Medi-Cal Program Overview and New Provider Training

About Medi-Cal Managed Care

Medi-Cal Managed Care plans contract for health care services through established networks of organized systems of care, which emphasize primary and preventative care. Managed Care plans are a cost-effective use of the health care resources that improve health care access and assure quality of care.

Medi-Cal Managed Care plans provide high quality, accessible, and cost-effective health care through managed care delivery systems.

Members select a PCP who is responsible for members' primary and preventative care and arrange and coordinate all other aspects of their health care.

To view a list of contracted Managed Medi-Cal plans, please see the Active Contract List (ACL) located on the Managed Care Department's SharePoint site.

For more information about a specific contracted Managed Medi-Cal plan, please contact the Managed Care Department by sending your request to: managedcare@stanfordhealthcare.org

Managed Medi-Cal plans provide training programs specific to their plan. To view a provider training program specific to a contracted Managed Medi-Cal plan, please send your request to: managedcare@stanfordhealthcare.org and we will send you a current link to the Managed Medi-Cal plan's information.

Medi-Cal Managed Care Policies and Procedures

Balance Billing is Prohibited

Providers who offer services or supplies to Medi-Cal Members are prohibited from balance billing the member for any cost-sharing not related to the member's share of cost. This includes deductibles, co-insurance, co-payments and non-covered charges.

Medi-Cal State Fair Hearing Process

Medi-Cal members or their authorized representatives have the option of filing a State Hearing with the Department of Social Services if they disagree with a Medi-Cal Managed Care Plan's decision regarding Denial of a requested service. A State Hearing is an appeal with an Administrative Law Judge from the Department of Social Services. Expedited State Hearings may also be requested.

Requests for State Hearings can be submitted by telephone at 800-952-6253 or in writing to:

California Department of Social Services
State Hearing Division
Post Office Box 944243, Mail Station 9-17-37 Sacramento, CA 94244-2430
Fax: (916) 651-5210 or (916) 651-2789
Online: http://www.dss.cahwnet.gov/shd/PG1110.htm

A Medi-Cal member must first exhaust a Medi-Cal Managed Care plan's appeals process prior to proceeding with a State Hearing. Requests for State Hearings must be submitted within 120 calendar days of an action with which the member is dissatisfied. For standard State Hearings, the State will make a decision within 90 days of the request. For expedited State Hearings, the State will make a decision within 72 hours.

Member Rights

Members have the following rights per DHCS:

1. To be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.
2. To be provided with information about the plan and its services, including Covered Services.
3. To be able to choose a Primary Care Provider within the plan's network.
4. To participate in decision making regarding their own health care, including the right to refuse treatment.
5. To voice grievances, either verbally or in writing, about the organization or the care received.
6. To receive oral interpretation services for their language. This includes communication access to SPD beneficiaries in alternative formats or through other methods that ensure communication, including assistive listening systems, sign language methods that ensure communication, including assistive listening systems, sign language interpreters captioning, written communication, plain language or written translations and oral interpreters, including for those who are limited English proficient, or non-English speaking.
7. To formulate advance directives.

8. To have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the plan's network pursuant to the Federal law.
9. To request a State Medi-Cal state hearing, including information on the circumstances under which an expedited state hearing is possible.
10. To have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.
11. To access Minor Consent Services.
12. To receive written Member informing materials in an alternative format (including Braille, large size print, or audio format) upon request and in a timely fashion appropriate for the format being requested.
13. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
14. To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
15. Freedom to exercise these rights without adversely affecting how they are treated by the plan, providers, or the State.
16. To receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and 164.526.

Serving Seniors and Persons with Disabilities

What is defined as a disability and/or functional limitation?

- Disability may be physical, cognitive, mental, sensory, emotional, developmental or some combination of these. A disability may be present from birth or occur during a person's lifetime
- Functional limitations are difficulties completing a variety of basic or complex activities that are associated with a health problem. For example, vision loss, hearing loss, and inability to move one's legs are functional limitations.

How SPD members may have barriers to access and care:

Physical Access – the ability to get into a building or the area where healthcare services are offered. Areas of the office to consider building entrances, restrooms, parking lots, door, doorways and hallways, waiting areas and reception desk, drinking fountains and water coolers, elevators, posted signs, telephones, forms and documents

Communication Access- the ability of the provider and member to communicate and understand the information asked and directions given. Methods of communication: Qualified ASL Interpreters, Relay Service, Assistive listening device, Text message, Email, Captioning, Qualified readers, Audio recordings, Braille, Large print

Cultural Competency

Organizational cultural competency is the ability of health care organizations and individuals to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Cultural competency requires the recognition and integration by the health care professionals of health plan members' behaviors, values, norms, practices, attitudes, and beliefs about disease causation and prevention into health care services provided.

Being culturally competent means improved communication between providers and health plan members who may be from different ethnic and cultural backgrounds. Culturally competent care ultimately leads to improved access and health outcomes.

Member Complaint Requirements

Providers must have a process for documenting and submitting to the managed care plan any complaint submitted by members in their office(s).

Timeframes for filing & resolving complaints	
Timeframe for filing (from date of denial, service, incident or bill)	
Type of complaint	**Timeframe**
Appeal	60 calendar days
Grievance	No time limit
Timeframe for processing	
Type	**Grievance and appeals processing**
Standard	30 calendar days
Expedited	72 hours

Timely Access Requirements

Providers must be aware of the following timely access standard as defined by the Department of Managed Health Care (DMHC).

Primary Care Providers

Appointment type or service	Criteria	Standard access timeframe
Urgent appointment	Immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation.	Appointment offered within 48 hours of request.
Non-urgent/routine appointment	Immediate care is not needed. For example, this appointment type could be related to new health issues or a follow-up for existing health problems.	Appointment offered within 10 business days of request.

Specialists

Appointment type or service	Criteria	Standard access timeframe
Urgent appointment	Immediate care is not needed for stabilization, but if not addressed in a timely way could escalate to an emergency situation.	Appointment offered within 96 hours of request.
Non-urgent/routine appointment	Immediate care is not needed. For example, this appointment type could be related to new health issues or a follow-up for existing health problems.	Appointment offered within 15 business days of request.

Obstetrics and Gynecology

Appointment type or service	Criteria	Standard access timeframe
First prenatal visit	Immediate care is not needed.	Appointment offered within 2 weeks of request.