Plan Model) based on complex medical conditions shall not be approved for an eligible beneficiary who has:

1. Been a member of either plan on a combined basis for more than 90 calendar days.
2. A current Medi-Cal provider who is contracting with either plan.

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3. Begun or was scheduled to begin treatment after the date of plan enrollment.

(§53887(a)(2)(B), effective December 19, 2000)

585-6

In the Two-Plan Model:

- (a) The Health Care Options Program shall use a combined enrollment/disenrollment form in operating the Health Care Options Program. This form shall be made available at the health care options presentation and at designated sites. The form shall be mailed to a beneficiary within three working days of receiving a telephone or written request for a form.
- (b) Plans shall make the form available at the member services departments and shall mail the forms to the beneficiary within three working days of receiving a telephone or written request for a form.

(§53888 as modified effective December 19, 2000)

585-7

In assigning an eligible beneficiary to a plan, in the Two-Plan Model, the Health Care Options Program shall consider, among a number of criteria, that there is a preference for placing family members in the same plan. (§53884(b)(4))

585-8

State regulations provide that:

- (a) Each plan (in a Two Plan model) shall ensure that primary health care services provided through the plan are no more than 30 minutes travel time or ten (10) miles travel distance from each member's place of residence, unless the department has approved an alternative time and distance standard.
- (b) An eligible beneficiary may voluntarily choose to receive services from a plan service site with a travel time or distance that exceeds the requirements in subsection (a).

(§53885)

585-9

Except for pregnancy, any eligible beneficiary in a Two-Plan Model granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and begin receiving care from a plan provider without harmful medical effects, as determined by the beneficiary's treating physician up to 12 months from the date the medical exemption is first approved by the Health Care Options Program. A beneficiary granted a medical exemption due to pregnancy may remain with the fee-for-service Medi-Cal provider through delivery and the end of the month in which 90 days post-partum occurs.

Any extension to the 12-month medical exemption time limit shall be requested through

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the Health Care Options Program no earlier than 11 months after the starting date of the exemption currently in effect. The Health Care Options Program shall notify the beneficiary 45 days before the expiration of an approved medical exemption and will inform the beneficiary how to request an extension. An extension to the medical exemption shall be approved if the eligible beneficiary continues to meet the requirements of subsection (a)(2).

(§53887(a)(3) and (4), effective December 19, 2000)

585-10

Exemption from plan enrollment or extension (in the Two-Plan Model) of an approved exemption due to a complex medical condition shall be requested on the "Request for Medical Exemption from Plan Enrollment" form (HCO Form 7101, June 2000). Exemption from plan enrollment or extension of an approved exemption due to a beneficiary's enrollment in a Medi-Cal waiver program, as specified, or a beneficiary's acceptance for care at an Indian Health Service facility, shall be requested on the "Request for Non-Medical Exemption from Plan Enrollment" form (HCO Form 7102, October 2000). The completed request for exemption shall be submitted by mail or fax to the Health Care Options Program by the Medi-Cal fee-for-service provider or the Indian Health Service facility treating the beneficiary. Request for exemption from plan enrollment or extension of an approved exemption shall not be submitted by the plan.

(§53887(b), effective December 19, 2000)

585-11

In the Two-Plan Model, the Health Care Options Program shall accept and process all completed enrollment and disenrollment requests, including expedited disenrollment requests, from eligible beneficiaries within two working days of receipt if such requests meet the conditions for plan disenrollment specified in §53891.

Approval of enrollment and disenrollment requests is conditioned upon receipt of a fully completed enrollment/disenrollment form and all required supporting documentation.

The Health Care Options Program shall notify beneficiaries in writing of the approval or disapproval of enrollment and disenrollment requests, including expedited disenrollment requests, within seven working days of receipt of the request. This notice shall include the effective date of the enrollment and/or disenrollment, as specified in subsection (h) below.

(§53889(e), (f) and (g), effective December 19, 2000)

585-12

Notwithstanding this article or section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994 except for contracts in county organized health systems.

Notwithstanding any other provisions of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but not enrolled in a pilot project shall continue to submit billing for CCS services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed

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care contracts.

For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 123840 of the Health and Safety Code.

(Welfare and Institutions Code (W&IC) §§14094.3(a), (b) and (e))

585-13

Services (in the California Children's Services Act) mean any or all of the following:

- Expert diagnosis
- Medical treatment
- Surgical treatment
- Hospital care
- Physical therapy
- Occupational therapy
- Special treatment
- Materials
- Appliances and their upkeep, maintenance, care and transportation
- Maintenance, transportation or care incidental to any other services

(Health and Safety Code §123840)

585-14

Each plan shall provide or arrange to provide for all Medi-Cal covered services, unless excluded under the contract, in accordance with the terms and provisions of the contract between the plan and the Department. The scope of services shall include preventive services, case management and emergency care. Each plan shall refer and coordinate for those services that are excluded under the contract, whether or not covered under Medi-Cal, pursuant to the requirements of the contract between the plan and the DHS. (§53851)