Seniors and Persons with Disabilities Transition into Medi-Cal Managed Care

Jane Ogle
Deputy Director, Health Care Delivery Systems

Athena Chapman,
Chief, Medi-Cal Managed Care Division,
Program Monitoring/Medical Policy Branch

Joint Assembly and Senate Health Committee Oversight Hearing
December 7, 2011

Goal of Transition

- To ensure beneficiaries are getting appropriate and medically necessary care in the most appropriate setting.
- Will result in better outcomes for beneficiaries and lower costs for the state.
  - Support to stay in their community
  - Reduce avoidable ER visits
  - Prevent duplication of services

Enrollment Overview

- DHCS oversees entire enrollment process.
  - Informing beneficiaries of their choices.
  - Processing choice (enrollment) forms
  - Defining default process
  - Processing changes and disenrollments

Enrollment Numbers

- Enrollment numbers slightly lower than expected and trending downward.
  - Lose eligibility
  - Become eligible for Medicare or other health coverage
  - File a Medical Exemption Request (MER)
- Number enrolled by default are going down
- DHCS working hard to link beneficiaries to a plan with the provider they currently see in fee-for-service (FFS) Medi-Cal.

Enrollment Challenges

- DHCS has worked to rectify these challenges:
  - Accidental enrollment of dual eligibles into managed care has been fixed and impacted beneficiaries were notified
  - Provider linkage numbers initially low; added additional primary care provider (PCP) data from plans to increase linkage percentages

Enrollment Successes and Improvements

- Provider linkage has doubled since first enrollments in June.
- Low inter-county plan transfer rates.
- Enhanced outreach and education.
- Low rates of calls and fair share hearings regarding access issues.
- DHCS continuously monitors SPD enrollment and implementation process.
  - Working closely with advocates, stakeholders, CMS and plans.

Overall SPD Enrollment Results

Enrollment Month	May*	October**		Percentage Growth
		New	Total	
2-Plan SPD (Medi-Cal Only)	128,859	133,190	262,049	103%
2-Plan SPD (Dual)	50,613	18,237	68,850	36%
GMC SPD (Medi-Cal Only)	22,393	23,452	45,845	105%
GMC SPD (Dual)	10,706	3,012	13,718	28%
COHS SPD***	154,534	110,800	265,334	72%

* May is all voluntary enrolled SPDs prior to mandatory transition start.
** October includes all transitional, voluntary and mandatory SPDs.
*** Managed care expanded into 3 COHS counties during this time.

Source: (MOE May 2011 and October 2011) COHS capitation report and FAME health care plan capitation report
Aid codes: 10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V (2-Plan, GMC & COHS)
13, 17, 23, 27, 63, 65, 67, 6R, 6W, 6X, 6Y, C1, C2, C3, C4, C7, C8 (COHS)

SPDs Enrolled During Birth Month from FFS

Enrollment Month	June	July	Aug	Sept	Oct	Total June-Oct
Total Enrolled	23,743	22,754	24,345	20,396	19,178	110,416
Defaulted	11,501 (48%)	10,248 (45%)	7,130 (29%)	5,665 (28%)	5,337 (28%)	39,881 (36%)
Chose a Plan	8,763 (37%)	9,052 (40%)	9,419 (39%)	8,129 (40%)	7,520 (39%)	42,883 (39%)
Continuity of Care (Linkage)	3,479 (15%)	3,454 (15%)	7,795 (32%)	6,602 (32%)	6,321 (33%)	27,651 (25%)
Overall Choice and COC	12,242 (52%)	12,506 (55%)	17,214 (71%)	14,731 (72%)	13,841 (72%)	70,534 (64%)

Numbers and percentages as of October 5, 2011, as reported by HCO. Includes 2-Plan & GMC enrollment.

SPD Monitoring

- Dashboard
  - Data regarding enrollment, MERs, emergency disenrollments, Ombudsman data, and more.
  - After first year, will include utilization data measures.
- Ombudsman
  - Tracking beneficiary calls related to access for SPDs.
  - Calls relatively steady since June (2500-2700/month).
  - Calls on mandatory enrollment for SPDs continues to fall (64.7% of all calls in June and 39.6% in September; a drop of 25%).
  - Calls data and Plan reporting demonstrate no major access issues.

Calls to the Ombudsman's Office

Enrollment Month	June	July	August	September
# of All Calls	2,660	2,834	2,799	2,757
# Mandatory Enrollment	1,722	1,916	1,241	1,093
% Mandatory Enrollment	64.7%	67.6%	44.3%	39.6%

Ombudsman Calls: Access Issues

This is the number of calls on access to care and accessibility issues for SPDs and all other members and the percentage of those calls out of all calls for SPDs and all other members.

Enrollment Month	June	July	August	September
# SPD	101	123	113	90
# Other Members	134	149	111	20
% SPD	11.5%	19.2%	13.8%	12.5%
% Other Members	8.4%	10.7%	9.5%	1.7%

Plan Monitoring

- DHCS performs enhanced monthly monitoring of 6 health plans; includes calls to members.
  - Rate of satisfaction of health plan performance is 3.87 out 5.
- Access to specialists is monitored.
  - Nearly 24% increase in contracted specialists in specific areas.
- Inter-Agency Agreement with DMHC
  - Provide medical surveys; ensure contract compliance; provider network adequacy
- DHCS (A&I) performs ongoing on-site monitoring at plan and provider level.

Health Care Options (HCO)

- HCO provides beneficiaries with resources to make informed decisions about benefits.
  - Help beneficiaries understand, select, and use managed care plans.
  - HCO contract requires that beneficiary experiences are monitored, includes quality assurance, wait times, and ensuring sufficient staffing requirements are met.
- DHCS is developing additional ways to track the type of calls received.
  - High volume calls in a certain area would indicate an issue.

Health Care Options (HCO)

- In response to advocates concerns, DHCS has been working to improve protocols to ensure information being provided to beneficiaries is accurate and consistent with SPD transition policies and regulations.
  - Provided additional training for CSR and ESR staff as issues came up during the SPD project. Call Center scripts were adjusted accordingly.
  - Increasing the monitoring of the taped inbound and outbound Call Center calls to ensure accurate and consistent information is being disseminated to the beneficiaries.

Medical Exemption Request (MER)

- For complex medical conditions and pregnancy.
  - Submit MER to request a temporary exemption from managed care enrollment; continue receiving services through FFS (Title 22 Section 53887).
- MER form and instructions included in Choice Packet.
  - Request MER by having physician complete form and file it with HCO.

Medical Exemption Request (MER)

- Each MER is unique and decisions are made on a case by case basis.
  - Reviewed by clinical staff – licensed RNs and MDs.
  - Carefully evaluate all information; prior MERs, MEDS, TARs.
  - To approve, clinical staff determine if beneficiary can be safely transitioned to an in-network provider or the same specialty without deleterious medical effects.
- If MER is denied, beneficiary may file for a state fair hearing.

Medical Exemption Request (MER)

- MERS process applies to mandatory enrollees who receive services through FFS in Two-Plan and GMC counties. MERs do not apply to COHS counties.
- An emergency disenrollment request (EDER) is essentially a MER but expedited because provider believes it needs to be processed immediately.
- Plans are reaching out to fee-for-service (FFS) providers for continuity of care, but the providers do not want to accept payment from the plan, even at current FFS rates.

MER Data

- Received 8800 MERs as of end of October.
  - Represents 2.9% of total SPD enrollment in Two-Plan and GMC counties.
  - Does not reflect actual beneficiaries.
    - Beneficiaries often file more than one MER.
  - Between June and September – 333 MER state fair hearings requested, only six have been granted.

MERs – Ongoing Issues

- SPDs often have complex medical conditions that do not necessarily exempt them from mandatory enrollment.
  - A complex medical condition that is appropriately managed by the plan can result in better outcomes and achieve cost savings for the state by reducing ER and LTC services.
- DHCS maintains a policy of requesting additional information for MERs to help clinical staff determine approval or denial based on regulations.
- SPDs with chronic conditions, such as cancer and diabetes, or who are pregnant can be safely enrolled in a plan when their condition has stabilized.

Areas of Improvement

- MER Form:
  - Form is outdated; DHCS working with advocates to update the form; requires changing regulation.
  - More immediate communication with advocates and providers through provider bulletins and release of policies and procedures regarding the MER process.
- Consistency and clarity of MER process:
  - DHCS implemented a more standardized review process and requires MD to review all final MER decisions.
- Backlog:
  - DHCS redirected several clinical staff to work on MERs; eliminated backlog.

Areas of Improvement

- Special cases and immediate disenrollments:
  - Staff dedicated to dealing with both of these; call to beneficiary and provider to ensure we have all information needed to process the MER.
- Continuing work with HCO to train staff processing MERs
  - Identify and fix systematic issues
- Communication with advocates:
  - Continue to engage with advocates on ways to improve process.
  - November meeting; DHCS agreed to provide more information on MERs and advocates agreed to provide information on actual beneficiaries experiencing problems
  - DHCS will review cases and identify and address systematic or access to care issues.

Medical Exemption Request (MER)

Enrollment Month	June	July	Aug	Sept	Oct
Total SPD MERs	1729	1741	2140	2288	870
SPD MERs Approved	296	169	199	509	205
SPD MERs Denied	494	383	495	644	285
SPD MERs Deferred*	939	1189	1446	1135	380

**Deferred/Incomplete MERs come back into the system as new MERs.*

A beneficiary may have more than one MER in process at any time.
The number of MERs does not reflect unique beneficiaries.

MERs – State Fair Hearings

MERs That Went To State Fair Hearing

Month	Total	Denied	Granted	Withdrawn	In Process	Other**
January 2011	28	14	2	9	1	2
February 2011	27	13	2	7	1	4
March 2011	54	14	7	20	4	9
April 2011	59	20	6	20	4	9
May 2011	72	24	4	19	12	13
June 2011	105	28	2	20	44	11
July 2011	95	10	0	17	65	3
August 2011	68	0	0	5	62	1
September 2011	65	0	4	4	33	0
TOTAL: **June-Sept**	333	38	6	46	204	15

**Other includes dismissed, non-appearance, redirect and closed by compliance.

Extended Continuity of Care

- For *all* SPDs transitioning from Medi-Cal FFS into mandatory Medi-Cal managed care.
- To ensure smooth transition – allows SPD to continue seeing FFS doctor for up to 12 months.
- *NO* pre-existing condition requirement; for most beneficiaries it eliminates need for MER.
- FFS Medi-Cal doctor must agree to work with plan; have no quality of care issues; accept plan's contracted rates or FFS rates, whichever is higher.

Extended Continuity of Care

- Beneficiaries notified of this option in enrollment packet.
  - Entire section on the process and how they can initiate it
  - Also FAQs in all threshold languages available on website
  - Provider bulletin went to FFS providers and is on website for providers, beneficiaries, and advocates.
- Plans report they are approving most requests.
  - Denials generally from providers unwilling to work with the plan.
- No special provision for certain populations, such as HIV patients; working with advocates to put providers in touch with plans to establish contractual relationships.

Lessons Learned for Future Enrollment

- Telephone not the most effective outreach channel
- More effective to hold outreach meetings across state
  - Beneficiaries, providers, and advocates can participate
- Allowing more time to make a choice and additional mailings has not improved choice rate
  - Focus on campaigns that reach both beneficiaries and providers and utilize advocate network
- Information needs to be accessible immediately for people with disabilities and in all threshold languages.
- Define processes early; get stakeholder input prior to implementation.

Lessons Learned for Future Enrollment

- Continue training for staff at all levels.
- Educating advocates and provider community may be potential step to increase choice rate.
- Updating informing materials to make it clear to beneficiaries that moving to managed care does not mean they are losing their Medi-Cal benefits.
- Continue working with plans.
  - To ensure network has adequate access to specialist or processes allowing for out of network access.
  - To ensure up to date information to appropriately link beneficiaries to providers in the plan.

Conclusion

DHCS.CA.GOV/SPDINFO