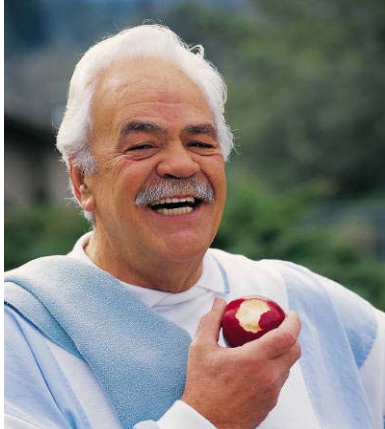




Consumer Center for Health Education and Advocacy

Annual Report
July 1, 2007 – June 30, 2008



***Helping low-income individuals
and families access health care***

TABLE OF CONTENTS

The Consumer Center's Work	1
Data Analysis	3
Barriers to Care and Systemic Issues	12
▪ Medi-Cal	12
▪ County Medical Services	24
▪ Mental Health	31
▪ Medicare Part D	36
▪ The Uninsured	39
Outreach	42
Case Summaries	48

THE CONSUMER CENTER'S WORK

Who We Are

An Informed, Empowered Consumer is a Healthier Consumer. The Consumer Center for Health Education and Advocacy (Consumer Center) was founded in 1999 to help health care consumers navigate San Diego County's complicated physical health and mental health systems of care. The concept was simple: educate and empower consumers so that they can become and remain healthy.

We advocate for the whole person. By providing quality health education and advocacy services, the Consumer Center offers a "no wrong door" approach that recognizes the importance of accessing and coordinating care. Our services are available to applicants or beneficiaries of managed care or fee-for-service Medi-Cal, Healthy Families, county-funded mental health or County Medical Services and/or related county-funded physical and mental health providers. Clients, regardless of their issues, receive culturally and linguistically appropriate services in a professional and respectful manner.

The Consumer Center is an organization that: *"Respects, promotes and protects the rights and responsibilities of consumers of health services independent of the control of government and other parties of influence."*

Part of our success is the result of collaborations, which allow us to maximize our effectiveness. We are a member of the Health Consumer Alliance (HCA), an innovative partnership between community-based legal services agencies and statewide legal support centers. HCA teaches individuals and community organizations how to access the health care

system and identifies the underlying problems that make it so difficult for people to find the care they need. Brochures and issue briefs are available on the website, www.healthconsumer.org.

The Consumer Center receives funding from the County of San Diego, The California Endowment, The California Wellness Foundation, the Office of the Patient Advocate, the Alliance Healthcare Foundation, Scripps Health Community Benefit Fund and the Legal Aid Society of San Diego, Inc.

Our Goals

- Improve access to quality health care
- Empower consumers
- Protect consumer and patients' rights



Ways We Help

We help people who are:

- Told they do not qualify for a program or service
- Denied care or services
- Having problems getting medications
- Discharged from care they think is still necessary
- Told their services will be terminated or reduced
- Dissatisfied with health services
- Interested in being actively involved in planning their care and treatment
- Filing a grievance or appeal concerning a specialty mental health service



Bilingual advocates are available Monday through Friday between 9 a.m. and 5 p.m. Advocates are also available to meet with clients on a walk-in basis during regular office hours at our downtown office located at 1475 Sixth Avenue, 4th Floor, San Diego, CA 92101. The toll-free hotline (1.877.734.3258) operates seven days a week, 24 hours per day. Messages can be left on our easy-to-use voice mail system and client calls are returned within one business day.

Staff and volunteers. The core and strength of our program are the Consumer Center's advocates. They identify the issues clients face and work toward the best resolution. The advocates' persistence, skill and empathy improve the quality of life for those they represent. In some cases, their actions even make the difference between life and death.

The Consumer Center also utilizes volunteers to help low-income clients access health care. During this contract year, volunteers contributed 917 hours averaging 18 hours per week. Many of the volunteers are mental health or physical health consumers they provide invaluable support to our program.

Our Services

Individual advocacy

The Consumer Center staff assists clients in getting the care they need by providing advice, referring to appropriate programs and services and empowering consumers. In more complicated cases, staff negotiate with decision makers including county staff, providers and, when necessary, represent clients at hearings.

Consumer education and outreach

Staff regularly participate in health fairs throughout the county and provide trainings to community-based organizations, client groups and family support groups interested in

learning about our services or about the availability of health and human service programs. Educational materials in the Medi-Cal threshold languages, are distributed.

Advocate for system-wide change

The Consumer Center partners with county and state agencies, community-based organizations, and client groups to improve the systems of care. We also work with advocates statewide and identify those issues that impact our consumers so that various issues can be resolved statewide for all consumers..

Access to care for all health care consumers

Our ultimate goal is to ensure that all eligible San Diego County consumers receive the benefits and services they need to manage their physical and mental health conditions. Areas identified to ensure access include:

- **Coverage.** Increase the number of people enrolled in public programs and expand the services covered under those programs.
- **Consumer Participation.** Promote greater consumer participation in the individual physical and mental health care decisions, as well as in the various dialogues leading to systemic change.
- **Cultural Competence.** Ensure that services are provided in a culturally and linguistically appropriate manner to the diverse populations throughout the county.

DATA ANALYSIS

Data Collection



The Consumer Center utilizes two data systems that allow staff to capture information about client problems, monitor case progress and spot systemic problems. Initially, staff enter client information into the Kemps system, including case notes and demographic data. The information is then exported into the Health Consumer Alliance (HCA) database, which is designed to capture specific information related to health coverage, access issues and outcomes. These two systems store information that become the basis for reports used to inform management, the community and our funding sources about health care trends and lay the foundation for our advocacy agenda.

Services Provided to Individuals

At the heart of the Consumer Center’s mission is our determination to help individuals access health care. The following is a brief summary of our work with consumers.

Case Volume

The Consumer Center has staff working under a variety of funding sources and projects. Through these combined efforts, the Consumer Center closed a total of 3,221 cases and helped 3,624 individuals between July 1, 2007 and June 30, 2008. During this one-year time period, we assisted 3,006 consumers with non-Medicare part D issues and closed 2,628 cases. Staff is presently handling 585 cases

Range Of Services: Case Complexity

The Consumer Center helps consumers in various ways, including: counsel and advice, negotiations with county and providers staff as well as representation in a formal appeal process. As the county-designated Title 9 Patient Advocate for outpatient mental health services, the Consumer Center also helps clients resolve grievances and appeals. Cases are classified as follows:

Advice. Legal education and counseling is a significant part of our work and empowers consumers to understand the health care system and advocate further on their own. Advocates answer consumer questions, assess consumers' eligibility for the numerous public benefit programs with their various and complex rules and educate consumers about their rights and options. The Consumer Center also advises eligible consumers on how to apply for health coverage. Just about one-third (35%) (of our non- Medicare Part D consumers) were assisted through this form of counseling. Compared to the prior year, advocates resolved slightly fewer cases with advice and more through negotiations in this report period (35% vs. 38% advice, 53% vs. 52% negotiation, 10% vs. 9% hearings).

Negotiation to solve problems. If the consumer was incorrectly denied eligibility or services, if coverage was terminated, if the consumer has a concern with an agency decision or the services s/he received, or if the consumer cannot access services, the advocate will usually first attempt to negotiate with agency staff or providers to assess the problem and try to resolve it. Advocates contact the appropriate decision maker and research the rules to establish a basis for their argument. Usually this involves contact with a county eligibility worker. Negotiations are also an integral part of the county's Beneficiary Problem Resolution Process for persons with mental health disabilities.

During the past year, the Consumer Center resolved 53%, (of non-Medicare Part D cases), through this form of advocacy. This data indicates that a significant portion of our work involved resolution of problems through dialogue with decision makers, an approach that resolved many consumers' problems quickly and efficiently and at the lowest possible level.

Representation at the hearing level. If the problem cannot be resolved through agency contacts and whenever the consumer has a right to appeal, the advocate

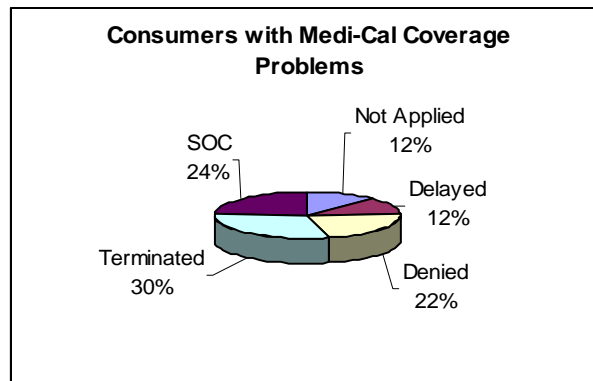
advises the consumer on the appeal or grievance process. Although many of these cases are resolved thru negotiation with the worker at the Family Resource Center, some (10%) (of the non-Medicare Part D cases proceed to be scheduled for a hearing). In addition, some consumers have initial contact with us at the time of their scheduled Medi-Cal hearing as a result of our special outreach project at the administrative hearing office (Viewridge).

These hearing level cases are resolved through negotiations with the county appeals workers (58%) of all our hearing level cases or decided by an Administrative Law Judge (ALJ) (42% of total). Our presence at the hearing office during scheduled hearings allows us to address a wider range of issues and ensure that consumers get help with this effective but more complex process for problem resolution. CMS cases are not subject to negotiation but must go directly to hearing due to internal county procedure.

Access to Health Coverage: Eligibility Issues

The primary reason people contact our office is to seek help in getting or keeping no-cost or low-cost health coverage. Of the cases handled in the reporting period, (other than our Medicare cases), 66% had eligibility issues. Of the people with these eligibility issues, we assisted 77% with Medi-Cal, 20% with County Medical Services (CMS) and/or the Courage Initiative and almost 3% with the Healthy Families Program (HFP). The remaining had eligibility issues related to In-Home Supportive Services, private insurance and other programs.

Medi-Cal. Of those consumers with Medi-Cal coverage problems, 11% had not applied and may not have known they were eligible, 11% had a delay in the processing of their applications, 20% had an application denied and 27% were terminated or were about to be terminated from Medi-Cal. Another 22% had a problem with a share-of-cost¹. The remaining almost 9% had other eligibility problems.

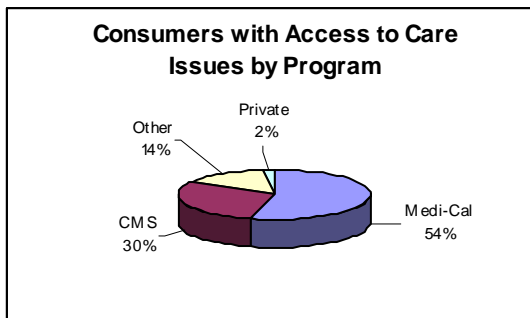


Over two-thirds (69%) of those helped had received a negative decision from the county – either a denial, termination or a decision that they would have to pay an amount for their medical care. Thus, a large part of our work involved resolutions of negative county actions¹ and resulted in expedited enrollment or continued coverage for consumers, many with critical health care needs.

County Medical Services (CMS). There was a decrease in our CMS cases relative to the number in the last annual report period. However, we still handled a higher number of CMS cases than in the years prior to major changes in the program, including a more difficult process for requesting coverage for emergency room services. Almost half of our CMS eligibility cases (44%) involved a CMS denial. The next largest group was those who had not applied (29%), followed by those who had a delay in getting a CMS decision (13%). Since CMS is generally for a closed period of time, there were very few terminations (3%). Callers who only had questions about the new lien form requirement and were willing to sign the form so that this did not become a barrier to their eligibility were coded under a separate "services issues" data section and represented only a small portion of our CMS cases.

Access to Care

Ten percent of the cases handled by the Consumer Center (other than Medicare Part D cases) involved problems with access to care. These included cases where services were denied, delayed or unavailable. Of the consumers we helped with either physical health or mental health access problems, 37% had Medi-Cal fee-for-service, 17% were enrolled in Medi-Cal managed care plans, 30% were CMS eligible, and 2% had private health insurance. Advocates helped 50% more people with CMS access issues than they did in the previous year even though the previous year had seen a one-third increase from the prior year.



¹ A share-of-cost is an amount a Medi-Cal beneficiary has to pay or obligate for their medical care before Medi-Cal pays the rest of their bills for that month.

² Or an explanation of ways to deal with them in the case of correct but high shares-of-cost.

In reviewing this data, it is important to consider that the proportion of clients who contact us with an access to care problem with a particular program depends not only on the actual accessibility of that program but also on the:

- proportion enrolled in each program,
- the medical needs of those enrolled, and
- the extent to which consumers are given Consumer Center contact information

The number of people enrolled in different programs ranges widely. There are over 300,000 San Diego County residents enrolled in Medi-Cal. Although slightly more than half are in health plans, those in fee-for-service Medi-Cal are more likely to be aged or disabled. There were almost 18,000 unduplicated individuals who received CMS in FY08.

The dissemination of contact information about the Consumer Center is critical to our work. Just over a year ago, the county agreed to provide the Consumer Center contact information on notices denying services under CMS. The increase in our CMS access cases may be due to the information the county now gives about the Consumer Center to those who are denied CMS services.

Billing Issues

Perhaps for the same reason, there was a 67% increase in CMS billing cases. These represented 22% of our billing cases. When all programs are included, the data shows that, about 15% of our cases involved billing issues. Of the consumers helped with billing issues, 38% had coverage under Medi-Cal, 2% had private health insurance and 36% had no health coverage when they called about their bill.

Whenever possible, advocates help consumers enroll in health insurance programs to cover the bill. When it is not possible because the consumer is ineligible or the bill is too old, consumers with hospital bills are informed about patient assistance programs.

Quality or Appropriateness of Care Issues

Nearly 4% of the non-Medicare cases the Consumer Center staff opened in FY08 involved callers who were concerned about the quality or appropriateness of their care or reported concerns with customer service. Of these, 82% called concerning quality or appropriateness of their mental health care and/or customer service problems with their mental health provider or agency.

Mental Health

Our advocates opened 155 mental health cases. Similar to the past years, 92% of the mental health cases involved service problems, for example, unprofessional behavior, medication-related problems and violations of confidentiality.

An additional 602 persons with mental disabilities were helped by the Consumer Center with other health care related issues. Of these, 63% concerned Medicare problems, 25% concerned Medi-Cal and the remaining problems were with other health programs. Other LASSD teams also helped 1,085 mental health clients with Family, Housing, Consumer Law problems and SSI Benefits.

Working with LASSD SSI Advocacy Program, the Consumer Center helped mental health clients obtain SSI benefits. The SSI team assisted these clients through one of three ways:

- Making an appointment for those on General Relief at one of the Family Resource Centers
- Meeting eligible patients on-site at the Scripps Mercy Behavioral Health Unit
- Working with a clubhouse peer advocate to complete the initial application

In addition, all eligible clients were provided with representation at Social Security Administration appeals. Once SSI is approved, Medi-Cal benefits can be granted retroactively. Whether in Medi-Cal fee-for-service or managed care, these (many who were chronically homeless clients) now have access to community-based primary care and prevention services.

Client Demographic Data

The consumers we assisted this year reflected the geographic, ethnic and racial diversity of the county. Services were provided to clients in the six County of San Diego Health and Human Services Agency (HHS) regions as follows:

- 29% Central
- 23% South
- 13% East
- 11% North Inland
- 11% North Coastal
- 9% North Central

This regional breakdown closely represents the low-income population served by the public health systems of care. In addition, more than one-fifth of this year's closed cases came from five zip codes, that is, those representing City Heights (92105) and the South

Bay (91950, 91911, 91910 and 92154). The number of clients served from these communities correlate with the highest concentration of Medi-Cal beneficiaries. When comparing our Medi-Cal clients to the San Diego County Medi-Cal clients' racial and ethnicity, the percentages were consistent with the county's diversity. The following table lists the consumers we served this fiscal year.

Consumer Center Medi-Cal Consumers FY 08*		
	Number	Percentage
Hispanic	1217	46%
White	1000	38%
Black	179	7%
Asian/Pacific Islander	164	6%
Other	55	2%
Native American	13	0%
TOTAL	2628	100%
*Note: not all clients provided this information		

Among the consumers who sought our help and gave us demographic information, 56% were female and 44% were male. In addition:

Age Range	% of Clients
0-5	9%
6-18	10%
19-24	6%
25-34	8%
35-54	31%
55-64	16%
65 +	20%

This data is consistent with past demographic information. Women make the majority of health care decisions for their families and the greatest number of individuals in need of health care information and assistance are adults.

Satisfaction Survey Results

Consumer satisfaction surveys

All consumers as soon as their case closed, regardless of whether the service provided related to Medi-Cal, Medicare, mental health or other health programs, were mailed a four question Consumer Satisfaction Survey. In FY 08, 2,489 surveys were mailed. As a result of language-specific surveys nearly one out of five were returned. As in previous years, all county contract outcome objectives were either met or exceeded. When asked

about our services, for example, 92% of the clients who returned and responded to this question rated us as “good” or “very good.”

For consumers who participated in our educational programs and returned evaluations, the contract objective was for 85% to report an increased knowledge about their rights to physical and mental health care. This year, 88% of those who returned the evaluations reported increased knowledge. The second outcome objective was that 25% of consumers who responded to the survey report an increased knowledge and confidence in advocating for themselves. The 12-month average was considerably higher, that is, 89% increased their knowledge and confidence to self advocate.

Outreach program evaluations

Community-based organization (CBO) staff also reported very high levels of satisfaction with the trainings. The outcome objective was for 85% of CBO staff who participated in educational presentations to show increased knowledge about the physical and mental health benefits for which consumers are eligible. Similar to previous years, 94% of staff who responded to the survey reported increased knowledge.

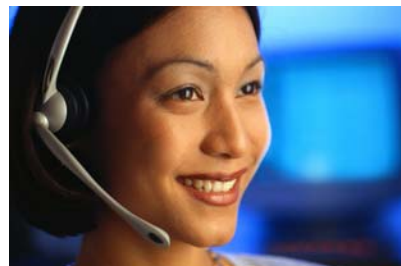
In addition to the quantitative responses described above, we were delighted to read handwritten comments received from the CBO staff who participated in the trainings. The comments below, we believe, are reflective of the quality and impact of our educational presentations.

- “Great presentation. Very engaging and informative.”
- “Very interesting and inspirational.”
- “Very stimulating talk on health care and potential solutions.”
- “Amazing, passionate and inspiring.”
- “Very informative. Highlighted key services for our target population.”

The last contract objective reflects the outcome of annual survey of HHSA Program Managers, HHSA personnel and related contract staff who work with the Consumer Center. The objective is 75% of those who are surveyed and responded report that our services are good or very good. In September 2007, surveys were mailed to 163 individuals. Of those who responded, 95% rated are services as good or very good. We believe our partnership with the county is reflected in this quantitative data.

Referral Data

Our advocates provided referrals to callers who requested assistance with problems that are either outside our scope of service or did not meet our eligibility criteria. As a result, more than 750 referrals were made in FY 08 to various agencies, health plans,



government entities and information and referral lines. Once the referral was given, advocates entered the information into the Kemps database under "Other Services" (formerly coded as "Other Matter").

To find the most appropriate referral, advocates utilized a variety of online resources and written documents including the Consumer Center's Resource Manual and the Operational Policies and Procedures Manual. More often, advocates used health-related Internet sites including 2-1-1, the County of San Diego and the Health Consumer Alliance. The majority of referrals were to the LASSD's toll-free number for assistance with non-health care related issues, 2-1-1 San Diego, the San Diego Lawyer Referral Line or a Family Resource Center. For questions about Medicare eligibility or benefits, callers were referred to the Health Insurance Counseling Assistance Program (HICAP) and/or were given Medicare's website and toll-free number. Callers also were provided information about CANHR, a long-term care advocacy organization, for questions or concerns about nursing homes.

Among the referrals provided to persons with psychiatric disabilities and/or family members, our advocates offered phone numbers, hours of operation and addresses to the contracted clubhouses and crisis walk-in clinics as well as the client-operated Warm Line and San Diego Access and Crisis Line. Calls asking for help with payees or conservators were referred to the Public Defender's office, NAMI and the county payee program. For issues concerning the augmented Board & Care homes, Short Term Acute Residential Treatment (crisis centers) or Institutes for Mental Disease, advocates either placed a three-way call or referred the caller directly to the University of San Diego Patient Advocacy Program (USD). The caller's information subsequently was placed on the USD Referral Log. In the case of complaints involving non-augmented Board and Cares homes, callers were referred to Community Care Licensing.

In addition to providing referrals and other resources, advocates mailed callers language-specific informational material, flyers and brochures and directed them to the Health Consumer Alliance's webpage.

BARRIERS TO CARE AND SYSTEMIC ISSUES

Medi-Cal Enrollment and Retention

1. General Background and Barriers to Access

Medi-Cal provides free or low-cost health coverage to eligible low-income children and their parents, pregnant women, seniors and persons with disabilities who meet the program requirements. Income and resource limits and other rules vary among the different Medi-Cal programs. Medi-Cal provides a broad scope of medical services to legal residents as well as emergency and prenatal care to undocumented residents who meet the other eligibility criteria for the program. In the last year, there have been minimal improvements to the program and more barriers to enrollment.



Eligibility rule complexity. The Medi-Cal program does not have a single set of rules, but rather a complex array of rules that are different for different programs. The result is a confusing system composed of over 200 aid codes that make it difficult for workers to accurately determine eligibility and make it more difficult for consumers to obtain and retain coverage. In addition, misunderstandings about the rules on confidentiality and “coaching” can discourage others from providing assistance and can limit enrollment in programs that are difficult to understand.

New application forms. The state recently released a new joint application for children who apply for Medi-Cal and Healthy Families. Advocates had submitted extensive recommendations, many of which were accepted by the state. The new form is better organized, has less unnecessary language, a lower reading level, better information for those who are pregnant or disabled, and one less signature block.

Problems with the new state-operated computer system. In June 2006, the county implemented the new operating and data system called CalWIN, overseen by a statewide consortium. Although many of the initial problems were resolved, the change still prevents the county and stakeholders from getting certain useful management

reports to monitor progress with enrollment. The county indicates that these reports should be available in the next few months. In addition, since the program is run by a consortium, it is sometimes time consuming and difficult to get all affected counties to agree on changes that would improve enrollment in our county.

Reduced funding for outreach. The loss of significant state funding for outreach, education, retention and utilization forced agencies to terminate outreach workers who had helped enroll children and families in Medi-Cal and Healthy Families. We had worked closely with these staff to ensure access to these programs and miss this opportunity for continued collaboration. It also is unfortunate because the availability of extra staff had a positive impact on enrollment of eligible children and families.

Changes for hospital inpatients. Hospital patients face unique barriers since their medical conditions can compromise their ability to access documents and complete the application process in a timely manner. Many consumers must rely on hospital staff and county staff stationed at the hospital to make sure that an application is properly filed in the month of service. We have assisted many clients who were subject to unnecessary and erroneous denials resulting from a lack of adequate procedures, coordination, and outreach to help people in this position. A new IT system to track CMS cases improves coordination between these staff.



Maintaining Medi-Cal coverage can be challenging. Eligible consumers enrolled in Medi-Cal can have problems maintaining their coverage. The new CalWIN system has created additional problems with retention. The program will automatically terminate a beneficiary if the worker does not enter new information by a certain date. If the worker is behind in entering the information or fails to send a renewal packet in a timely manner, the beneficiary can be terminated even if she/he remains eligible and has submitted all the necessary information to renew the case. When this happens, consumer health advocates contact the worker or the supervisor and get the beneficiary reinstated.

Even before the new CalWIN system, our data showed that 40% of the beneficiaries who called the Consumer Center because they were about to be terminated were being terminated due to failure to provide forms or documents, not because they were no longer eligible for Medi-Cal. (See <http://healthconsumer.org/MediCalLostRpt.pdf>).

New documentation requirements. Medi-Cal applicants have always had to provide extensive documentation to establish income, resources, residency and immigration

status. Since May, 2008, citizens applying for a full scope of Medi-Cal services must also provide an original document or a copy certified by the issuing agency to establish citizenship and identity. Although states that have already implemented the new rules have seen a significant decline in Medicaid enrollment, it is too soon to assess the impact in California.

When applicants experience delays in getting needed documents, their access to needed health care is also delayed. Populations that are most vulnerable are: individuals with immediate medical needs, pregnant women needing coverage for labor and delivery, those who cannot easily access documents, and people who are homeless and vulnerable to losing track of their belongings. Additionally, these new rules also place a particular burden on those who were not born in California.² There are some legal protections: exceptions for certain populations County eligibility workers must provide additional outreach and assistance for vulnerable populations. The challenge is getting all stakeholders to work together to reduce the impact of these new rules.

2. Actions Taken to Improve Medi-Cal Enrollment and Retention

- **Advocated for individuals**

During the past 12 months, Consumer Center advocates assisted over 1,655 consumers with a variety of Medi-Cal eligibility issues. Our advocates try to resolve consumers' problems with the county eligibility workers, and if this is not possible, with the appropriate supervisors at the local Family Resource Centers. During these discussions, Consumer Center advocates remind county workers about complex Medi-Cal rules. When we find that a number of staff misunderstand or are unaware of a rule, we suggest that the county provide additional education to its staff.



When we cannot resolve consumers' concerns with Family Resource Center staff, we advise consumers to request an administrative hearing. With our assistance, more than half of the consumers we represented who requested a hearing had their issues successfully resolved with the county appeals workers prior to the hearing. Through one-on-one discussions and hearings, we are able to address important substantive issues and thus have an impact on those whom we do not directly represent.

The Consumer Center's Hearing Outreach Program (Viewridge) is an innovative approach to help people who are unaware of our services. We station specially-

² The county can perform a data match with the California Department of Vital Statistics for those who do not have the ability or funds to access the necessary documents.

trained staff at the hearing office to answer questions and represent clients who request our services and have problems getting or maintaining their Medi-Cal benefits.

- **Participated in stakeholder meetings**

We have attended multiple meetings where we updated stakeholders about new rules and developed approaches to enrollment and retention. In individual bimonthly meetings with county Medi-Cal policy staff, we identified procedural problems and developed approaches for addressing them. We increased the number of statewide meetings we attended with other advocates, staff from California counties and the state's Medi-Cal eligibility branch staff. In addition, we were pleased that the county followed our suggestion and reinstated some important stakeholder meetings critical to improving enrollment. We hope that more data will be available to these groups in the near future to improve enrollment.

- **Encouraged county to place the county's Medi-Cal program rules on the Internet**

For a number of years, the Consumer Center has asked the county to transfer their lengthy Medi-Cal Program Guide to the internet so that it could be easily accessed by advocates. We are pleased that this lengthy and important project will be completed soon.

- **Provided input and training on various new county procedures**

At the county's request, we provided specific recommendations for changes to new county Medi-Cal Program Guide materials. Our suggestions included technical changes to conform county language with state guidelines and rules as well as changes to improve the clarity of the instructions and substantive changes. We commented on the instructions for how to treat income when there is a married minor child, for putting children moving from Healthy Families to Medi-Cal into a presumptive eligibility aid code and on Medi-Cal eligibility for battered aliens and victims of trafficking.

In addition, we informed advocates and community stakeholders about the changes. We ensured that Certified Application Assistants and health plans knew about the change to a presumptive eligibility aid code since children placed into this aid code cannot maintain their enrollment in Medi-Cal managed care.

- **Encouraged a forum for discussion of coordination issues between Healthy Families and Medi-Cal**

The Healthy Families Program (HFP) provides low-cost coverage to eligible children and adolescents who are not eligible for free Medi-Cal. However, the HFP requires regular premium payments and does not provide as large a scope of services as does Medi-Cal. HCA advocates raised concerns at meetings between high level stakeholders about various coordination issues between the two programs, particularly the failure of the Healthy Families Program to evaluate for all Medi-Cal programs. As a consequence, regular conference calls have been scheduled between county representatives, advocates from various HCA funded groups, including the Consumer Center, the Department of Health Care Services and MRMIB staff who oversee the Healthy Families Program. Discussions are focused on various proposals to protect the rights to Medi-Cal especially for disabled children, pregnant teens and their babies.

- **Participated in state and local workgroups to comment on policies and develop training for health care and county workers related to new citizenship verification requirements.**

Because of the lengthy implementation process for the new citizenship verification rules, the Consumer Center had an invaluable opportunity to review and comment on policies before they were adopted. On the state level, we worked with other HCA advocates to provide comments on new state notices, posters, and forms and on the rules for the BCCTP Program (Breast and Cervical Cancer Treatment Program). Consumer Center



staff also drafted special notices for pregnant women who will need to know about their option to receive “limited Medi-Cal” to cover pre-natal care and labor and delivery even if they cannot submit their documents in time.

Locally, we participated in two workgroups dedicated to reducing negative impacts on San Diego consumers. One addressed general outreach and education. The other workgroup piloted procedures for staff at Federally Qualified Health Centers and Disproportionate Share hospitals to collect, verify, and forward documents to the county. Our approach involved extensive coordination with county staff to understand the new rules, review procedures, and share ideas about how best to implement these changes and train health care workers. We worked with County staff to develop a four-hour training unit consisting of a student manual, a power point, “cheat sheets,” and case studies.

We conducted three such trainings throughout San Diego County. Since participation by these clinic and hospital staff is purely voluntary, such trainings, followed up by open channels of communications, are critical to encouraging their involvement. The development of the training modules by the county coincided with the development of their new policies. As a result, while developing the training with them, we had a chance to review and comment on policies that were drafted and elevate concerns raised at the trainings to focus our advocacy on critical barriers and protections.

- **Effectively advocated for removal of barriers for pregnant women related to the new citizenship verification rules.**

We consistently raised concerns about the barriers the new citizenship verification requirements may pose for pregnant women. “Presumptive eligibility” under Medi-Cal allows women to fast-track onto Medi-Cal for a few months but only covers pre-natal care and is time limited. Regular Medi-Cal covers labor and delivery but requires citizenship and identity documentation. The county initially suggested that pregnant women unable to submit necessary documentation could specify that they were going to “stop making good faith efforts” to obtain the documentation and then they could be made eligible for “limited Medi-Cal” which would cover emergency care, pre-natal care, labor, and delivery without the need for such documentation. The problem with this approach, as we learned from the clinic staff, is that many women would be unwilling to make such a declaration, worried that they would be perceived as uncooperative.

After raising these concerns, the county adjusted their policy as follows: a) at any time, a pregnant woman who says she wants limited Medi-Cal can get it and b) the county will do affirmative outreach at the time of application and in the sixth month of pregnancy explaining this important option for all pregnant applicants.

The county is considering drafting written notices explaining these requirements and protections. We have provided suggestions for model language to be contained within these notices.

- **Effectively advocated for reducing harsh impact of retroactive implementation of new citizenship verification requirements.**

In mid May, 2008, San Diego County implemented the new citizenship verification requirements to apply to all those who applied on or after April 1, 2008. This retroactive implementation for those whose applications were still pending effectively denied many a determination within the requisite 45 day time frame (90 days for disabled applicants). We raised these concerns and even identified particular consumers whose access to necessary medical care was

being placed at risk due to these delays. Responding to our concerns, the county adopted an exception for individuals who stated that they had “immediate medical needs”. However, the county has not adopted a written notice informing applicants of this exception nor has the county required the workers to do affirmative outreach to this population.

3. Recommendations for Improving Medi-Cal Enrollment and Retention

We were pleased that the county has implemented a number of our past recommendations for action: initiating the process of placing Program Guide materials on the Internet, reinstating stakeholder meetings and referring more proposed rule changes in draft form for our review.

On the other hand, the state budget crisis has not only delayed state action on numerous simplification recommendations but legislators are considering changes which would increase barriers to enrollment. We can only hope that some of the presently proposed draconian measures to balance the budget are rejected by the legislature. For that reason, we are not including any recommendations for state actions since the present goal is to just “hold the line”. Our recommendations for county action include the following:

1. Adopt written notices to adequately inform pregnant women of their options to continue care under restricted Medi-Cal.
2. Reach out to all pregnant applicants in their eighth month to place them onto limited Medi-Cal unless they have submitted their documents
3. Provide additional training and outreach to the clinic and hospital workers to identify barriers and best practices for the collection and transfer of citizenship verification documents.
4. Provide focused notices and outreach for vulnerable populations, such as the disabled and homeless, explaining opportunities to extend deadlines and obtain county assistance in obtaining citizenship and other documents
5. Consider means to purchase out-of-state birth certificates, use portable copier and implement other best practices to reduce the impact of the new documentation requirements.
6. Encourage meetings of stakeholders including on-the-ground and key county staff to share data, address systemic barriers and coordinate efforts.

7. Maximize school participation in Express Lane Eligibility.

In addition, Consumer Center advocates plan to expedite access to Medi-Cal for disabled consumers. Adults without children are usually not able to access Medi-Cal unless they can establish that they are disabled according to the Social Security Administration's (SSA's) definition of disability. Establishing disability through SSA can sometimes be a lengthy and tedious process. Our advocates will be working in the next year to ensure that the disabled can access care more quickly by requesting Medi-Cal hearings when an SSA disability determination is delayed.

Access and Quality of Care under Medi-Cal

1. General Background and Barriers to Access

Services for Medi-Cal beneficiaries are provided by fee-for-service providers or managed care plans. These health plans must provide all medically necessary care, except for services that have been "carved out" and provided by other health care systems. These "carved out" services include dental care, specialty mental health and California Children's Services, a program for children with certain physically disabling conditions.

Coordination between these health care systems is necessary for prompt and complete access. Guidelines for coordination of care between individual health plans and public health systems are set forth in Memoranda of Agreement. Despite these agreements, some consumers experience problems when they seek care from multiple sources or seek special care.

All Medi-Cal beneficiaries have the right to request a hearing of a denial, termination or reduction of services. Health plan members who have quality of care or access issues have additional avenues for addressing their concerns. While providing useful alternative means of resolution, these multiple avenues for resolution can confuse consumers. Our advocates explain these various options to health plan members and, while encouraging resolution at the lowest level possible, protect members' rights to an administrative hearing.

Problems finding providers who accept Medi-Cal. Although Medi-Cal recipients report an overall satisfaction with the program, they also indicate difficulty finding a nearby doctor. Although a judge recently stayed the state legislature's 10% rate reduction action, California's reimbursement rates remain low. Although the 2-1-1 program provides some information about doctors who accept Medi-Cal, it is impossible to maintain an updated list because doctors can take a limited number of fee-for-service patients and close their practice to new Medi-Cal patients at any time.

Barriers to children’s access to dental care.

According to a report by UCLA’s Center for Health Policy Research (Haves and Have-Nots” A Look at Children’s Use of Dental Care in California), less than 30% of young San Diego children ages 1-11 have visited a dental provider in the last year even though all children should visit a dental provider annually beginning at age one.



One of the barriers to access involves orthodontia for children. Even when a child does not meet the requirement for orthodontia under Denti-Cal, a child still may qualify for orthodontia services under the more generous criteria required by the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) program. (All Medi-Cal eligible children under 19 are covered under EPSDT) However, dentists must respond to several burdensome questions before the request for services can be reviewed under these broader standards.

Barriers to accessing Medi-Cal prescription drug coverage for those beneficiaries who are also eligible for Medicare (“dual eligibles”). Dual eligibles are entitled to medically necessary prescription drugs covered by the Medi-Cal program, even if the recipient’s Medicare Part D prescription drug plan does not cover the drug. Some drugs, for example, are not covered under Medicare Part D and are covered by Medi-Cal. These include benzodiazepines, certain over the counter medications, vitamins and barbiturates. However, some pharmacies seem to be unaware that Medi-Cal needs to be billed. As a result, some dual eligibles still are incorrectly billed for these medications and are effectively denied access.

2. Actions Taken To Improve Access or Quality of Care

■ Represented consumers who were denied care

During the past 12 months, the Consumer Center advocates:

- Assisted 140 Medi-Cal consumers with delays, denials or reduction in services
- Assisted 143 with Medi-Cal billing issues
- Assisted 49 Medi-Cal consumers with quality of care concerns.

We represented consumers when they were unable to obtain critical services including medical procedures, dental care and specialty care as well as the in-home supportive services that would allow them to remain safely in their own homes (IHSS).

- **Encouraged procedures to protect continuity of care for former Blue Cross Medi-Cal members who were transferred to other Medi-Cal health plans**

In early December, the state sent notices to Blue Cross Medi-Cal members that Blue Cross would no longer be contracted to provide care to Medi-Cal managed care members as of January 1. Those who were required to enroll in a managed care plan (mandatory members) had to submit a completed form to the state by December 21 if they wished to choose their new plan. While the usual period for these transitions is 60 days, in this case the transition period was much shorter. At our request, several conference calls were immediately scheduled which included up to 20 key staff from state agencies, health plans and the Consumer Center. Critical agreements were made to share information about members, continue members on needed medications and change plans or disenroll consumers on an emergency basis when needed.

A major problem occurred because one plan closed their panel of providers at two major clinic systems. Clinics and patients called us to help maintain care with former providers. We had to involve high level staff at the state to protect these patients' rights to continuity of care and to ensure that state agencies would handle these situations on an emergency basis.

These continuity of care problems were discussed at several Healthy San Diego Joint Consumer and Professional Advisory Committee meetings. The county, with the assistance of the Consumer Center, provided a chronology of actions and problems to the state. A number of stakeholders then reviewed the pertinent aspects of the plan contracts and suggested contract language to prevent this from happening in the future.

- **Worked to simplify hospital billing for Medi-Cal services**

A new rule to prevent identity theft restricts use of Social Security numbers for billing purposes and requires use of the Beneficiary Identification Card (BIC) number instead. This change created problems for hospitals since emergency room patients do not always have their BIC card or may not have received their card. The situation was aggravated when the state sent an e-mail that told counties that they could not release the needed information to any providers including hospitals. After we reviewed the many rules which applied to this situation, we determined that the state had failed to follow an important exception to the rules that apply to hospitals as well as long-term care facilities.

The state finally agreed to release an All County Welfare Director Letter (ACWDL) instructing counties correctly. Upon request, we reviewed several drafts of this

letter, and a final letter was released in February. The final ACWDL provides exceptions for hospitals, long term care facilities, licensed primary care clinics and hospital based physicians as well as provides an exception when the beneficiary has an immediate need for medical services, does not have a card in his/her possession and the county eligibility worker can confirm the beneficiary's identity.

■ **Protected consumers' rights to information and access to discount plans and charity care from hospitals**

New state legislation on patient assistance policies took effect on January 1, 2007. The new rules require hospitals to have written financial assistance policies, to post conspicuous notices about the policies in locations visible to the public and to provide information to consumers without health coverage who are below 350% of the Federal Poverty Level upon request and when they are billed. Information about the individual hospital programs is at <http://syfphr.oshpd.ca.gov/>. The Consumer Center has helped consumers to access hospital financial assistance programs by providing them information, helping them draft letters to hospitals and participating in three-way conference calls with consumers and hospitals. As a result, many consumers have received charity care or discounted care.

■ **Advocated for Adult Day Health Care Services for those with mental health problems**

Through continued outreach the Consumer Center has helped Medi-Cal beneficiaries secure coverage for important Adult Day Health Care Services (ADHC). ADHC provides the aged, and persons who have both physical and mental health problems, with access to rehabilitation, vocational and occupational therapy services at community-based facilities. These services enable aged and disabled persons to remain in their communities, avoiding unnecessary and expensive institutionalization. Through our representation we have learned that the Medi-Cal Field Office has, in some cases, applied the ADHC medical necessity and eligibility criteria narrowly to Medi-Cal beneficiaries' who have recently immigrated. Some of the immigrants' mental health problems were characterized as non-severe, temporary adjustment disorders due to their recent move.

In addition to its direct advocacy work, the Consumer Center has also been tracking the implementation of the sweeping statutory and regulatory changes brought by Senate Bill 1755 (2006). Beginning February 1, 2008 this bill has changed the medical necessity and eligibility criteria by providing more detailed criterion and adding an additional requirement that the beneficiary use each required service on each day of attendance at ADHC. The Consumer Center will continue to monitor how the local Medi-Cal Field Office interprets and applies these changes. The last phase of the bill's implementation will occur by August 1, 2010 and will change the reimbursement methodology of ADHC programs in California to permit separate

service billing and reimbursement on a prospective cost basis. This will mark a dramatic improvement to the current retrospective reimbursement process.

■ **Addressed barriers to dental care**

The Consumer Center has taken various approaches to improving consumers' access to dental care. We represented children with serious malocclusions who needed orthodonture based on the more generous EPSDT criteria for children on Medi-Cal. We advised consumers on their right to request a hearing when a dental service was denied. In a few cases involving dentures, the state actually reversed the denial action prior to the hearing.



The Consumer Center continues to monitor and bring the experiences of consumers to the attention of the statewide Denti-Cal Stakeholder Group. Recently, at the request of HCA advocates, the state made training available to Denti-Cal providers on the more generous EPSDT criteria for children.

Advocates at the Western Center on Law and Poverty are addressing problems with abuses in marketing of credit for dental care through their support of SB 1633, the Dental Consumer Protection Act.

3. Recommendations to Improve Medi-Cal Access and Quality of Care

In an atmosphere of budget restraints, with optional services under Medi-Cal threatened with elimination, the main focus of the Consumer Center's advocacy is to maintain rather than expand programs that are not federally required. At the same time, advocates support efforts to continue required services and improve the coordination and efficiency of service delivery.

1. Improve access and awareness of preventive services as well as delivery of services to children under EPSDT

The National Academy for State Health Policy's EPSDT forum made numerous recommendations in the report they released in July 2008 entitled "New Opportunities and Continuing Challenges". One of the recommendations is to align the EPSDT screen standards and guidance with the most recent edition of the American Academy of Pediatrics's Bright Futures tool while also maintaining the

expansive nature of the EPSDT requirements. Another is to improve outreach and support to families accessing services.

2. Improve provider participation through rate adjustments, incentive programs and providing needed resources.

3. Improve coordination of care and access to care.

Coordination of care between Medi-Cal health plans, the County’s Mental Health Plan, California Children’s Services and other public health agencies is critical to the efficient provision of medical care services to consumers. To enhance oversight, we suggest that plans and public health agencies share critical information and concerns with advocates and stakeholders.

4. Coordinate managed care service denial information and assistance.

Consumers who contact the local Health Care Options Program with questions about denied services are referred to the health plan’s member services department. If these callers were referred to the Consumer Center instead, advocates could directly assist these clients at all levels of appeal. In addition, all information about member concerns would be included in our reports to health plans and the county.

Advocates now have an improved summary of the Knox-Keene rules which describe the services and protections accorded to health plan members. <http://healthconsumer.org/cs016knoxkeene.pdf>

County Medical Services

1. General Background and Barriers to Access

The County Medical Services (CMS) program is the medical program of last resort for San Diego County residents. It provides physical health services to eligible, indigent residents who are not eligible for other health coverage.

CMS provides care for only a small fraction of those who otherwise would be uninsured. In FY08, about 18,000 county residents were on CMS for at least one six-month period leaving about 400,000 uninsured county residents.

CMS ELIGIBILITY REQUIREMENTS:

(As of July 1, 2008)

Ages between 21 and 65 years old

Legally reside in San Diego County

Income below 350% of the Federal Poverty Level

Resources below set limits

This past fiscal year has seen numerous and significant changes in the CMS program. Some changes have improved access. A new IT system tracks cases and scans

documents. The program also adopted a series of changes to include those with significantly higher incomes. Specifically, in December 2007, the Board of Supervisors eliminated co-pays instituted earlier in the year³ and adopted rules providing free CMS to otherwise eligible county residents whose incomes were below 165% of the Federal Poverty Level (\$1,404 for 1 person, \$1,883 for 2). Those over the limit could request a financial or medical hardship waiver. The medical hardship waiver required extensive documentation of future medical expenses and was eliminated and replaced with a share of cost process beginning July 1, 2008.

However, some changes in the CMS program have made it more difficult for people to obtain and retain CMS coverage. In fact, despite the increased income limit, the number of county residents covered by CMS only increased from about 17,000 to 18,000. Now, consumers must:

- get a medical form completed by a medical provider before a recertification appointment can be scheduled;
- sign a lien form as a condition of eligibility;
- provide proof of citizenship and identity;
- sign a Credit Check Authorization Form;
- sign a reimbursement agreement if income is over 165% FPL.

In addition, homeless applicants are adversely affected by the new IT system because a CMS card is no longer issued at the time of the eligibility appointment. CMS card issuance is delayed by the need to enter the information in the computer and by a new requirement that 50% of the cases be reviewed by a supervisor.

Other barriers that were identified in our report last year remain, including gaps in the appointment system, low reimbursement rates limiting provider access and problems getting timely access to care due to the delay in getting application appointments. For example, the county's phone system did not keep a record of calls made during non-business hours or when staff were at meetings and still does not record when consumers call to ask for postponements.

On the other hand, due to efforts by the Consumer Center and the county, other improvements have been made including:

- Hernia repair surgery "employability" standard eliminated
- Certification period of six months restored
- Lien requirement clarified and scope limited

³ For those whose income was between 135% and 165% of the FPL.

2. Actions Taken to Improve CMS Access

Most of the changes in the CMS system have occurred in the last six months and many have been implemented since April. Therefore, the Consumer Center is at the initial stage of our advocacy regarding many of these changes. We are now analyzing the changes, training our staff on the new rules, and monitoring their impact.

■ **Commented on new medical need form and had longer certification period reinstated.**

In a notice dated December 19, 2007 and effective December 1, 2007, the county shortened the certification period to three months for all beneficiaries except those certified to have diabetes or hypertension. In addition, CMS instituted a new form, called a Medical Need form, which has to be completed by a medical provider and received by the county's CMS Administrative Services Organization before the county will schedule a recertification appointment.

The Consumer Center was invited to make comments on amendments to these new rules. Several of our suggestions were accepted including (1) an exemption to the medical need form requirement for those who have been determined "chronic" (i.e. diagnosed with diabetes or hypertension) and (2) allowing the physician's designee to complete the form. However, the requirement remains, thereby imposing burdensome and unnecessary requirements on applicants and providers. Some consumers have not been granted coverage until just before or after the end of their certification period and have had to pay for a clinic visit to get the form completed.



After we raised concerns about the impact of the shortened certification period on consumers, a six month certification period was reinstated for many consumers. However, some applicants are only given a three month certification period since their recertification is conditional on application for other programs.

■ **Advocated for changes in new rules requiring applicants to sign a lien form.**

In December, 2007, the county began requiring a signature on a CMS Lien Information form and an additional Grant of Lien form as a condition of eligibility. While California statute permits the county to seek repayment for money it expends on CMS beneficiaries under certain conditions, the county seemed to have gone beyond their authority in a number of important respects. Specifically, the county required that the amounts were

“immediately due and payable,” while ignoring the person’s ability to repay, made the beneficiary liable for services received prior to the date the lien form was signed, and obligated the person’s successors and heirs. Not only did the county inaccurately explain the effect of the lien to applicants but also some workers gave misleading information, indicating that the applicant could not sell or buy a home or adjust their immigration status until the consumer reimbursed the county. In addition, the form indicated that the county would notify the U.S. Customs Enforcement Department of applications made by non-citizens. Finally, the county required the signature of the applicant’s spouse which created an insurmountable barrier for those who were separated and did not know their spouse’s whereabouts.

After raising concerns, the county temporarily suspended the lien requirement in February and then reinstated a new lien form in April. The new form explains that the lien is not enforceable against a home during the applicant’s lifetime, their spouse’s lifetime, or under certain other situations. In addition, it appears that the county began referring those with questions about the lien to the Consumer Center for information. Under court order, the county will be developing a question and answer sheet to explain some of the complexities of the new rules.

■ **Commented on new rules making it difficult for homeless people to prove residency.**

Prior to April, CMS followed Medi-Cal’s rules for verifying residency. The Medi-Cal rules specifically note that “documents provided by a homeless applicant/beneficiary must be considered even it [sic] does not include an address.” The county not only eliminated this language, but also added the phrase “listing a San Diego County address” to the options for using a driver’s license, ID card and vehicle registration. To make it even more difficult, the county eliminated language permitting evidence from a San Diego County agency, such as an affidavit from a homeless shelter. In addition, the county no longer listed documents that could previously be used to verify residency. These included documents that showed the receipt of local public assistance, that the applicant is employed locally or registered with local employment services.



Although the county’s own rules state that a “fixed address” is not a requirement for CMS eligibility, these new rules made it very difficult, if not impossible, for those without a fixed address to establish residency. This was an effective barrier for the homeless. We have raised these concerns with the county, researched related rules and asked the county to enumerate the specific and reasonable verification guidelines for this population. The county agreed to change the rules.

- **Evaluated how best to represent those with denials in light of changes in the supervisory review process.**

Although in late 2006 the county reinstated the first level of appeal, the supervisory review, the persons responsible for performing the review changed. Whereas previously a supervisor in a different office reviewed the appeals (a more neutral evaluation), now the eligibility worker's immediate supervisor does this review. This change resulted in significantly fewer cases resolved through supervisory review. We have contacted the county when a supervisor consistently misapplies the rules. In addition, we now carefully assess individual cases to determine when it is best to request a hearing immediately and bypass the supervisory review.

- **Provided extensive comments on the new verification requirements for U.S. citizens.**

At the invitation of the county, we provided eight pages of comments on the county's proposed changes to verifying identity and citizenship. Following the submission of our comments, the county made two major changes – accepting copies of documents (not just originals and certified documents) and expanding the list of accepted documents to be used to verify identity for citizen applicants. Unfortunately, this remains a very burdensome requirement particularly for those who have lost their naturalization or Legal Permanent Resident documents. The county will not use the “A” number that is posted on receipts for copies of naturalization certificates which Medi-Cal will use. This is particularly problematic because a new document can take several months if not over a year to obtain.

- **Effectively argued for good cause exception to time limit for submitting documents and following certain procedures before denying applicants.**

The Consumer Center has helped a number of applicants who were denied for failure to provide required documents. This issue has gained increased importance now that citizen applicants must provide verification of citizenship and identity.



CMS follows the Medi-Cal rules on timelines for submitting the numerous verifications and other documents. These rules require the worker to send certain notices and make several contacts within a specified timeline in an attempt to get the required documents. In addition, the worker must extend the deadline if the applicant indicates that he/she has

difficulty in meeting the deadline and the applicant is making a good faith effort to obtain the verifications and/or the delay is beyond the applicant's control. The Consumer Center was finding that workers were not always consistently following these rules.

We successfully represented several clients who had been denied for "failure to provide" the required documents since the county failed to follow this process. In one case, the decision granted coverage to a consumer with a \$980,000 medical bill.

In addition, we raised the issue with the county and since then, some workers have understood their obligation to be more flexible in extending the time to submit documents when warranted. However, we believe that more consumers would benefit from this approach if the county included information in the notices that the time to submit documents can be extended for good cause.

■ **Analyzed impact and shared information about the new CMS IT system.**

The county implemented an IT system to maintain case records. While this new system greatly improves coordination of CMS activities, it also creates certain barriers. The county no longer issues the CMS card at the intake appointment. As a consequence, homeless beneficiaries must return for their notices and CMS cards. Since over 50% of applications are now reviewed by a supervisor prior to approval, the intake worker cannot predict when the documents will be available, further inconveniencing the homeless and the clinics where the homeless person must go to collect the documents. We have shared the information about the new process with those who work with this community. We also recently asked the county how this system can work better for those without an address.

■ **Expanded access to hernia repair.**

Previously, to be eligible for hernia repair, the county required the beneficiary to get a letter from a past or future employer indicating that the hernia condition prevented him from working or being hired. After successfully representing a number of men who had been denied the surgery, we asked the county to change their criteria. The county's materials indicate that they now provide surgery to those whose hernias are symptomatic and interfere with work or daily activities. However, the county requires a patient history that shows pain of sufficient duration and an affect on employability or both a physical exam showing that there is an incarcerated hernia and a work history.

■ **Monitored changing rules on income and how they affect consumers.**

As noted above, there have been many changes in income rules in the past year. The Consumer Center trained staff on the complicated waiver rules, advocated for the application of the rules to our individual clients and monitored those who were put in pending status awaiting a court order.

3. Recommendations for Improving CMS Access

The Consumer Center recommends that the county:

1. Improve the CMS application process by eliminating unnecessary forms, making it easier and faster to get application appointments and reinstating appointment intakes at convenient clinics.
2. Reinstating an effective supervisory review “appeal” system by using an independent team of well trained neutral experts to perform the review.
3. Implement a reasonable retroactive period to cover the time period between hospital admission and the actual application date.
4. Create an effective referral system between CMS and County Behavioral Health Division to ensure access to mental health assessments and treatment for mental health conditions and substance abuse.
5. Increase the reimbursement rate for CMS providers.
6. Reinstating a stakeholder group to review data, monitor trends and suggest ways to improve access.
7. Use all available methods for accessing available documentation of citizenship and identity including the SAVE system and the MEDS system.
8. Improve the new IT system so that CMS cards can be generated on the same day as the application and cards display the expiration date
9. Expand the types of acceptable documentation that can be used to establish eligible alien status.

Mental Health

1. General Background and Barriers to Access



The state carved out specialty mental health services 10 years ago from the Medi-Cal managed care plans and transferred responsibility to the counties. In preparation for the carve-out, clients and family members met with county staff to advocate for funding an independent entity to be the voice for persons with mental disabilities. As a result, the Consumer Center became the county-designated Patients' Rights Advocate responsible for investigating issues involving specialty mental health outpatient.

San Diego County Mental Health Services (SDCMHS) or the Mental Health Plan (MHP), a part of the Behavioral Health division under the Health and Human Services Agency, contracts with and/or reimburses entities for services ranging from outpatient counseling to case management to hospital care for children, youth, families, adults and older adults. Through these various entities, SDCMHS serves approximately 55,500 unduplicated clients per year.

Among the largest external entities is United Behavioral Health (UBH), which holds the Administrative Services Organization (ASO) contract. Medi-Cal beneficiaries seeking specialty mental health services are able to call the San Diego Access and Crisis Line (ACL), a 24/7 toll-free number operated by UBH and staffed by master's level clinicians. The ACL provides referrals and authorizations for Medi-Cal reimbursable mental health services. The ACL also provides information about available services for the uninsured and referrals to publicly funded alcohol and drug programs. Furthermore, round-the-clock crisis intervention staffed by bilingual master's level clinicians is available for people in need regardless of their health insurance.

Beneficiary Problem Resolution Process. The grievance and appeal process, Beneficiary Problem Resolution Process, was adopted by the county in July 2004. Of the 143 mental health cases opened this year, 54% were grievances or appeals. Despite the new grievance process being implemented four years ago, the following obstacles remain:

- **Arbitrary timelines to resolve cases.** Although every effort is made to resolve grievances or appeals according to county procedures, there are cases where the timelines can not be met for a number of reasons. In these cases, the deadlines do not permit us to provide a satisfactory resolution and clients become

frustrated with the grievance process. Our advocates continue to work closely with the Fee for Service and organizational providers and UBH to minimize these problems.

- **The federal process was not designed for mental health issues.** The resolution process was adopted from managed Medi-Cal and does not necessarily fit mental health cases. Barriers that illustrate this problem:
 - a) **Fear of reprisal.** Clients may be reluctant to submit a grievance and/or follow through for fear of reprisal and/or termination of services.
 - b) **Late or unreturned paperwork.** Written authorizations that allow us to work on a client's behalf are either returned late or not at all. We also see delayed responses from providers who were initially uncooperative or unaware of the county grievance process.
 - c) **No mailing addresses or phone number.** Homeless clients without permanent residences may not receive the required paperwork and/or remaining in contact with their assigned advocate.

Jurisdictional Gaps. Though University of San Diego Patient Advocacy Program has the responsibility for acute inpatient facilities and other 24-hour residential settings, the grievance process neither includes non-augmented Board and Care homes nor Independent Living Facilities (ILF). Moreover, Community Care Licensing Division only has jurisdiction over Board and Cares. For complaints involving an ILF, finding the right entity that has the responsibility to investigate and enforce violations often involves multiple phone calls. Although we make every effort to advocate on behalf of the residents, oftentimes little can be done to ameliorate the situation except provide referrals to other resources.

Lack of Coordination between County Medical Services (CMS) and County Mental Health Services. Coordinating physical and mental health services for certain low-income clients are problematic given the separate systems of care. In the past, there was little awareness about how to actually "apply" for mental health services. For the uninsured consumers, problems include the lack of medications and the county not reimbursing hospitals for involuntary holds or for services provided to those who initially may present with physical health symptoms and later receive a final mental health diagnosis. This leads to large hospital bills being directed to the consumer. As a result of our Medical-Legal partnership with Scripps Health, our advocates have been able to help clients apply for Medi-Cal, CMS or Charity care.

2. Actions Taken to Improve Mental Health Access

■ Maintained the Beneficiary Problem Resolution Process

The County's Mental Health Problem Resolution Process, designed to meet California Code of Regulations Title 9 covers Medi-Cal beneficiaries, SED-certified children through the Healthy Families Program and persons without Medi-Cal receiving county-funded services.

Grievances and appeals were monitored and trended so that systemic problems could be identified and solutions developed. To alleviate problems, resolve issues and foster cooperation, monthly meetings with UBH, the County's Quality Improvement Unit and USD Patient Advocacy Program were scheduled. We employ non-adversarial methods with UBH and the contracted fee-for-service and organizational providers to ensure an impartial and successful grievance resolution process.

When a grievance or appeal is a clinical issue, Medicaid regulations require that the decision-maker be an individual with the appropriate clinical expertise. To meet this requirement, the Consumer Center contracts with a Board-certified psychiatrist who reviews the medical records and renders an unbiased recommendation. Using this process, we successfully assisted Medi-Cal beneficiaries who first must exhaust the MHP's appeal process. This oftentimes eliminates the need for a client to request a state fair hearing.

■ Conducted Individual Advocacy

Our advocates continue to assist clients and family members who call concerning specialty mental health services. As in previous years, the top reasons for calling us are:

- **Quality/Appropriateness of Care** – service, professional conduct or appointment scheduling
- **Staff Issues/Customer Service** – rude, inattentive and unprofessional behavior
- **Patients' Rights** – privacy, confidentiality or being treated with dignity
- **Denial or Delay of Services** – denial, reduction or termination of care
- **Medication** – the type, dosage or denials of specific medications as well as problems with accessing prescribed medications

Our staff make every effort to identify the issue, negotiate with the provider and resolve the problem. In addition, we provide information about client- and family-driven recovery options. If the specialty mental health service is not within our jurisdiction, referrals are made to other agencies such as USD Patient Advocacy Program, Protection and Advocacy, Inc. and NAMI. Mental health clients also seek our help with physical

health problems including CMS, Medi-Cal eligibility and Medicare medication-related issues (see Data Section for more details).

■ **Participated in Planning for the Mental Health Services Act Programs**

Since the passage of Proposition 63 (Mental Health Services Act or MHSA) in November 2004, the Consumer Center staff has participated in multiple meetings, forums and committees designed to develop and oversee innovative community-based services for underserved residents. This past year, membership in the Children’s Mental Health System of Care Council, Older Adult Mental Health System of Care Council and its Quality of Life and Housing Committee have allowed staff to gain a better understanding and provide input to new and proposed Community Services and Supports (CSS) programs. Membership on these councils also allowed us to inform other agency staff, clients and family members about our services. For example, we provided updates on services related to Medicare Part D medications, which was especially significant as more than 30% of people over 65 in San Diego County have a cognitive disability.

As the chair of the San Diego Mental Health Coalition, a voluntary association comprised of 40 agencies and individuals, our Mental Health Program Manager advocated for expanded services for those who are homeless and at risk of homelessness, the uninsured and dually diagnosed (mental health and substance abuse) clients including supporting the Full Service Partnerships. We will continue to watch the priorities and allocations as the county unveils the next MHSA components.

■ **Advocated for Improved Coordination**

As a member of the CHIP Behavioral Health Work Team, our Mental Health Program Manager has actively participated in supporting increased care coordination. Trainings were provided to clients, family members and agency staff in conjunction with UBH, NAMI and Healthy San Diego. Our trainings emphasized the importance of using the Healthy San Diego Coordination of Care Form. One MHSA-funded program considered a model for coordination is the Council of Community Clinic’s Primary Care and Mental Health Integration Project. This project assists eligible clients (i.e., those who meet specific diagnostic criteria, are unfunded for mental health services and have a Social Security number) accessing mental health in a



primary care setting. In addition, many mental health clients have chronic co-morbid health problems, such as hypertension, diabetes and obesity, and take medications for these diseases that are prescribed by different physicians in separate systems of care. Coordinating care between the various systems remains a systemic problem that several collaboratives, including Healthy San Diego, are addressing.

3. Recommendations for Improving the Mental Health System

Encourage Coordination and Integrated Services

The Consumer Center continued to work with the county to create a bridge between CMS and mental health programs. As many clients with mental health disabilities have limited or no income, the county's responsibility for these at-risk individuals must also include mental health treatment. Many of the county's 10,000 homeless people have limited access to routine health care and, when they are in need of care, go to an emergency room. This is an expensive option resulting in an increasing amount of uncompensated health care. The number of homeless individuals with mental illness is testimony to the need to provide coordinated care between the various agencies and providers including FSPs, housing and social service organizations.

As in previous years, the San Diego County ACL offers callers with information on emergency services, hospital and outpatient services, support groups and substance abuse services. We frequently refer clients who are in need of crisis intervention or suicide prevention and refer other callers to 2-1-1 for up-to-date information about short-term crisis residential centers and Board and Care bed availability. As a member of the Residential Care Committee (formerly known as the Board and Care Committee), our voice is heard on the newsletter editorial board that has been an effective means to promote Patients' Rights and recently has included advocating for improved nutrition.

Use MHSA Funds to Fill the Gaps

With the release of MHSA funds, mental health outpatient services in the county has expanded substantially; however we believe targeted funding is needed to augment case management services and housing options. With the cost of living rising to unprecedented levels, nearly 15% of the county's population lives below the poverty and/or self-sufficiency level. The CSS funds have allowed San Diego to create meaningful "best practice" programs and offer services that are peer-operated, culturally competent and outcome based. We support expanding services to those at-risk individuals by providing access to physical and mental health services in the rural communities and for Latino and Asian/Pacific Islanders and transitional age adults.

Uninsured dual diagnosed clients are treated in the emergency rooms and/or briefly hospitalized. Oftentimes, they are discharged to addresses or facilities that cannot accommodate them and without follow-up care, rehospitalization occurs. We believe

that providing on-going care and seamless service through increasing private-public partnerships is one solution.

Participate in the Implementation of a Mental Health Court Calendar

Persons with mental illnesses reportedly represent nearly one third of all prisoners. We support the rapid development of a Mental Health Court Calendar that would offer court-supervised and community-based treatment in place of incarceration. Throughout the state and nation, mental health courts have proven to effectively divert nonviolent, mentally ill offenders. We are committed to working on creating an integrated community-based model.

Medicare Part D

1. General Background and Barriers to Access

Dual Eligibles

Even though the number of dual eligibles (people with Medicare and Medi-Cal) who were unable to obtain their medications from a Medicare Part D (Part D) plan has decreased since the Medicare Modernization Act (MMA) was implemented in January 2006, consumers continued to call the Consumer Center with troubles accessing their prescriptions. One reason for the continued need for assistance is that an estimated 14% (12,000) of the 435,000 Medicare beneficiaries who live in San Diego County are dual eligibles. Many of these individuals are disabled with language barriers and limited education and, as a result, accessing and affording medications required outside help.

Although Part D allowed some consumers who previously were without drug coverage to obtain medications, the MMA had serious implications for dual eligibles. Instead of receiving their medications from Medi-Cal, these beneficiaries had to enroll in one of the private drug plans that contracted with Medicare. First, the consumers had to determine if the plan that Medicare automatically assigned them into best covered their medications. If not, the only course for comparing plans was using the Medicare website or calling Medicare's toll-free number. These options proved to be difficult for beneficiaries who did not have a computer or the ability to use the Internet as well as for beneficiaries who could not navigate Medicare's automated telephone system. Second, dual eligibles living on limited incomes were now charged co-payments ranging from \$1.10 to \$5.35 (depending



on whether the drug was generic or a name brand). Third, if their drug plan did not cover a needed medication, consumers had to ask their physicians, not the pharmacist, to complete the exception form.

Additionally, Medicare and the Social Security Administration (SSA) did not always enroll dual eligibles into a Part D plan and the Low-Income Subsidy (LIS) in the month that it should have. As a result, beneficiaries either did not have prescription drug coverage and/or the costs of the medications were mistakenly higher than expected. To fix the problem, Medicare, SSA and the drug plans sometimes had to be notified repeatedly until accurate information about the beneficiaries' Part D and LIS enrollment status was obtained.

The Low-Income Subsidy

Medicare officials realized that some low-income beneficiaries needed help paying for the costs of Part D plans and worked with SSA to provide the subsidy. Even though dual eligibles and people with Medicare Savings Programs should automatically receive the LIS, other low-income beneficiaries had to apply. SSA was responsible for mailing applications to these beneficiaries; however, an estimated 12,000 eligibles in San Diego County did not apply. Reasons for this included lack of unawareness about the program, language barriers, difficulty of the questions and the stigma of government assistance.

2. Actions Taken to Ease Transition

Grants and collaborations

Dual Eligibles

To support our advocacy and collaborative activities, the Consumer Center received grants from The California Endowment and The California Wellness Foundation. These grants allowed us to:

- Conduct educational trainings for professionals, consumers and family groups regarding the impact of Part D on dual eligibles.
- Educate dual eligibles on Part D, assist with giving drug plan options and troubleshoot enrollment problems by speaking with Medicare, SSA, Part D plans and pharmacists.
- Collaborate with a broad-based stakeholder group of community advocates and governmental agencies including conference calls to discuss systemic problems that dual eligibles continued to face with enrolling into Part D plans and the LIS.
- Collect client case stories about how enrollment problems impacted dual eligibles' ability to obtain Part D plan medications. These examples were e-mailed to the Health Consumer Alliance staff for additional advocacy.

The Low-Income Subsidy

The Alliance Healthcare Foundation gave the Consumer Center a 24-month grant to expand our outreach and education efforts and focus on reaching eligible beneficiaries from who had not yet enrolled in the subsidy, with a particular focus on the Vietnamese, Arabic, Filipino, and Latino communities. After developing material in multiple languages, we distributed these flyers at health fairs, meetings and on-site events. To further educate the community about our services, we published articles in the Consumer Center's newsletter, posted information on the LASSD website and sent out press releases to mainstream and ethnic media.

This grant also funded our efforts to lead the San Diego Access to Benefits Coalition (SDABC). During monthly meetings, we educated professionals about our services and offered to provide outreach and specific on-site activities that targeted Medicare beneficiaries. One example of this partnership led to staff working with the San Diego Hunger Coalition to educate eligible consumers about the Food Stamp program.



Our multi-lingual staff assisted eligibles with applying for the subsidy either over the phone at the Consumer Center or during on-site appointments at SSA offices. In cases where beneficiaries were ineligible for the LIS but had Medi-Cal with a share-of-cost (SOC), we advised these clients to either meet the SOC or apply for a Medi-Cal program that does not have a SOC, such as the Aged and Disabled Program or the 250% Working Disabled Medi-Cal Program. As a result, beneficiaries would automatically receive the LIS. While working with LIS eligibles, we informed them about their legal rights that included the appeal process.

3. Recommendations to Improve Access to Care

Dual Eligibles

The Consumer Center will continue to help beneficiaries obtain Part D medications by:

- Informing providers and agencies that serve ethnic minority communities about our services.
- Building partnerships and referral networks.
- Helping dual eligibles with Part D access problems.
- Presenting information at various venues about beneficiary rights to change plans and file appeals.
- Collecting client stories to share with state and federal advocacy groups.

The Low-Income Subsidy

By partnering with SDABC members, providers will be informed about Part D and will refer LIS eligibles to our project staff for education and enrollment. We intend on expanding the SDABC membership by outreaching to diverse entities including governmental and non-governmental agencies.

Additionally, we will continue to collect client stories about how applying for the subsidy has allowed eligibles to save money on Part D drug plan costs. The National Health Law Program and other advocacy organizations agree to use these stories to further advocate for changes in the LIS, which includes raising the income and asset levels and translating the applications into more languages.

The Uninsured

Our Executive Director and Director of Training, Policy and Development continue to be active in state and local policy work to help expand coverage to the large numbers of San Diegans who are uninsured and cannot access health care.

Expanding Coverage/The Uninsured/Coverage Initiative

1. General Background and Barriers to Access

The Coverage Initiative

On March 29, 2007, San Diego County was awarded a federal grant of over \$13 million annually for three years to expand healthcare coverage and strengthen the safety net in San Diego County. For many months, the Consumer Center's Executive Director had participated in stakeholder meetings to develop guidelines for this major coverage expansion called the Coverage Initiative (C.I.). The group decided to target those who, without care, can experience serious damage to their health and are often repeated users of emergency room services. The Coverage Initiative program targets those with diabetes and hypertension, providing them case management and enhanced specialty and dental services in addition to inpatient and outpatient care.

Presently, to qualify, a consumer must be:

1. Diagnosed with diabetes or hypertension
2. Ineligible for Medi-Cal
3. Between the ages of 21 and 64 years old
4. A San Diego County resident
5. A US citizen or legal permanent resident/ qualified alien with 5 years residency (with some exceptions)

6. Under 200% of the Federal Poverty Level (\$ 1,734 per month for a single adult)

Consumers apply at designated clinics. Since the Coverage Initiative program is federally funded, it must follow federal rules, including requirements to provide original or certified copies to establish citizenship and identity and stricter requirements for length of legal stay in the United States than in Medi-Cal. Additional rules which had created barriers to access were eliminated.

Expanding coverage to low-income workers

The Consumer Center's Executive Director continues to take an active part Vice-Chair in San Diegans for Health Care Coverage (SDHCC), a diverse coalition of health care stakeholders focused on health reform and expanded health coverage. Under its umbrella, the Business Health Care Connection recently received a one year grant from the California Endowment to continue its work. The objectives of the grant are to strengthen the coalition, expand its membership, and raise awareness about issues related to health reform and advocate for increased enrollment in coverage programs. The group proposes two reports; one on the impact of lack of insurance on the community and the other to identify barriers to enrollment. Consumer Center staff will continue to take an active part in both organizations.



2. Actions Taken to Improve Access to Coverage

- **Encouraged expansion of C.I. coverage to those with children who are not Medi-Cal eligible, those with incomes between 0 and 135% of the Federal Poverty Level and all eligible legal immigrants.**

Originally the coverage initiative only covered those who did not have children since there was a concern that some consumers with children could be eligible for Medi-Cal. After several discussions and careful consideration, the county adopted our suggestion to include those parents who had applied for Medi-Cal but had been denied and ask beneficiaries to report any changes that could affect their eligibility for Medi-Cal.

In addition, the original rules excluded those whose incomes were below 135% of the Federal Poverty Level. It was later determined that it would be best if those who were CMS eligible but had hypertension or diabetes were considered eligible for the Coverage Initiative.

The county's materials originally indicated that only citizens and immigrants who had adjusted his/her status at least five years ago were eligible. After the Consumer Center researched the federal rules and shared the information with the county, the county expanded the program to other immigrants eligible under federal rules.

Through this concerted effort by the county and other stakeholders there was a significant increase in enrollment from only about 100 in early April 2008 to over 1,000 by August, 2008. Efforts included expansion of the eligibility rules, assignment of a tiger team to identify potential recipients and enlisting the help of the media and the 2-1-1 information line.

- **Reviewed county material and prepared comparison chart of various coverage programs.**

Based on the Consumer Center's comments, the county agreed to numerous changes in the C.I. rules, program notices, referral forms and other materials that were submitted for our review. The county agreed to put the Consumer Center's contact number on notices, clarify the rules regarding the time to request a review, improve outreach to those who need to submit a status report to retain coverage, add information to the application form to capture information about possible deductions, make clear in the forms that copies certified by the issuing agency are acceptable to establish citizenship and define critical terms such as "good cause" and "failure to cooperate." In addition, the county agreed to accept a doctor's note in lieu of the Medical Need form and will eliminate the term "medically verifiable condition" when only a simple diagnosis is required. The county will also follow our suggestion to only accept written requests for discontinuances. These changes will take some time to implement, however, since the county indicates that they will not occur until the forms are updated and/or the actual Program Guide materials are issued.

Since the various programs and requirements were confusing, we prepared a chart comparing various rules for Medi-Cal, CMS, and C.I. including income and resources limits, rules for proof of citizenship and immigration status requirements. We made sure that the chart was widely distributed.

- **Argued effectively for a review process for the Coverage Initiative Program.**

Those denied the Coverage Initiative can now request a review of a C.I. determination. The process is described in the C.I. handbook.

3. Recommendations to Improve Access for the Uninsured

Coverage Initiative

1. Incorporate C.I. rules into a Program Guide that can be easily searched and updated
2. Improve coordination with other programs including CMS and Medi-Cal
3. Increase time period to request program review
4. Increase outreach to get the word out about the program

OUTREACH

Education and Outreach Summary



In FY08, the Consumer Center staff educated and trained 2,030 low-income individuals, providers and staff members of community-based organizations (CBOs). The focus of our outreach activities remained the same with all our audiences: to help the uninsured obtain or retain coverage, educate consumers on how to best access services and encourage coordination of care. To achieve these objectives, we utilized the following methods:

- Presentations to CBO staff, clients and family members
- Distribution of educational information at health and resource fairs
- Distribution of Consumer Center newsletters and press releases
- Meetings with health plans and providers

Through these activities, providers learned more about various health care options, eligibility requirements and regulatory updates. We also conducted presentations and trainings to consumers about specific health programs and the availability of our services. For both audiences, our staff collaborated with a wide range of agencies and provided topic-specific trainings such as eligibility for fee-for-service and managed care Medi-Cal, County Medical Services and the Healthy Families Program. Outreach staff also provided trainings on Medicare Part D and mental health services, including Patients' Rights and the grievance/appeal resolution process.

Physical Health

Developing focused partnerships with CBOs proved critical in helping us identify systemic issues that impact consumers and provided us with the platform to train staff

on new rules, regulations and laws. We collaborated with SanDiCAN, Family Resource Center, Family Health Centers of San Diego, Casa De Mariana, SAY San Diego, Cancer Navigator, Senior Community Centers and San Diego American Indian Health Care. In addition, trainings were provided to Sharp Community Medical Group, Sharp Grossmont Hospital's emergency room nurses, Social Security Administration workers, Aging and Independence Services staff and Scripps Well Being Center personnel.

As part of our outreach and to stay updated on recent changes in health care, the Consumer Center participated in meetings with the Community Health Group Public Policy Committee, Health Care for the Homeless, Molina Healthcare Community Advisory Committee, San Diego Community Partners for Wellness and San Diego Kids Health Assurance Network (SD-KHAN).

Our outreach strategy also included participating in health and resource fairs such as the Lakeside Community Center Health Fair, SanDiCAN End of Life Event, Mountain Empire Community Center, San Diego Self-Advocacy Conference, Linda Vista Multi-Cultural Fair and Juneteenth Day George Stevens Center. Other direct outreach was provided to the local organizations and events serving special needs populations such as the Latino Coalition, Children's Hospital and Autism Speaks.

Mental Health

Educational activities focusing on mental health issues targeted a range of clients, family members and providers. This year's outreaches were scheduled to ensure that the diverse communities and geographic regions of our county were reached.

Clubhouses continued to be excellent venues for reaching persons with psychiatric disabilities as the clubhouse members focus on strengths not on their illness. In addition to the job training and placement opportunities, clubhouse members receive help in finding housing, advancing their education, obtaining appropriate psychiatric and medical care, and maintaining government benefits. Our outreach topics therefore fit well into the rehabilitation and recovery model.

Trainings were provided in a culturally competent and respectful manner. Two advocates who conducted outreaches in mental health settings are persons with mental disabilities. Their presentations consistently were well-received as they "walk the talk" and are examples of the recovery model. We provided training to the county-funded (fully and partially) clubhouses, which included The Meeting



Place, Visions, East Corner, Friend to Friend, Mariposa, Casa Del Sol and Bayview. Outreaches also included reaching ethnically and culturally diverse groups. Our Vietnamese-speaking staff conducted trainings at the Eastwind Clubhouse that primarily services Asian/Pacific Islanders. We also outreached to the San Diego Deaf Mental Health Services and Chaldean Service Center.

Information on the LASSD and Consumer Center services included a description of the Title 9 Patients' Rights Advocacy designation and SSI eligibility. For those interested clients, we provided information on the contracted clubhouses that work with the LASSD SSI Advocacy Program. This fiscal year, new presentations were developed that focused on better communication with providers, Medicare Part D, the 250% Working Disabled Medi-Cal Program, the Covered Initiative Program and Food Stamps. Clubhouse members rated these topics highly. Describing these low or no-cost government benefit programs enabled us to help hundreds of clients apply for programs, save money and obtain needed prescription medications.

As in previous years, staff conducted trainings at county-funded or county-operated mental health programs including the Southeast Mental Health Center and UCSD Outpatient Psychiatric Services (Gifford Clinic). MHSA-funded Full Service Partnerships (FSPs) were contacted including IMPACT, North Star Intensive Assertive Community Services (ACT) and Heritage Clinic, as were private sector agencies that serve Medi-Cal beneficiaries, including Alvarado Parkway Institute and Jewish Family Services. We also outreached to staff at crisis residential facilities and IMDs to present our Medi-Cal, County Medical Services and Medicare-related services. Our outreach staff also provided information to agencies that serve children, adolescents and transition age youth such as Providence Community Services' Oasis Clubhouse. At these outreaches, staff offered referral information and distributed the San Diego Access and Crisis Line's brochures in English and Spanish as well as restocked agencies' supplies of grievance/appeal forms and brochures.

We also provided trainings about the public mental health system to physical health providers such as Family Health Centers and La Maestra Community Health Centers. The majority of these presentations were devoted to educating staff and providers on managed care Medi-Cal and the importance of coordinating care. We also conducted trainings to self-help family and consumer groups such as NAMI San Diego and Partners in Care. These presentations all were well-received.

This year, we improved upon our previously developed PowerPoint presentation that detailed the unique San Diego Patients' Rights Advocate model and illustrated effective advocacy methods. The presentation continued to be the foundation by which additional information was added to a CHIP presentation, which now includes examples of advocacy and addresses consumer empowerment.

As a result of these educational outreaches, consumers, family members and providers contacted the Consumer Center with questions about how to access mental health services, file an appeal or grievance and eligibility questions.

Medicare Part D

The Consumer Center's staff and volunteers educated beneficiaries, family members, and professionals about Medicare Part D at over 126 events. The various methods included distributing press releases, writing case stories and conducting on-site events. Due to these media releases, advertisements and hands-on activities, our call volume concerning Medicare prescription drug problems increased.

To support our outreaches, language-specific written material was developed in all five county threshold languages and addressed issues that affected dual eligibles (Medicare and Medi-Cal). The Consumer Center's staff and volunteers also disseminated over 14,500 written materials. The materials described how to contact us if dual eligibles had problems obtaining medications from Part D instead of Medi-Cal. In addition, Medicare Savings Programs (MSPs) and extra help or low-income subsidy (LIS) informational flyers were developed to educate low-income beneficiaries about the program and their eligibility. This material was mailed, e-mailed, and faxed to pharmacies, consumers, professionals, and organizations working with low-income Medicare beneficiaries.



Project staff led trainings to inform consumers and professionals regarding the LIS, MSPs, and Part D updates. If requested, follow-up trainings to agency staff and clients also were provided. As a result, the trainings generated referrals regarding questions about Part D as well as Medi-Cal eligibility, share-of-cost issues and Treatment Authorization Request delays. Focus groups at local senior centers were organized to obtain input on how to improve our written materials and how to more effectively outreach to beneficiaries. Moreover, we provided trainings at the San Diego Access to Benefits Coalition (SDABC) monthly meetings, which included, but were not limited to, representatives from HICAP, San Diego Hunger Coalition, North Coast Home Health Products, Community Health Improvement Partnership (CHIP), State Senator Ducheny, Congresswoman Susan Davis, Assemblywoman Lori Saldanas, ElderHelp, NAMI-San Diego, FMC Dialysis, Hillcrest Pharmacy, Care 1st, Evercare (Health Net), San Diego American Indian Health Center, Deaf and Disabled Telecommunications and San Diego Hospice. Attendees used information gathered during the trainings to answer consumers' basic questions and refer complicated cases to us.

Project staff worked in partnership with five local SSA offices to conduct on-site enrollment events for Medicare beneficiaries. As a result, staff answered 140 beneficiaries Part D questions and used laptops with Internet capabilities to help LIS eligibles apply for the subsidy. In addition to receiving Part D plan options, clients were screened for other programs, such as Medi-Cal, MSPs and Food Stamps.

Additionally, the Consumer Center developed and disseminated Part D media releases countywide. Additionally, many of our dual eligible clients allowed staff to share their Part D stories with the media. These stories highlighted the difficult issues faced when paying and obtaining medications from Part D drug plans. As a result, articles describing the LIS, client stories and our services were shared with the Health Consumer Alliance and other national advocacy staff. We have found that poignant vignettes gathered from outreaches and trainings are excellent examples to share with decision makers about continued barriers to accessing and affording medications.



Other Activities

The Consumer Center routinely participated in multiple meetings (listed below) with agency staff to identify systemic problems and develop approaches to improve access.

Key Meetings per County Contract	Purpose
Community Health Improvement Partnership (CHIP)	Increase awareness of local health needs and expand coordination among health improvement projects
Health Services Advisory Board	Improve health care services countywide
Healthy San Diego Joint Consumer and Professional Advisory Committee (JCPAC)	Discuss issues faced by Medi-Cal managed care beneficiaries
Healthy San Diego Quality Improvement Subcommittee	Improve quality of care of Medi-Cal managed care beneficiaries
Mental Health Board	Advocate for mental health services
Mental Health Managed Care Advisory Group (<i>ad hoc basis</i>)	Monitor and improve coordination of mental health for managed care enrollees
Quality Review Council of the Mental Health Plan	Review quality of care policies and issues for programs.
Other Meetings	Purpose
Business Health Care Connection	Improve health care access to small business employees
CHIP 2-1-1 Protocol Committee	Plan training and materials to support 2-1-1 staff
Community Health Group Public Policy Committee	Advice on improving services to plan members
Enrollment Workgroup of JCPAC	Discuss enrollment issues faced by Medi-Cal managed care beneficiaries
Health Care for the Homeless Program	Identify resources for the homeless population
Health Net Community Advisory Committee Meeting	Improve cultural and linguistic access to the health plan's services
Healthy Families Program (HFP) Retention Workgroup	Discuss and recommend strategies for retention
Meetings with county staff	Address Medi-Cal, CMS, CalWORKs and mental health issues
Older Adult Mental Health Systems of Care Council	Provide community representation and feedback to agencies serving older adults resulting in improved services
Outreach and Eligibility Subcommittee	Discuss Medi-Cal eligibility issues and increase Medi-Cal enrollment and retention
Safety Net Study Workgroups	Issue brief preparation for county and state action on safety net issues.
San Diego Mental Health Coalition	Provide oversight and suggest changes to improve mental health services

CASE SUMMARIES

Medi-Cal Issues

At the Hearing Level Denti-Cal Authorizes Upper and Lower Dentures Based on new Medical Evidence

Facts: Denti-Cal denied approval for upper and lower dentures for a disabled individual with a series of overlapping medical problems including sleep apnea, and TMJ syndrome, a painful disorder of the jaw. The consumer requested a state fair hearing and obtained the services of a Center health advocate in order to assist him with his appeal.

Action & Outcome: Our advocate reviewed Denti-Cal's position that the consumer was not eligible for the requested services because he did not meet Denti-Cal's criteria for upper and lower dentures to be approved. Despite the fact that Denti-Cal's written criteria were not met, the advocate asked the consumer's medical doctors to comment whether the upper and lower dentures were medically necessary in order to improve his dental closure and alleviate the medical problems the consumer suffered due to his sleep apnea. His medical doctors agreed that with improved functional interaction between his teeth (occlusion) his breathing would improve. They provided the advocate with letters which detailed this opinion. The advocate submitted these letters, along with other medical documentation and a position statement in which the advocate argued that the dentures were medically necessary to prevent disability, pain and a more serious medical condition, to the ALJ and to the Denti-Cal representative. The advocate argued that the ALJ and Denti-Cal should approve the request for dentures under Denti-Cal's general obligation to provide medically necessary services. Denti-Cal reviewed these materials, along with the advocate's arguments, and agreed to approve the dentures. The ALJ incorporated this agreement into a hearing decision. The consumer soon thereafter received his dentures.

Systemic Issue: As the Center has noted repeatedly, Medi-Cal beneficiaries with severe illnesses have difficulty protecting their rights to challenge state agency decisions and obtain benefits they desperately need. The Center can help gather medical documentation to support the need for care when a consumer does not meet specific criteria for the treatment.

Medi-Cal Granted for Child who had been without Health Coverage for Three Months due to Delay in Processing Case after Healthy Families to Med-Cal Transfer

Facts: The mother of a 2-year-old child received notice from Healthy Families that her child was no longer eligible for Healthy Families due to a decrease in the family's income. Healthy Families notified the mother that the child's case would be transferred to Medi-Cal and that Medi-Cal would contact the mother within 45 days. Three months after the child was terminated from Healthy Families, the mother still had not received any notice from Medi-Cal and the child had no health coverage. The mother did not know who to contact since she had not received any notice from Medi-Cal and she had no idea who the worker was.

Action & Outcome: The Consumer Center advocate first determined who the Medi-Cal worker was for the child's case by contacting the county's public assistance information line. When the advocate called the number given for the assigned worker, she got a voicemail message which indicated that it was a general voicemail and that there was a delay in processing Medi-Cal applications. After the advocate failed to receive a return call, the advocate called the Medi-Cal supervisor. The advocate explained that Healthy Families had forwarded the child's information to Medi-Cal approximately three months prior and that according to Medi-Cal's own rules, there was a 45 day limit to process applications. The child had been without any health coverage for at least two months due to Medi-Cal's delay in processing the application. The supervisor reiterated that the office was behind in processing applications, but that they would expedite processing upon notification that someone was in need of immediate medical attention. The supervisor assured the advocate that a worker would contact the mother. The mother was finally contacted by a worker and Medi-Cal was approved for the child.

Systemic Issue: It is difficult enough for consumers to try to navigate through one public benefit program. Trying to navigate through two programs can be daunting and time consuming without a knowledge of program rules or an understanding of the duty that each program has to coordinate efforts to make the transition from one benefit program to the other as seamless as possible. Advocates armed with this knowledge can assist applicants to more easily and effectively navigate public health programs.

Medi-Cal Application Processing Expedited for Child without Health Coverage and in Need of Surgery

Facts: A 17-year old girl needed an urgent surgery. Her mother applied for Medi-Cal. The mother received an eligibility appointment that was two days prior to the scheduled date of surgery for her daughter and approximately two and a half weeks from the day she contacted the Consumer Center. The child needed to have Medi-Cal in order to have the surgery performed.

Action & Outcome: The consumer health advocate contacted the Medi-Cal office to discuss expediting the application process for the family due to the child's urgent need for surgery. The first representative that the advocate spoke with at the Medi-Cal office suggested that the mom show up at the office on any weekday at 7 a.m. to check for cancelled appointments. According to this representative, this was the only way for the family to get an appointment sooner than the one they already had scheduled. The advocate called the Assistant Manager at the Medi-Cal office to explain the situation. The advocate requested that the application process be expedited in light of the child's immediate and urgent need. The Assistant Manager informed the advocate that she would have someone contact the mother immediately. A worker contacted the mother the following business day and set up an eligibility appointment. The child was granted Medi-Cal prior to the date of her surgery.

Systemic Issue: Consumers who have an urgent need for health services often do not know that their applications for Medi-Cal must be processed in an expedited manner. The Medi-Cal program has rules in place to help applicants who have an urgent need for health services. These rules do not permit workers to strictly adhere to the "first come, first served" rule. Instead, workers are required to process the applications for those who have an urgent need as quickly as possible. Advocates who know and understand program rules are able to help consumers obtain the health coverage they need without unnecessary delay.

Consumer Center Helps Cancer Patient Obtain Medi-Cal for Immediate Treatment and to Cover Medical Debt

Facts: A 46-year-old mother of two, diagnosed with lung and liver cancer, applied for Medi-Cal in February 2008. A decision on the consumer's application was delayed despite her immediate need for chemotherapy.

Actions & Outcome: The Consumer Center's advocate assisted the consumer in contacting the Medi-Cal worker and supervisor who failed to respond to numerous messages over the next two months. Both county workers continued to delay processing the application so the advocate contacted the District Manager requesting the consumer's application be processed immediately under special rules that require such processing when there is a medical need. The advocate further argued for and successfully obtained full scope free Medi-Cal retro-active to the initial date of application for the consumer and her family.

After getting Medi-Cal, the medications' and MRI request from her physician were both denied. The advocate assisted the consumer in requesting and receiving enough of the prescription drugs for 72 hours at no cost and advised her about the procedures to get reimbursed for her medical costs.

Systemic Issue: Consumers with severe illnesses have difficulty obtaining medical services or, as in this case, they may be forced to forego care altogether due to the lack of knowledge or misunderstanding on the part of county workers about the numerous Medi-Cal programs. Consumer Center advocates are able to intervene on behalf of the consumer to ensure they are appropriately evaluated for the benefits they desperately need.

Consumer Center Helps Disabled Woman obtain Medi-Cal and cover Medical Costs

Facts: A woman on kidney dialysis was denied Medi-Cal for failure to provide the needed verifications. The woman and her husband lost all paperwork when their home was lost in the 2008 wildfires. The husband suffered from severe depression due to their extensive financial and medical problems.

Actions & Outcome: Our consumer advocate advised and assisted the woman in requesting a hearing to appeal the denial. The advocate helped to resolve the consumer's issue by obtaining a conditional withdrawal from the county appeal's representative. According to the agreement, the consumer's case was sent back to an eligibility worker to allow the consumer more time to provide requested documentation. The consumer's Medi-Cal application was granted but with a high SOC. The consumer was unable to pay the SOC and therefore, unable to receive transport to and from her dialysis treatments. The consumer and her disabled spouse were assisted in applying for and receiving low cost Medi-Cal under the 250% Working Disabled program. The consumer's outstanding hospital bills were paid and she was able to get to her dialysis treatments.

Systemic Issue: If not for the Benefits Advocacy Project between the Consumer Center and Scripps Mercy, the consumer likely would not have appealed the Medi-Cal decision or been able to follow through with what was needed to resolve her problem. This case demonstrates the importance of assisting individuals with both physical and mental disabilities who are unable to represent themselves.

Medi-Cal Reinstated for Minor Child Whose Application was Initially Filed by a Caretaker that was not Related to the Minor

Facts: A six-year old child had been living with his former babysitter for over three-years. The mother of the child had appointed the babysitter, who is not related to the child, Power of Attorney for the child while she was in prison and asked her to care for the child in her absence. The caretaker applied for and received Medi-Cal for the child when he began to suffer from a blood condition. Almost three years later, Quality Control noticed that the child's initial Medi-Cal application was completed on the minor's behalf by his caretaker who was not a blood relative and terminated the case.

The county argued that the babysitter/caretaker was not permitted to apply for the child because she was not his relative.

Action & Outcome: Our health advocate represented the child at the fair hearing and submitted a post-hearing brief arguing that the county was incorrect in terminating the child's Medi-Cal. The advocate requested that the county continue the Medi-Cal pending the decision, which would allow the child to continue his Medi-Cal benefits without change until a decision was made. The Administrative Law Judge (ALJ) granted this request. The advocate argued that the child's caretaker was a proper person to apply for the child's Medi-Cal because she was informed of his medical condition and therefore his need to apply for Medi-Cal. Moreover, the child could not be expected to complete the application himself. The ALJ found that the county incorrectly terminated the child's coverage and ordered the county to reinstate his Medi-Cal benefits.

Systemic Issue: Due to the complex nature of Medi-Cal regulations, the Consumer Center provides a voice for those consumers who may not be able to advocate for themselves.

Judge Orders County to Properly Code an Aged Woman as Disabled so she could get low cost Medi-Cal

Facts: A 67-year old disabled woman contacted the Consumer Center when her Share-of-Cost (SOC) for Medi-Cal coverage was increased and she could not afford to meet the SOC.

Action & Outcome: Our advocate advised the consumer about the 250% Working Disabled Program because the consumer babysat her grandchildren and was paid monthly for this work. The 250% program would provide her with low cost Medi-Cal. The advocate communicated with the case worker who informed the advocate that the consumer could not be coded as disabled, a requirement of this program, even though she had been receiving SSI a couple of years ago and alleged an ongoing disability, because the Medi-Cal database had automatically "coded" her as an "aged" person and not as a "disabled" person when the consumer turned 65. The advocate advised the consumer to request a hearing. Our health advocate represented the consumer at the hearing. The county argued that there was no proof that the consumer was still disabled and even if she was disabled the county could not override the Medi-Cal database to code her as disabled without a court order. The advocate requested that the record be left open for the consumer to get the requested information from the Social Security Administration (SSA) regarding her disability status. This was permitted. The consumer, due to her age and disability, was unable to get the requested documentation from the SSA. The advocate contacted SSA and was able to get a letter from SSA regarding the consumer's disability. With this evidence, the Administrative Law Judge

(ALJ) ordered the county to code the consumer as disabled so that she was able to take advantage of the 250% Working Disabled Program.

Systemic Issue: Once they turn 65, older people who are disabled are automatically coded as “aged”. This excludes them from a program that provides low cost coverage. State Fair Hearings are sometimes the only avenue available to resolve such issues. An advocate provides a great service to the consumer when the advocate advises the consumer of the right to request a hearing and the problem can be resolved by a judge’s order.

Advocate Helped Obtain Dental Services for Consumer by Resolving Miscommunication between Provider and the Healthy Families Program

Facts: A 17-year-old’s teeth were growing crooked and he had several cavities because, despite his doctor’s recommendation for immediate dental treatment, the consumer had not been able to see a dentist in four years. The consumer was unable to receive such treatment because the dental provider claimed that the young man did not have coverage under the Healthy Families Program.

Action & Outcome: A bilingual health advocate was able to communicate with a representative at Healthy Families and inform the Spanish-speaking consumer that he had effective coverage and there should not be a problem with dental treatment. The advocate had Healthy Families send confirmation of the consumer’s eligibility to the dental provider. However, the dental provider still refused coverage because their database showed Healthy Families had not activated the young man’s dental plan. The advocate contacted representatives from both the Healthy Families Program and the dental provider several times and had documentation faxed to the provider on multiple occasions. The consumer had an upcoming dental appointment and needed authorization of his dental coverage or the dentist would not see him. The advocate finally spoke to a supervisor with the dental medical group where she learned that there had been a communication problem between Healthy Families and the provider for several months. After making several more phone calls to MRMIB and the dental provider the consumer’s dental coverage was authorized and he was able to see the dentist.

Systemic Issue: The inability of some Spanish-speaking consumers to communicate with providers, coupled with bureaucratic miscommunication between medical programs and providers creates a barrier preventing consumers from obtaining medical benefits they are entitled to. Bilingual Consumer Health Advocates have the ability and experience to break through these barriers and provide assistance for consumers who may, otherwise, be overwhelmed by the process.

Health Advocate Assisted in Getting Consumer's Unpaid Medical Bill Covered by Medi-Cal

Facts: A 37-year-old Vietnamese man was hospitalized for 10 days at a mental health facility due to suicidal tendencies. The consumer was uninsured, had incurred a medical bill of over \$45,000 and needed ongoing care.

Action & Outcome: The consumer health advocate who helped this consumer was fluent in Vietnamese which allowed her to communicate with his family while the consumer was struggling with severe anxiety and depression. The advocate used her knowledge of the Medi-Cal program in advising the consumer to apply for SSI because an individual found disabled through SSI is automatically linked to Medi-Cal. In addition, the advocate advised the consumer to apply for Charity Funds for the hospital bills and to tell the hospital that a Medi-Cal application was pending so that the bill would not be sent to collections. The consumer was eventually approved for SSI and his \$45,000 hospital bill was paid and he was able to access care under Medi-Cal.

Systemic Issue: Many consumers who do not speak English have an additional barrier in obtaining Medi-Cal coverage. Consumer Center advocates can help consumers break through this barrier, as well as simplifying and explaining the Medi-Cal program to consumers who are in the midst of difficult medical situations. An advocate's assistance and advice is often the difference between a bill going to collections and Medi-Cal covering the bill.

Children get free Medi-Cal after Advocate Researches Property Rules

Facts: A consumer filed the annual Medi-Cal renewal and her children were approved with a share-of-cost (SOC). A month prior to this, the consumer's children were on the free 1931 (b) Medi-Cal program. Having a substantial SOC meant that the family had to spend a significant amount on their medical care in any month before Medi-Cal would pay the rest of the medical cost. The family's only income was from the husband's employment and a rental, a granny flat in the back of their home. The county worker referred the children to Healthy Families.

Healthy Families (HFP) determined that the children did not qualify for HFP because they qualified for free Medi-Cal.

Actions and Outcome: The Consumer Advocate researched the property rules and discovered that a portion of expenses from the entire property can be prorated and deducted from the rental income when the rental property is located on a property that is exempt as principal residence. After the advocate deducted prorated rental expenses she determined that, in fact, the children did qualify for the free 1931 (b) Medi-Cal program. The advocate contacted the county worker and explained how she

incorporated the prorated rental expenses in her calculations. The county worker asked the advocate to fax a copy of the rules. The county worker responded within a week after discussing the case with his supervisor. The family was approved for free Medi-Cal.

Systematic Issue: Medi-Cal is an all-encompassing name for what is a group of separate and distinct programs that have different rules. Many workers misunderstand the complexities of or lack particulars on these all too numerous programs. This may cause beneficiaries to lose health care coverage. Consumer Center advocates well-informed and with access to the extensive program rules can intervene on behalf of beneficiaries and ensure appropriate evaluations of Medi-Cal programs.

Infant with Aggressive Brain Tumor in Dire Need of Chemotherapy was Expediently Approved for Medi-Cal

Facts: A 16-month-old infant had an aggressive brain tumor that was surgically removed. Immediately after the surgery the infant needed to begin chemotherapy. Unfortunately the infant was uninsured and his Medi-Cal application was denied for failure to establish California residency. Consequently, the infant was also denied the life saving therapies.

Actions and Outcome: The advocate assisted the mother and requested an *expedited* appeal on the infant's behalf. Having quickly gathered the required documentation showing ties to the county, the advocate was able to negotiate an agreement with the County appeals representative that residency had been established. The advocate was effective in communicating the urgency of the situation and as a result the turn around was quick and the infant was granted Medi-Cal.

Systemic Issues: The Medi-Cal application process is cumbersome and slow. Some cases need an immediate response. Advocates do their best to assist all consumers through the lengthy process and prioritize those that need an eligibility determination as quickly as possible.

Consumer with Severe Depression gets Medi-Cal and SSI

Facts: A 52-year-old man went to the ER with severe depression and was hospitalized at the Behavioral Health Unit. He has CMS insurance, but that does not cover mental health care. The hospital advised him to apply for SSI and Medi-Cal and informed him that he must do so within 10 days from the date of his visit in the hospital. The consumer was then referred to the Consumer Center advocate to assist him with his coverage.

Actions and Outcome: The consumer met with the consumer health advocate to discuss his case. The consumer informed the advocate that he had SSI in 2007, but that he was sent to jail for four months and did not know what happened to his SSI. The advocate knew that a SSI case could be reopened if the case had been closed for less than a year. The SSI office had closed the case due to “whereabouts unknown”. The SSI office informed the advocate that the person only had two weeks before the deadline, or he would have to reapply for benefits. The advocate repeatedly encouraged the consumer to take the needed action and made sure that he did so despite his mental health problems. The consumer was able to get his SSI reinstated and was given a notice confirming this. The advocate then informed the SSI/Medi-Cal worker that SSI was active and faxed her the proof. The county worker re-activated the consumer’s Medi-Cal so that the consumer’s hospital bills were paid. The man was able to get SSI benefits to support himself and health coverage to continue his treatment.

Systemic Issue: This case highlights the importance of responding timely and appropriately to consumer’s needs and helping consumers take the required actions to get care.

Infant with Heart Condition gets Medi-Cal after Long Delay

Facts: A county worker failed to process Medi-Cal for a newborn for three months after the mother had informed her that the baby was born. The infant has a heart condition and needs medication. The mother kept calling the worker, but had no response so she finally called the Consumer Center.

Actions and Outcome: The consumer health advocate left a message for the county worker, but the worker did not respond. The advocate then contacted the worker’s supervisor. After investigating, the supervisor called the consumer health advocate and said that she could not find the paperwork the mother had submitted. She first offered to make an appointment to turn in the paperwork, but later called the mother back to let her know she found the paperwork. The baby was able to get his medication for his heart problem.

Systemic Issue: Workers with large caseloads often lack an in-depth knowledge of applicable policy and the time to review case files. Rules exist to prevent unnecessary pending of benefits. Consumer Center advocates with knowledge of the applicable law can help beneficiaries obtain their public benefits and needed health care.

Medical Bill Resolved Once Complaint Filed

Facts: A woman was covered by Access for Infants and Mothers (AIM). At the time of her delivery, she provided her health plan/AIM insurance card to the hospital. The

hospital's intake worker refused to let her use her P.O. Box address and so she had to use her physical address on the hospital forms.

Almost a year later, she was contacted by a collection agency regarding the bill for her baby's delivery. The hospital had been unable to contact her because mail could not be delivered at her physical address. The hospital finally agreed to use the P.O. Box address and her health insurance information to bill the health plan. But the plan refused to pay because the bill was past the claim deadline.

Action and Outcome: The consumer finally called the Consumer Center. She told the advocate that she was relieved to find someone who could assist her in Spanish. She said that it was frustrating and distressing to try to resolve her problems in English. The advocate attempted to resolve the case by making numerous conference calls and other calls to both the health plan and hospital staff. When that was not successful, the advocate wrote letters to the hospital and health plan's complaint departments in envelopes labeled "TO BE OPEN ONLY BY MANAGEMENT." Within one week, the woman received a letter from the hospital stating that her bill had been paid in full by the health plan.

Systemic Issue: Advocates try to resolve issues at the lowest level possible. However, it is sometimes necessary to challenge decisions in a more formal manner. Advocates know how to use all avenues of appeal to resolve issues for consumers.

Medicare Part D

Medicare Beneficiary Advised on Programs to Save Money on Medications

Facts: A 54-year old Medicare and Medi-Cal beneficiary (dual eligible) has a combined monthly Social Security and pension income of \$1,458. Through his Medicare Part D (Part D) plan, he used to pay \$28-\$42 a month for his three medications. One of these medications is Topamax, which he needs to control his epilepsy. In October 2007, the consumer reached his Part D plan's coverage gap (donut hole), which caused the cost of his Topamax to drastically increase to over \$600 a month. The cost of this medication alone was over 40% of his monthly income. Without the Topamax, however, the consumer was afraid that he would die due to uncontrolled seizures. Per the manufacturer's warning, Topamax should not be stopped abruptly. If the drug is withdrawn, the frequency of seizures increases.

Action and Outcome: The consumer initially contacted the San Diego Epilepsy Foundation and was referred to the Consumer Center. After screening him for government programs, an advocate determined that he was \$162 over income for the low-income subsidy (LIS). (If he had been eligible, the monthly cost of the Topamax during the donut hole would have been \$90 instead of \$600). To plea for co-pay relief,

the advocate contacted Ortho-McNeil Neurologics, the manufacturer of Topamax, and explained the consumer's predicament. The plea was denied, unfortunately, since epilepsy was not listed as one of the diagnosis for charity help. To receive the Topamax, the consumer's only option was to ask his doctor for samples. His doctor decided to change the medication to a less expensive one. To help pay for the medications in the future, the advocate advised the consumer to apply for the 250% Working Disabled Medi-Cal program, which will help meet his Medi-Cal share-of-cost. Upon doing so, the consumer will automatically receive the LIS, and the medications will cost no more than \$5.35 each.

Systemic Issue: Unlike other government programs, the LIS does not have a spend-down option, which would have allowed consumers with disabilities to become eligible by reducing their countable incomes when they pay for other health care costs.

Advocate Helps Dual Eligible Consumer with Medicare Part D Problems

Facts: In October 2007, a 74-year old Medicare and Medi-Cal beneficiary (dual eligible) had billing problems at the pharmacy, which caused her to pay the full price of \$60 for one hypertension medication. Before January 1, 2006, Medi-Cal covered the medication at no charge.

Action and Outcome: To determine the reason for the increase in her drug costs, the pharmacy referred her to a Social Security office. The consumer was advised to call the Consumer Center. An advocate called the pharmacy and the toll-free Medicare number and determined that the consumer was not enrolled in a Medicare Part D (Part D) plan. If she had been in a Part D plan, the cost for her medication would have been no more than \$3. When the advocate attempted to file a complaint because Medicare had not assigned the consumer to a plan, the representative refused to take the complaint. As a result, Medicare Region 9 was contacted, and a Region 9 office worker stated that the consumer had been assigned to a Part D plan starting September 2007.

Since Medicare did not assign the consumer to a Part D plan in January 2006 when it should have, she went over a year and a half without a Part D plan. The Medicare worker stated that the consumer was assigned to a plan in 2006; however, due to a computer glitch, she had been mistakenly disenrolled.

When the advocate and consumer called the assigned drug plan and asked for information the pharmacy needed to bill the plan, the representative stated that Medicare had not notified them of the consumer's enrollment. The plan representative promised to contact the consumer within 48 hours. It was not until the advocate called the drug plan again three weeks later to verify the enrollment, however, that the consumer finally received the needed information. With this information, she is now able to receive her medications for \$3 each.

Systemic Issue: With the implementation of the Medicare Modernization Act in January 2006, dual eligibles no longer receive most of their prescription drugs from Medi-Cal. Instead, Medicare should automatically enroll them into Part D plans and the low-income subsidy, which is a program that significantly reduces Part D plan costs. These enrollments, unfortunately, do not always happen when they should, thereby causing dual eligibles to make the choice of either paying high costs or foregoing their medications

Advocate Helps Disabled Elderly Mental Health Consumer get low cost medications through Part D and LIS (Low Income Subsidy)

Facts: A 65-year old dual eligible consumer (beneficiary with Medicare and Medi-Cal) with mental health disabilities has a monthly income of \$836. When the consumer went to the pharmacy in January 2007, he was charged mistakenly the full price for his prescriptions. Four of these were psychiatric medications, since these costs would have represented nearly 50% of his income, he left the pharmacy empty handed. If he would have paid for the medications, he would not have been able to pay rent as well as buy food and other living necessities. Since he was without these important medications, the consumer's mood and memory was affected including not remembering the names of the other drugs. Desperate to fix the problem, he took his pharmacist's recommendation and went to the local Social Security office where he was referred to the Consumer Center.

Action & Outcome: The consumer called us for assistance. An advocate determined that the incorrect expenses resulted from Medicare not assigning him to a Part D plan. The advocate walked the consumer's pharmacist through the process of enrolling him in the emergency point-of-sale (POS) program, which should have enrolled him into a plan. However, this POS did not work, and he still could not obtain his drugs. The consumer was finally enrolled in a plan as a result of the advocate contacting the Medicare Region 9 office. After the advocate worked with the drug plan to update his Low-Income or Extra Help subsidy level, the consumer finally purchased each of his medications for \$1 and \$3.10.

Systemic Issue: Since the implementation of Part D, dual eligibles receive most of their medications from a Part D plan instead of Medi-Cal. Medicare has the responsibility to facilitate the enrollment of dual eligibles into prescription drug plans. However these enrollments do not always occur, causing consumers to forego their medications and affecting their health. Our Part D advocates provide invaluable assistance to Medicare beneficiaries by educating pharmacists about the emergency POS plan. Advocates also contact the regional Medicare office so that consumers are properly enrolled in plans as well as charged the correct co-payments and maintain their health.

The Low Income Subsidy and Other Programs Helps Senior

Facts: A 65-year-old woman with mental health disabilities receives a monthly Social Security Retirement income of \$267 and she recently became eligible for Medicare. Instead of continuing to receive her drugs from a mental health clinic, she was told to join a Medicare Part D prescription drug (Part D) plan. Without Part D, the medications the woman however needed to take were unaffordable; however she did not know which drug plan to enroll in or even how to enroll and went to her local Social Security Administration (SSA) office for help.

Actions & Outcome: The SSA representative referred the woman to a Consumer Center advocate who told her about several government programs that she was eligible for, including Part D. She was helped to apply for the Low Income Subsidy (LIS), which reduced the costs of her medications from hundreds of dollars to just \$1.00 to \$5.60 per medication. In addition, the consumer also learned that she was eligible for free health insurance through Medi-Cal and that her monthly income could increase by enrolling in a Medicare Savings Program (MSP). The State of California would pay for her Medicare Part B premium of \$96.40 instead of it being deducted from her Social Security check. Also, Supplemental Security Income (SSI) could augment her current income. With assistance from the advocate, the consumer enrolled in these programs and as a result the medications became affordable. Medi-Cal also provided her with more health care services than Medicare and her monthly income increased by 71% since she enrolled in a MSP and receives SSI. The consumer stated that she never would have known about these programs if the advocate had not assisted her.

Systemic Issue: The Medicare Modernization Act of 2006 allowed Medicare to contract with private companies to provide beneficiaries with prescription drugs. Applying for a Part D plan, however, can be complicated. Beneficiaries often find themselves stymied due to the large number of choices, especially for those without access to the Internet. Calling Medicare's toll-free number to enroll can also be frustrating for beneficiaries who do not like to wait on-hold or chose from an automated system. Beneficiaries who meet income, asset and eligibility criteria can call a Consumer Center advocate and become educated about Part D and learn about plan options that best meet their medication needs.

Woman with Disabilities Saves Money on her Prescription Drugs

Facts: A 52-year-old woman suffers from seizures, bipolar disorder, rheumatoid osteoarthritis and chronic pain. She has Medicare and a monthly income of \$1,271 from Social Security. Although the consumer was enrolled in a Part D plan, she still paid \$102 every month for her eight medications. This represented almost 10% of her monthly income.

Actions & Outcome: After being referred to the Consumer Center for help with the high medication costs, the consumer learned how enrolling in the LIS would reduce the costs significantly. Upon receiving the LIS subsidy, her total monthly drug plan costs were reduced from \$102 to \$24.70, now just two percent of her monthly income. The advocate performed a drug plan search for the consumer to ensure that she was in the plan that best covered all her medications. Since she did not have Medi-Cal, the advocate educated her about applying for the 250% Working Disabled Medi-Cal Program. To save even more money on food, she followed the advocate's advice and agreed to apply for Food Stamps.

Systemic Issue: To help low income Medicare beneficiaries pay for the costs of their prescription drugs, the SSA offers the LIS. To receive the subsidy, certain beneficiaries however need to apply. Reasons that eligibles do not apply include being unaware of the program and their need to enroll and confusing wording of the questions on the application. The paper application is only available in English and Spanish; therefore, beneficiaries who need other languages have to enlist the help of a translator to apply. Beneficiaries can contact the Consumer Center's multilingual staff and receive assistance with completing the LIS application.

Advocate Fixes Enrollment Problems for Consumer

Facts: A 67-year-old woman with a mental health disability receives monthly Social Security benefits of \$950. She also receives Medicare and Medi-Cal (dual eligible) and has a MSP and thus the State of California pays for her Medicare Part B premium of \$96.40. However, she has to pay over \$400 per month (42% of her monthly income) for her eight medications. If she paid for all her prescriptions, she would not have enough money left for other living expenses. A social worker at her group home advised her to call the Consumer Center for help.

Actions & Outcome: The consumer spoke with an advocate and learned that since she is a dual eligible and had a MSP, Medicare should have automatically assigned her to a Part D plan and the LIS. The reason she paid so much for her medications was because these enrollments did not happen. Our advocate helped the consumer enroll in the LIS and a Part D plan. Instead of paying \$400 a month, she began paying \$12 a month. This represents just one percent of her monthly income. Now able to afford her medications, the consumer told our advocate that she can afford to buy the food and other items she needs.

Systemic Issue: Medicare should automatically enroll certain beneficiaries into the LIS and a Part D plan, including dual eligibles as well as SSI and/or MSP recipients. These enrollments unfortunately do not always occur, which results in higher medication

costs. Beneficiaries are faced with the choice of paying more or forgoing their medications. Consumer Center advocates help fix these enrollment problems and report them to state and national Medicare advocacy organizations.

Mental Health Issues

Psychotherapy Visits Authorized

Facts: For nearly 10 years, a 49-year-old client had been in therapy with a clinical psychologist and since 2002 had been seeing her twice a month. Despite the provider documenting the need for continued treatment, the request for twice monthly outpatient psychotherapy visits was denied and instead community support programs were recommended that included clubhouses and other peer provided services. Upon receiving the Notice of Action (NOA), the client called us and filed an appeal.

Action & Outcome: As part of the County's Beneficiary Problem Resolution Process, contacts with the client's therapist and psychiatrist were made immediately. Progress notes, medical records and support letters were obtained. Upon a review of the information presented, our advocate negotiated a reasonable plan with the County Mental Health. It was agreed that the client would benefit from a transitional plan rather than an abrupt decrease in therapy and authorized monthly sessions. In addition, his treatment plan was modified to include activities that would increase his social support. The client agreed to attend church activities twice a week and Recovery, Inc., a community-based member managed self-help mental health program. All parties agreed to this compromise.

Systemic Issue: This case illustrates the importance of an independent agency advocating on behalf of clients. Reviewing records alone oftentimes does not reveal the path that individuals need to take for their recovery. Our peer advocate staff are skilled at negotiating outcomes, which would provide for transitional services enabling clients to feel more confident about moving to community-based supportive programs.

Client Helped To Obtain Missing Personal Items

Facts: A client with a mental disability had given her personal journal and some irreplaceable childhood photographs to her therapist. Shortly thereafter, the client decided to stop seeing the therapist and asked for the items to be returned so that she could move on. In the meanwhile, the therapist was hospitalized with a serious illness and was unable to contact his clients. During the therapist's absence, his assistant unfortunately was unable to find the missing articles.

Action & Outcome: The client filed a grievance regarding these personal items that she had entrusted to the provider. The advocate contacted the therapist who explained that some clients “forgot” or sometimes even deliberately left possessions at his office to test his loyalty. The journal was located and the photographs were later found. The client was happy to be re-united with her missing articles.

Systemic Issue: Keeping the lines of communication open is critical for recovery. Our job as advocates is to be impartial without choosing sides, yet always keeping the client’s best interest in mind. One could have very easily admonished the client for leaving personal items unattended or just as easily lay blame on the therapist for taking such a responsibility too lightly. Time and patience proved to be the best medicine in this case.

Community-Based Treatment Granted Instead of Incarceration

Facts: A 28-year-old man was arrested and charged with assault and robbery after he hit a woman and stole her purse. At the time of his arrest, he was off his medications. The court determined that the client was not ready to stand trial and sent him instead to Patton State Hospital. After two months, he was transferred to the Psychiatric Unit at the San Diego County Jail. The client’s mother called the Consumer Center requesting help in getting him into a locked mental health facility after his readiness hearing.

Actions & Outcomes: Our advocate first contacted the Mental Health Plan’s Administrative Service Organization to obtain authorization for the client to be transferred to a locked mental health facility. Roadblocks included having no payment mechanism since the client lost Medi-Cal when he was incarcerated. Ultimately, our advocate was able to dialogue with the young man’s mother and the jail’s social worker. After two court appearances, he was released to a comprehensive treatment program for clients on probation. He now has housing and supportive services, including medication management and peer support. Follow-up revealed that this young man is currently living in a downtown hotel, taking the prescribed medications that are delivered daily and has been reunited with both parents.

Systemic Issues: Criminalization of the mentally ill is a serious problem. This young man became a victim when he was arrested, sent to a state mental hospital and then to jail. Yet what he needed was housing, medication management and supportive services, not jail. For many persons with psychiatric challenges who find themselves in the criminal justice system, community-based services are the best alternatives to incarceration, ultimately saving taxpayers the high costs of unnecessary incarceration.

Reduction in Service Reversed Upon Appeal

Facts: A 56-year-old woman living with psychiatric challenges and multiple physical ailments had been seeing her psychologist weekly when she received a Notice of Action reducing the weekly psychotherapy sessions to bimonthly. At the time that these services were decreased, the client was in a deep depression, unable to get out of bed and living in chronic pain. She was unable to care for herself or her home.

Actions & Outcomes: After contacting the Consumer Center, the client was advised of her rights and filed an appeal using the County's Beneficiary Problem Resolution Process. Medical records were obtained from the treating psychiatrist and therapist, which subsequently were reviewed by our independent clinical consultant. Based on the consultant's recommendations, the County overturned the decision and granted the client three additional months of weekly therapy sessions. Our advocate also successfully referred the client to case management services, which offered her support as she transitioned from weekly individual therapy to community services.

Systemic Issues: Mental health treatment in San Diego County is moving in the direction of providing a range of community-based, peer-run services. Rather than abruptly reducing services, clients are in need of a transition plan. In this case, a three-month extension was used as a bridge to community-based services while introducing supportive services in a case management framework.

Consumer Reinstated in Homeless Shelter

Facts: A 46-year-old client with schizophrenia and depression had been living in a homeless shelter for approximately one month. The shelter required him to complete a two-hour chore each day that benefited the community. Despite having previously discussed a negative situation with his case manager the client was re-assigned to kitchen duty. He became aggravated when the kitchen manager raised his voice. He did not want to become violent like he had in the past and yet he could not tolerate verbal abuse. The client gathered his belongings, surrendered his badge that identified him as a resident of the shelter and walked to our downtown office.

Actions & Outcomes: Our advocate initially called 2-1-1 San Diego in an attempt to find an available crisis center bed. Unfortunately, there were no vacancies in either crisis centers or shelters. The client stated that he would like to return to the homeless shelter if he could have a different chore assignment. Since he had relinquished his badge, he would not be permitted to return to the shelter for 30 days. The advocate negotiated a special consideration that would allow him re-entry to the program that day.

Systemic Issue: Advocates are often best able to assist clients when they first find themselves in trouble. This client recognized when he walked away that he had made

an impulsive decision, though he did not know how to undo it. Working in a non-adversarial relationship with the shelter staff, our advocate was able to make immediate contact with the case manager. In doing so, we were able to rectify the client's hasty actions and maintain his space in this community-based shelter.

Treatment for Child Continued

Facts: The mother of an 8-year-old boy took her son to a psychiatrist at one of the county-funded mental health clinics. The child was diagnosed as having Attention Deficit Hyperactivity Disorder and was prescribed Abilify. Previously, he had been treated with Aderall. The mother was under the impression that Abilify was for the treatment of Schizophrenia and Bipolar Disorder. The mother was confused about the diagnosis and believed that the provider prescribed the wrong medication for her child. She contacted the Consumer Center and filed a grievance against the provider.

Actions & Outcome: Our advocate contacted the prescribing physician and requested copies of the medical records. These records subsequently were reviewed by our independent clinical consultant who concurred that the medication prescribed was appropriate for the child's diagnosis and within the standard of care. When the advocate shared the clinical consultant's findings with the mother, she gained a better understanding of her son's condition. The grievance was successfully resolved.

Systemic Issue: Parents often are the best advocate for their children, yet sometimes they are misinformed. As Title IX Patient Rights Advocate for Mental Health Outpatient Services, we have a responsibility to advocate and educate consumers and their families. In this case, we restored the mother's trust in the provider by obtaining a second opinion and the child continued being treated at the clinic.

County Medical Services (CMS)

CMS Approved for Consumer after Consumer denied CMS for missed appointment

Facts: A homeless patient was admitted to the hospital for a fractured hip. The patient was in the hospital for almost a week. While in the hospital, he filled out an application for CMS and told the worker that he was homeless and did not have a mailing address. The worker listed a homeless P.O. Box address. However, the worker did not tell the patient about this address and the application appointment notification was sent to this P.O. Box. The consumer was denied because he did not come to his scheduled appointment. He found out about the denial when he went to the hospital the following month to check on the status of his application.

Action & Outcome: The consumer health advocate advised the consumer to request a hearing. At the hearing, our advocate faced two issues: First, whether there was good cause for the late filing of the request for a hearing; Second, whether there was good cause for the consumer's failure to attend the appointment. We argued that the consumer had never been informed of the homeless P.O. Box that his mail would be sent to, nor did the hospital attempt to contact the consumer's "contact person" listed on his application and therefore the consumer had not received the notice, and could not timely request his hearing. Moreover, after reviewing the county's file, the advocate noticed that although there was a copy of the notice in the county file, there was no narrative that the worker actually mailed the notice out to the consumer. The Hearing Officer agreed and ordered the county to reissue a new appointment date for evaluation of the CMS application. The county mailed this notice to the advocate two days prior to the consumer's scheduled appointment and fortunately the advocate received it the afternoon before the consumer's scheduled appointment. The advocate located the consumer at the homeless shelter and informed him of the appointment the next day. The consumer had not yet received the appointment notice. The consumer attended the appointment. The advocate did follow-up to assure that the requested verifications had been provided. The county finally granted the consumer CMS to cover the hospital visit almost seven months prior.

Systemic Issue: Many times the issue that the consumer originally presents to the Consumer Center will be resolved but a new problem will occur. Follow-up is extremely important to assure that the consumer is getting the needed assistance and is able to obtain health coverage without unnecessary delay. This is especially true for homeless consumers who do not have a way to immediately get notices and messages.

CMS Granted to Consumer without Health Coverage and with Serious Medical Problems

Facts: A consumer was rushed by ambulance to the emergency room experiencing psychosis and uncontrolled diabetes. As it was not immediately apparent to emergency room physicians what was causing the consumer's schizophrenic type symptoms, she was placed on an involuntary psychiatric hold. The consumer was finally stabilized. Without health coverage, the consumer applied for County Medical Services (CMS). Since she met the eligibility criteria, she was given a number to call to apply. With the assistance of her sister, the consumer contacted the organization contracted by CMS to handle initial intakes and appointment scheduling while in the hospital and explained that she needed to apply for CMS coverage. This occurred the last day of the month. Rather than take an application, the worker instructed the consumer to call back once she was released from the hospital. The consumer did so a few days later which brought her to the first days of the following month. Because the earliest CMS can be granted is the month in which an individual applies, the consumer was not granted benefits for the month of hospitalization. This was both confusing and stressful for the

consumer because she applied exactly as CMS instructed and although eligible, did not receive benefits to cover her hospital and ambulance bills.

Actions and Outcome: First, the advocate assisted the consumer in requesting a supervisory review which upheld the denial. Second, the advocate represented the consumer at an administrative hearing where the denial was upheld a second time. The Hearing Officer (HO) found that while the consumer did make timely contact with CMS, she did so incorrectly. The HO indicated that there are different ways an outpatient and inpatient apply for CMS. The HO determined that the consumer was an inpatient but used the outpatient application procedure. This was quite frustrating because again, the consumer did make contact with CMS informing them of her situation but she was not given instructions on how to “correctly” apply. The advocate appealed this decision to the Superior Court and requested an order that CMS grant the consumer coverage for the month of her hospitalization. After filing the suit, the advocate was successful in negotiating a settlement with the County of San Diego. The consumer received coverage for the month of hospitalization.

Systemic Issue: The CMS application process is not well coordinated. There are multiple ways to apply and this is often confusing for the consumer.

Uninsured Consumer who Suffered Stroke was Granted County Medical Services to Cover \$38,000 Hospital Bill

Facts: The consumer was hospitalized because he suffered a stroke and is dependent on a pacemaker for his deteriorating heart condition. As the consumer was without health coverage, he applied for County Medical Services. CMS determined that he was over the property limit because his wife had a small interest in a home in Mexico. CMS denied his application. The consumer was in need of ongoing health care and medications to maintain his heart condition. He could not get it without CMS.

Actions and Outcome: The advocate advised the consumer to apply for Medi-Cal and assisted the consumer in filing an appeal of the CMS denial. The advocate represented the consumer at the administrative hearing. At the hearing the consumer and his wife explained that CMS erred in attributing 50% ownership in the property to the consumer and that they actually own only 25%. A document showed that the consumer owned 50% but this was clearly a mistake because when adding up all the ownership percentages, the total came to 125% - an impossibility. Regardless, the Hearing Officer (HO) upheld the CMS denial solely because the document, although nonsensical, gave the consumer a 50% interest. The advocate was successful in negotiating a settlement with the County of San Diego and avoided having to pursue costly litigation. The county agreed the property document was illogical, and agreed that the HO should have accepted the consumer’s hearing testimony that the intended property division

apportioned only a 25% interest to the consumer. The consumer's application for CMS was granted.

Systemic Issue: Sometimes common sense is the best defense. Document mistakes are common and by carefully reviewing both the County's and consumer's documents, and pursuing the issue when necessary, the Consumer Center is able to spot these errors and resolve the situation.

Consumer Represented at County Medical Services Hearing in Order to Demonstrate that the County Failed to Inform the Consumer of Proper Spend Down Rules

Facts: A consumer was hospitalized for three days after breaking her leg in four different places. She applied for CMS in the hospital and was told that because she had too much money in her bank account she would not be eligible for CMS unless she spent her assets down. However, the consumer was never told what she could or could not "spenddown" on and was denied because the manner in which she spent her assets was improper under the CMS guidelines.

Action & Outcome: A Consumer Center advocate researched the county's responsibility to inform applicants of proper "spenddown" rules. At the hearing the advocate demonstrated that the county failed to give the consumer adequate notice in regards to proper "spenddown". The consumer testified that had she known the rules she would have spent down properly. The Hearing Officer rescinded the county's denial and ruled that the consumer's assets must be re-evaluated only after she is informed of CMS "spenddown" rules. Thus, the manner in which the consumer had already spent down was permitted in order to meet the resource limit for CMS.

Systemic Issue: A consumer's lack of familiarity with CMS rules and the county's failure to inform applicants of necessary eligibility guidelines can result in an unjust denial of medical coverage. A Consumer Center advocate can aid in ensuring that consumers are properly informed of such rules.

Managed Care

Consumer with Complex Health Problem Allowed to Continue Care with Doctor Despite Change in Health Plans

Facts: In late 2007, the contract between Blue Cross and the state to provide health care to those on Medi-Cal ended. Medi-Cal beneficiaries who had been enrolled in Blue Cross had to choose another Medi-Cal managed care plan or, if they did not choose a plan, they were assigned one. Although most of the transition went smoothly, some established patients had problems because one of the Medi-Cal plans closed some of the

provider panels and asked patients to see new providers, disrupting their care with providers they may have seen for many years.

A consumer with a chronic disease who had recently been switched from Blue Cross to a new plan went to her pharmacy and was told her new health plan would not cover her medication. She went to the clinic to see her regular doctor about this and was told that her health plan had assigned her to a different clinic and a new doctor. The consumer refused to see a new doctor because she had seen her regular doctor for years and he knew about her complex problems. A clinic staff person's contact with the health plan to have the patient assigned her regular doctor met with no success. The consumer and staff at the clinic were very concerned about the serious health condition involved and decided to call the Consumer Center.

Actions and Outcome: The consumer health advocate realized the urgency of the matter due to the patient's chronic disease and difficulty with access. Since this was an entirely new and complex situation, the advocate did not have immediate success at resolving the problem, but was persistent and kept the consumer informed. The consumer health advocate's constant updates kept the consumer from giving up. Finally, Consumer Center staff were able to contact supervisory level staff at the Department of Managed Healthcare in Sacramento and top level staff at the health plan. The health plan reviewed the situation and then informed the advocate that they had contacted the patient directly and the issue would be resolved immediately. The consumer was able to continue with her doctor and get her medications.

Systemic Issue: The difficulty in changing members to a new plan was aggravated by the fact that the switch was done over the holidays and in a very short period of time. In addition, the situation was confused by the fact that some doctors who were listed as plan providers were limited from seeing any new members. Healthy San Diego hopes to address these issues and prevent these problems from repeating.