

Transitioning seniors and people with disabilities to Medi-Cal managed care



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Transition of seniors and people with disabilities to Medi-Cal managed care in California



- ~ 250,000 Medi-Cal only beneficiaries were transitioned to managed care health plans
 - Between June 2011 – May 2012
 - 14% seniors, 84% disabled, 2% blind*
 - SPD were one of the few populations still on FFS Medi-Cal
 - Only about 10% of SPD had voluntarily enrolled in managed care when it was voluntary
 - Population with complex care needs, rare disabilities, functional limitations
- Precursor to the Coordinated Care Initiative where 456,000 beneficiaries dually eligible for Medicaid and Medicare will be enrolled in Cal MediConnect.

Findings from two studies of the SPD transition



- **Provider/Health Plan survey**
 - 59 interviews with medical providers, health plans, community based organizations who serve SPD
 - Focus on 3 counties
 - Funded by Kaiser Commission on Medicaid and the Uninsured
- **Beneficiary telephone survey & focus groups**
 - Telephone survey of 1,521 SPD beneficiaries or their proxies
 - 6 focus groups with SPD beneficiaries/proxies
 - Data collection 6-16 months after transition to managed care
 - Funded by DHCS and California Health Care Foundation

Topics covered today



- **System issues revealed through health plan/provider survey**
 - Challenges of data sharing between DHCS, health plans and providers
 - SPD transition effect on organizational resources
 - Provider network adequacy
- **Beneficiary experiences with Medi-Cal Managed Care**
 - Beneficiary care continuity after transition
 - Beneficiary ratings of access to and quality of care in MMC
 - Beneficiary experiences with member services
 - Beneficiaries' ability to navigate managed care
- **The effectiveness of “linking” non-choosing beneficiaries to a managed care plan using FFS data**

Health plan/provider survey: Data sharing challenges



- **Incomplete beneficiary contact information**
 - Challenge for state to notify beneficiaries
 - Challenge for health plans to conduct health risk assessments
- **Health history sent to health plans 8-10 days after enrollment**
 - No medical records at the first appointment
 - Plans were not able to use health history data to recruit providers or pre-authorize care
- **Recommendation: Allow for a 60-day waiting period between enrollment and using a plan to allow for transfer of medical histories**

Provider Network Adequacy



- **Challenges to network expansion**
 - Difficulty recruiting primary care providers with expertise in complex care management
 - Difficulty recruiting specialists
 - FFS Medi-Cal doctors reluctant to join managed care
- **Strategies to improve provider recruitment**
 - Market the benefits of managed care to providers
 - Incentivize providers to join Medi-Cal managed care plans
 - ✦ Higher reimbursement, streamlined paperwork
 - Transfer beneficiary utilization data early to target provider recruitment

SPD transition affect on organizational resources



- **Challenges for health plans**
 - Reimbursement rates don't reflect utilization of mandatory SPDs
 - SPD Beneficiaries call member services line 4x as often as others
- **Challenges for providers**
 - Already over burdened practices take on more SPD patients
 - Providers lack expertise with the complex care needs of SPD patients
 - Patients with greater need for urgent care/same day appointments/more care management
- **Challenges for CBOs**
 - Provided assistance to beneficiaries during transition but were not compensated

Beneficiary Telephone Survey Results



What did beneficiaries have to say about the transition to managed care?

What are the characteristics of the people with negative experiences?

Care continuity after transition



- 35.4% of beneficiaries had to change primary care doctor
- 40% of beneficiaries had to change all or some specialists
- 39% of beneficiaries had to change some or all prescriptions
- Who changed providers/Rx?
 - Those with “poor” self rated health, cognitive deficits, limited health literacy
 - Those with 4+ ER visits since transition
 - Those who had been on Medi-Cal over 2-11 years before the transition.

Access to care in Medi-Cal managed care



- 18% said getting PCP appointments more difficult in MMC
- 19% said getting specialist apts more difficult in MMC
- 21% said getting prescription medications more difficult in MMC
- Certain beneficiaries report more difficulty getting appointments/Rx:
 - Those in “fair or poor” health and those with functional impairments
 - Those with difficulty concentrating or remembering
 - Those with 4+ ER visits since transition
 - Those who had been on Medi-Cal 2-11 years before transition

Beneficiary satisfaction with MMC



- 63% of beneficiaries were somewhat or very satisfied with benefits in MMC
 - Beneficiaries more specialist visits since transition
- 30% of beneficiaries were somewhat or very dissatisfied
- 21% of beneficiaries said care was worse now in MMC.
 - Those in fair or poor health,
 - cognitive and functional impairment
 - on Medi-Cal 2-11 years before transition
 - They called member services

Transition affect on Disability Access



- 14% said provider understanding of how to care for a person with their specific health condition or disability worse in MMC:
 - Those with “poor” self-rated health
 - 4+ ER visits since transition
 - Those who had been on Medi-Cal more than 11 years before transition.
- 39% (of those with disability access issues) said accommodations for their disability were worse in MMC.
 - Those with “poor” self-rated health, functional impairment, or mobility barriers.
 - Those on Medi-Cal more than 11 years before transition

Experiences with Member Services



- 37% of beneficiaries reported getting a call from plan to discuss their health needs
- 33% called their new plan's member services line
- 20% reported getting less help finding doctors and getting tests and treatments they need:
 - Beneficiaries in poor health, functional limitations, limited health literacy, and those on Medi-Cal over 2-11 years before transition

Ability to navigate managed care



- **Do you know?**

- how to make an apt with a PCP in new MMC plan (82%)
- how to get the tests and treatments they need (70%)
- how get medical advice over the phone (66%)
- how to find a doctor (63%)
- how to get medical equipment and supplies (57%)
- how to make an apt with a specialist (57%)
- how to request a state hearing (54%)
- that you can file a complaint/grievance (45%)
- that you can file a continuity of care provision (17%)

- Those less likely to know how to navigate plan: Latino, African Americans, “fair” health, limited health literacy, cognitive deficits, more ER visits since transition

“Linking” Non-Choosing Beneficiaries



- DHCS linked non-choosers to plan
 - Medi-Cal FFS primary & specialty care data, previous year
 - Identified one “top provider” based on utilization and costs

Strata	Description	Size
Active Choice	Chose plan on own	48%
Linked	Top provider in 1 plan	11%
Defaulted*	No match or no data	41%

* Default algorithm: weighted randomization, proportional to plans' quality rating.

Did Linking Work?



- Choosers had the best outcomes
- No significant differences between people linked to a plan compared to those who defaulted.

	Choosers	Link	Default
Getting PCP appointment more difficult	15%*	26%	23%
Less help finding providers & services	18%*	32%	26%
Provider limited disability access	8%*	14%	9%
Medi-Cal benefits worse	29%*	44%	40%

* $p < 0.05$ bivariate & multivariate comparisons.

Linking Assessment



- Linking beneficiaries to plan based on FFS utilization data did not differentiate outcomes compared to those assigned based on default algorithm
- Hypotheses
 - Choosing is an outcome improving act
 - Linking algorithm not robust enough to simulate plan choices
- Considerations for future:
 - Link based on *all* providers, not just a top provider
 - Expand utilization data to previous **2+** years

Groups to target for additional support



- **Beneficiaries who did well in managed care**
 - Those who actively choose a plan
 - Those who live alone
 - Those who have a health care proxy
 - Those who were relatively new to Medi-Cal (less than 2 years)
 - Those who had PCP and specialist visits since transition
- **Beneficiaries who had a harder time with transition to MMC**
 - People who don't actively choose a plan
 - People with “poor” self-rated health
 - Cognitive or functional impairment
 - People who have been continuously eligible for Medi-Cal long term (2-11 years before transition)
 - More acute care visits (ER and Hospitalizations) since transition
 - No PCP or specialist visits
 - People who call member services since transition

Thank you for your attention



For questions or access to the full report, contact:

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