

ISSUE BRIEF

Transitioning Beneficiaries with Complex Care Needs to Medicaid Managed Care: Insights from California



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EXECUTIVE SUMMARY

Between June 2011 and May 2012, the California Medicaid program (known as Medi-Cal) transitioned just under 240,000 seniors and persons with disabilities (SPDs) from fee-for-service to mandatory Medicaid managed care (MMC) as part of its “Bridge to Reform” Medicaid Waiver. SPDs who are dually eligible for both Medi-Cal and Medicare were excluded from this transition, which was limited to Medi-Cal-only SPDs. SPDs in California account for a disproportionately high share of the state’s Medicaid spending. Medi-Cal-only SPDs represent 40% of the state’s total SPD population and comprise mostly individuals with disabilities. Goals of the transition were to increase plan and provider accountability and oversight, improve beneficiary access to care, and make costs more predictable. This study examined how health service providers, plan administrators, and community-based organizations (CBOs) in Contra Costa, Kern, and Los Angeles counties experienced the transition of SPDs to MMC. Below are some key study findings that may help inform future transitions to managed care for populations with complex health needs.

Transition Readiness: Beneficiary Data and Information Sharing

The SPD transition necessitated information sharing across many entities, including the state, health plans, community-based organizations (CBOs), providers, and beneficiaries, and was key to improving plan and provider readiness for the transition. Challenges to efficient data transfers included incomplete or out-of-date beneficiary contact information and patient privacy provisions that prevented plans and providers from timely access to beneficiary medical records. Potential strategies to overcome these barriers include engaging groups familiar with the SPD population to help disseminate information, working directly with county social services, or using pharmacy data for beneficiary information.

Provider Network Adequacy

The expansion of MMC to the SPD population provided the opportunity for health plans to expand their provider networks. However, health plans reported barriers to recruiting both primary care and specialty providers with expertise in complex care. Potential strategies to broaden provider networks include contracting with health centers and other health plans, more effective marketing to providers, and higher provider payment rates and reduced paperwork burden.

Care Coordination: New Responsibilities and Expectations

Providing coordinated care for SPD beneficiaries was a primary goal of the transition and a requirement of the Medicaid waiver. SPDs had more complex and frequent care coordination needs and primary care providers reported insufficient training in care coordination. Potential strategies include creating care coordination teams, providing ongoing provider and staff trainings, and contracting with CBOs to assist with care coordination.

Ensuring Resources to Support the Transition

The transition had a substantial impact on health plan and providers' organizational structures and resources. Providers reported delivering unreimbursed care and plans reported that Medi-Cal capitation rates did not cover actual SPD costs. Potential strategies include collaborating with CBOs for assistance during the transition and developing a methodology designed specifically to pay for care delivered during the transition.

Taken together, the findings from this study of the SPD transition to MMC show the importance of both adequate time and planning to minimize care disruptions for high-need Medicaid beneficiaries.

INTRODUCTION

During the early 1990s, California's Department of Health Care Services (DHCS) began shifting large segments of the population enrolled in Medicaid, known as Medi-Cal in California, from fee-for-service (FFS) into a managed care delivery system. By 2012, managed care plans serving Medi-Cal beneficiaries were operating in 16 California counties. Delivering Medi-Cal through managed care plans was anticipated to increase accountability and oversight, improve beneficiary access to care, and make costs more predictable.

Mirroring national trends, seniors and people with disabilities (SPDs) in California account for a disproportionately large share of state Medicaid spending.¹ In 2009, SPDs made up 24% of California's Medi-Cal FFS enrollees, but accounted for 42% of FFS Medi-Cal expenditures.² Many but not all SPDs are dually eligible for Medicaid and Medicare. In California, the SPD population includes approximately 423,000 beneficiaries who have Medi-Cal, but not Medicare.³ These Medi-Cal-only SPDs make up approximately 40% of the total SPD population in California, with the other 60% being dually eligible for Medi-Cal and Medicare. The Medi-Cal-only SPD population differs distinctly from the dually eligible SPD population. While 70% of dually eligible California SPDs are seniors, more than three-quarters of Medi-Cal-only SPDs are younger people with disabilities; less than one-quarter are age 65 or over.²

Notwithstanding concerns about high Medi-Cal spending on behalf of SPDs, they were originally exempted from the managed care mandate in California because of countervailing concerns that managed care might limit access or decrease the quality of care for this high-need population. The findings from research conducted since this decision was made do not support these claims. Studies show no significant differences between FFS and managed care on measures of health care access and utilization for SPDs and have concluded that beneficiary satisfaction ratings and access to specialists may be better in Medi-Cal managed care (MMC).^{4,5,6} This evidence, along with the budget crisis in California and pressures to limit Medi-Cal spending, effectively softened the opposition to enrolling SPDs in MMC.

In March 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA). In November 2010, the federal government approved California's Section 1115 "Bridge to Reform" Medicaid Waiver, bringing \$8 billion in federal dollars to support Medi-Cal expansion and reform.⁷ One of the key components of the waiver was permission for California to mandate Medi-Cal-only SPDs into MMC. Between June 2011 and May 2012, DHCS transitioned 239,731 non-Medicare SPDs from FFS Medi-Cal to mandatory MMC, with beneficiaries required to choose or be assigned to

a health plan by the first day of their birth month.^{8,9} The waiver stipulated standards of care for SPD beneficiaries, including: the promotion of coordinated care delivery, patient-centered care, and care that is accessible for individuals who need physical accommodations. Plans were required to assess health plan accessibility, demonstrate that their provider networks were adequate to meet the needs of these new SPD beneficiaries, and meet state standards for geographic accessibility.

Health care reform in California and other states will result in many beneficiaries being transitioned for the first time into managed care delivery systems. Separate from the SPD transition, the Low Income Health Program in California expanded Medi-Cal to 569,000 previously uninsured individuals with incomes below 200% of poverty.^{10,11} Beginning in 2014, California will transition almost half a million beneficiaries who are dually eligible for Medicaid and Medicare into managed care plans. This transition of dual eligible individuals, known as “Cal MediConnect,” will be piloted in 8 California counties.^{12,13} Like the SPD population before them, this dually eligible population is comprised of beneficiaries who are low income seniors and people with disabilities with complex care needs.

While managed care has the potential to increase access to care, coordinate care, and make state costs more predictable for Medicaid beneficiaries with high levels of utilization, it also has the potential to cause disruptions in care for beneficiaries with serious health conditions, even when the transition is carefully planned and executed, as in the case of California. The transition of vulnerable beneficiaries from FFS to managed care is a complicated balancing act involving many actors, including the state; managed care plans; “delegated entities” such as independent physician associations and medical groups; medical care providers; community-based organizations that serve SPDs; and beneficiaries themselves. Although California’s DHCS took many steps designed to support a smooth transition – in particular, building in transfers and uses of beneficiary past utilization data to keep SPDs connected with their current primary or specialty care providers as they migrated to managed care plans – the SPD transition experience offers some lessons learned that may be applicable nationally to future expansions of both high and low-risk populations into Medicaid managed care.

The study examined how health service providers, plan administrators, and community-based organizations in three California counties experienced the transition of SPDs to MMC. Fifty-nine key informant interviews were conducted with MMC health plans, providers, and community-based organizations that serve SPDs (Appendix). The interviews were conducted in Contra Costa, Kern, and Los Angeles counties. These counties were selected to represent the three discrete regions of the state, as well as its rural-urban geographic diversity.

The goals of the research were to:

- » Examine how the managed care transition affected the delivery of care for Medi-Cal-only SPDs;
- » Identify challenges faced by health plans, community-based organizations, and providers during the SPD transition;
- » Identify potential strategies to deal with particular challenges and further steps needed to improve care for high-need populations in managed care; and
- » Inform similar transitions in other states, as well as the transition of dual eligible SPDs in California.

TRANSITION READINESS: BENEFICIARY DATA AND INFORMATION SHARING

The SPD transition necessitated the sharing of information and data across many entities: between the state and beneficiaries; between the state and the MMC health plans; between the plans and providers; between primary care and specialty providers; and between providers and community-based organizations that serve SPDs. Data and information that were shared included beneficiary notification materials, contact information for the new beneficiaries, medical and prescription history data, information from choice forms, health information forms, and Health Risk Assessments. The efficient transfer of beneficiary data across entities during a transition is essential for plans and providers to improve their readiness to serve SPDs. For example, health plans can use beneficiary medical and prescription history data to prepare to serve beneficiaries with complex care needs by recruiting needed providers into plan networks, pre-approving necessary treatments, and adjusting medication formularies. Similarly, providers ideally review patient medical and prescription histories prior to their new patients' first visit.

Incomplete or out-of-date contact information for SPDs was an obstacle to notifying beneficiaries of the transition to MMC.

The SPD population includes individuals who live in poverty, who may be marginally housed or periodically institutionalized, or who may have disabilities that present communication challenges. All of these issues, in addition to the prevalent use of prepaid mobile phones that expire, make it a challenge to keep phone numbers and addresses for beneficiaries up to date. Many key informants reported that the SPD beneficiaries they serve did not receive the state materials informing them of the transition and their right to choose a plan. According to the DHCS monitoring dashboard, 60% of SPD beneficiaries did not actively choose a plan and were thus assigned to one by the state.¹⁴ According to informants, beneficiaries who were surprised by the transition and who were assigned to a plan often had more difficulty with navigation and accessing care through their new plans and provider networks. Key informants recommended that states work with community-based organizations and provider groups that interact with SPD populations to help disseminate notification materials to hard-to-reach beneficiaries or their health care proxies before future transitions. In addition, more comprehensive outreach to providers before and during the transition was recommended to increase the ability of medical providers and clinics to educate and assist beneficiaries.

“[Enrollees] would go to the doctor, and the doctor said, ‘Sorry, I can’t see you; you’re in managed care.’ Many times that’s how they discovered that they were enrolled in a plan.”

– Provider

Health plans experienced barriers contacting beneficiaries by phone to complete Health Risk Assessments.

Health plans were required by the state to conduct a Health Risk Assessment (HRA) of all new SPD beneficiaries. These assessments were developed by each plan and were designed to gather information that would assist both plans and providers in preparing for the individual needs of new beneficiaries. According to the SPD monitoring dashboard, fewer than 60% of newly transitioned SPD beneficiaries were successfully contacted and administered an HRA. Health plans reported that incomplete beneficiary contact information from the state was often a barrier to completing these assessments. Furthermore, beneficiaries in group living arrangements have limited access to telephones. Health plans were required to complete HRAs between 45 and 105 days after the beneficiary began using the plan, which providers reported did not allow time to receive the information before the patient's first provider visit. Some plans reported more success completing HRAs through in-home visits or recommended outsourcing the HRAs to community-based organizations that have regular, direct contact with SPDs (such as Regional Centers for people with developmental disabilities, homeless shelters, churches, senior centers, and pharmacies). One health plan worked directly with county social services agencies to obtain missing beneficiary contact information.

The transfer of health and prescription history information from the state to health plans and providers was not timely. Privacy considerations prevented the state from transferring patients' FFS utilization records to health plans before the beneficiaries' enrollment in the plan was confirmed. Typically, health plans received health histories from the state 8 to 10 days after the date that beneficiaries began using the plan. Health plans reported that they would prefer to analyze beneficiary medical records ahead of enrollment to assist in targeted recruitment of specialists and to pre-authorize medications, tests, treatments, and medical equipment/supplies that had been granted in FFS Medi-Cal. Plans reported that, because the data were scheduled to arrive after the beneficiary began using the plan, this was a missed opportunity. Plans reported that the data from the state was sometimes 6 months out-of-date or not in a form that was easy to analyze. One plan worked directly with the county social service agency to obtain information about its beneficiaries' historical utilization of social services. One health plan reported using aggregate pharmacy data from DHCS to expand the formularies available to the SPD population before the transition.

“The state didn’t have accurate data. We weren’t prepared for this population, and didn’t know how to manage them. What services do they use? What conditions do they have? Who are their providers?”

– Health plan

The delay in obtaining medical records also made it harder for providers to effectively care for new patients. SPDs often required urgent visits with their new primary care provider, but medical records were often not available to providers before the first visit. Providers who were interviewed described how the absence of medical records at the time of the first visit was a major barrier to providing effective care. Some plans reported successfully collaborating with pharmacies to expedite information-sharing. Key informants suggested that there be a period of delay of 60 days between the date the beneficiary is assigned to a plan and the date he or she begins using the plan to allow adequate time for the transfer of patient medical history data to plans and providers.

Delegation to other health plans or IPAs sometimes caused further delays in data transfer as well as confusion about which entity was responsible for covering certain types of care. Many Medi-Cal health plans do not provide direct care to beneficiaries, but “delegate” care, either fully or partially, to other health plans, independent physician associations, or medical groups. While delegation was an important strategy that helped health plans expand their networks and it expanded beneficiaries' choice of providers, it was reported that this arrangement added more entities to the already complex web of information-sharing across settings that needed to occur. Informants cited that this was a problem, particularly following hospital discharge, when it was often unclear which entity was responsible for paying for post-hospitalization medical equipment and supplies.

“Traditionally in medicine if you are in private practice, you [know] your specialists. You feel good about making those referrals. Well with managed care... we don’t know who these doctors are. We don’t know their quality of care.”

– Primary care provider

The SPD transition disrupted established communication channels between primary and specialty care providers. Relationships between primary care providers and their “preferred” specialty care doctors was often disrupted when one or the other were not a part of the MMC network. Some primary care doctors were uncomfortable referring patients to specialists whose quality of care they were not familiar with and whom they felt were less likely to communicate consultation notes. Some primary care providers had established feedback systems to expedite the transfer of consultation notes from specialists.

PROVIDER NETWORKS: BUILDING ADEQUATE CAPACITY

The expansion of MMC to the SPD population provided an opportunity for health plans to substantially expand provider networks. They were required by CMS and the state to expand their provider networks to accommodate the expansion to the SPD population. Health plans aimed to expand their provider networks by recruiting FFS Medi-Cal providers, recruiting new providers into their MMC networks, and subcontracting (delegating) beneficiaries to other plans or medical groups.

Health plans experienced barriers recruiting primary care providers with expertise in complex care management. Health plans were often successful in expanding their primary care provider networks, especially with providers who already worked in low-income or Medi-Cal clinics. However, some clinics reported that their primary care providers were used to a healthier Medi-Cal population (mothers and children) and often did not have sufficient expertise to treat the complex care needs of their new SPD patients. Some providers referred new SPD patients to the emergency department because the patient’s medical needs were outside of the scope of his or her expertise. One interview from a CBO said that the plans were relying too heavily on mid-level providers, like nurse practitioners, who may have less experience managing complex care or serious illness. It was especially difficult for primary care providers (PCPs) when new beneficiaries had a dual diagnosis of mental illness. Successful strategies mentioned by plans to expand provider networks included adding delegates, such as other health plans and In-Person Assistants, and contracting with federally qualified health centers in neighboring counties that already specialized in serving segments of the SPD population (such as seniors and Spanish-speaking populations).

Health plans faced challenges recruiting specialty care providers, particularly given the wide range of conditions among the SPD population.

Key informants reported that beneficiaries’ ability to continue care with their FFS specialists was often the key to preventing disruptions in care after the transition to managed care. Unfortunately, informants reported that disruptions in specialty care were common for transitioning SPDs, due to limited provider networks. Plans cited the delay in receiving health history information as a major barrier to targeted recruitment of specific specialists. In all three counties, informants cited a number of different specialty areas that were under-represented in provider networks. Additionally, rural counties may have particular challenges expanding provider networks due to a dearth of specialty care doctors practicing in the county. One informant from a rural area said that every provider who could possibly be in the network was already affiliated before the SPD transition, and that beneficiaries thus had to be sent to neighboring counties for care.

The reluctance of FFS providers to join plan networks was a major barrier to network expansion. Health plans reported that many FFS providers refused to join their plan networks. This was especially true among providers practicing independently (i.e. those not practicing in clinics or physician practices). Furthermore, many providers refused to participate in the Continuity of Care Provision, a consumer protection that allowed beneficiaries to continue seeing their FFS provider for up to 12 months for medically necessary care if the provider agreed to accept managed care reimbursement rates. Key informants suggested that the prospect of more oversight in managed care, rumors of lower reimbursement rates/delays in reimbursement, and the more complex care needs of SPD beneficiaries were all disincentives for independent providers to join managed care plans. Some health plans stated that they need to do a

“Doctors were overwhelmed with the SPD health challenges and sent them to the ER to receive care.”

– Health plan

“About 30% of the SPD have a mental illness that requires treatment and medication, not something the PCP can handle. This affects your PCP who is not used to taking care of older adults with multiple chronic conditions with serious mental illness.”

– Health plan

better job marketing the benefits of managed care to encourage FFS providers to join their network. Plans also stated that they needed tools to incentivize providers, including: offering higher reimbursement rates for SPD, pay-for-performance metrics, and streamlined paperwork and reimbursement for providers, to encourage them to join MMC networks.

CARE COORDINATION: NEW RESPONSIBILITIES AND EXPECTATIONS

Providing coordinated care for SPD beneficiaries was a primary goal of the transition of SPDs to managed care and a requirement stipulated in the Section 1115 waiver. Lack of coordinated delivery in FFS Medi-Cal has been identified as a key contributor to poor access to care, more duplication in care, and higher costs for SPD beneficiaries. Managed care delivery systems in which primary care providers act as the single point of entry, have the potential to increase the number of beneficiaries with a usual source of care, improve access to appropriate services, reduce duplicative care, and lower costs. Since the SPD transition to managed care, health plans, providers, and CBOs all report significantly increasing their efforts to coordinate care across settings for SPD beneficiaries.

Primary care providers have more responsibility for care coordination for SPDs patients but feel unprepared and untrained for this activity. The higher level of effort required to coordinate care for newly transitioned SPD patients reportedly increased provider burden and burnout and staff turnover. Providers reported spending more time on obtaining authorizations and appealing denials, and less time on “real” care coordination. Some providers report that patients had been successfully managed by specialists for many years and that transferring the responsibility to the primary care provider disrupted those relationships. In response to the increased care coordination responsibilities, some clinics report shifting care coordination duties to non-physician staff (such as nurses or the front desk) to reduce the burden on physicians. Some clinics have attempted to create care coordination teams or partner with CBOs to help with care coordination. Some providers suggested allowing specialists to coordinate care when they were willing and able to do so. Health plans and clinics offered trainings for providers and other staff to improve their expertise in care coordination for SPDs. Staff and provider turnover required ongoing education and training efforts.

Health plans are providing care coordination to SPD who called the member services line up to 4 times as often as other beneficiaries.

SPD beneficiaries, many of whom were not notified ahead of time about the transition, are often new to managed care and need support finding the right provider, understanding changes to their treatment, and navigating the referral and authorization process. To better meet the care coordination needs of SPD beneficiaries after the transition, health plans reported expanding hours for member services telephone lines (in some cases, to 24-hour access) and significantly increasing member services

“Kern County is a closed system and so it is virtually impossible to expand our provider network in the county. So we really couldn’t do that. We actually have some pretty serious deficiencies in some areas as far as specialists go. They just don’t exist. Like endocrinology, for example. Orthopedics is difficult. Neurology is difficult. Rheumatology is difficult.”
–Health plan

“We got a grant to increase the level of expertise in handling specialty coordination and DME [durable medical equipment], things we have never dealt with before, to make the process easier for our staff. We are trying to increase duties of our support staff. We are starting with our nurses, to allow providers to have more time to deal with patients.”
– Medi-Cal clinic

staff. CBOs that serve SPDs (such as Regional Centers for people with developmental disabilities, independent living centers and agencies serving the homeless) suggested that health plans contract with them to supplement care coordination for certain segments of the population.

While care coordination has expanded on all fronts, the transition to managed care added complexities that generated even greater need for coordination. Transitioning a large number of beneficiaries to managed care resulted in many disruptions in care that required increased attention from all parties involved in care coordination, including providers, health plans, medical groups, and CBOs. Many beneficiaries were required to change doctors, prescriptions, pharmacies, and laboratories. Furthermore, previously covered prescriptions, tests, treatments, medical equipment, and medical supplies were sometimes no longer covered, or were covered with an alternative brand. Even beneficiaries who were able to stay with the same doctors were required to get authorizations for specialty services for the first time. Disruptions in care were especially problematic for individuals in active treatment for diseases like cancer, HIV, and serious mental illness, or who were on dialysis. Beneficiaries who were often inexperienced at navigating managed care, needed assistance to deal with disruptions and treatment changes. These needs required additional resources from plans, providers, and CBOs, especially during and immediately following the months of transition.

“With so many SPDs getting primary care for the first time...It really was a real challenge... So we had to retool our Utilization Management department...and beef up our case management.”
– Health plan

The mental health services “carve-out” poses barriers to care coordination. It is estimated that approximately 40% of SPD beneficiaries in California have a mental health diagnosis and just under 35% have a diagnosis that qualifies as “serious mental illness” that requires specialty mental health services.¹⁵ In California, specialty mental health care is a “carve-out,” meaning that the managed care health plans are not responsible for providing specialty mental health services. Instead, county mental health departments are responsible for managing and authorizing specialty mental health services provided by county staff and FFS providers. County public health departments oversee substance abuse services under a similar “carve-out” arrangement. However, *non-specialty* mental health care, such as treatment for depression and anxiety, are still treated through the SPD beneficiary’s primary care provider in the MMC health plan. Some key informants reported that certain SPD beneficiaries were erroneously terminated from county mental health services because county mental health providers believed that they were no longer covered under managed care. The transition of SPDs to MMC presented an opening for county mental health providers to reassess whether a diagnosis actually qualified as a serious mental illness. In some instances, county mental health providers contended that the responsibility for providing care should be shifted to the managed care plan. There were also cases where FFS providers had been treating serious mental illnesses, which the new MMC provider did not have the expertise to treat. This necessitated a transfer of the beneficiary to county mental health services, which required long waits for appointments.

Key informants also reported that some important psychiatric medications were not included in plan formularies, triggering denials from managed care plans. Health plans reported efforts to better coordinate with county mental health providers, including three-way phone calls with the county mental health provider, the beneficiary, and plan representatives, to resolve disputes. A county mental health department representative mentioned efforts to work with the MMC plans to get more psychiatric and substance abuse medications on plan formularies. Many counties were creating collaborations between managed care, primary care, and county mental health to facilitate data transfers and provide more timely consults. One county had signed a memorandum of understanding to facilitate Health Insurance Portability and Accountability Act (HIPAA)-compliant information exchange with health plans so

that primary care, mental health care, and substance abuse treatment providers could more easily refer patients and consult together. One provider group created a paper form that is passed between primary care and mental health providers to facilitate communication.

ORGANIZATIONAL RESOURCES: ENSURING ADEQUATE TRANSITION SUPPORT

To effectively plan for a large wave of enrollment of high-need beneficiaries into Medicaid managed care, it is important to have a realistic view of how such a transition may impact organizational structures and resources and what can be done to minimize strain. One goal of this study was to better understand the impact of the transition of SPD to MMC on both the financial and human resources of organizations that serve this population and successful strategies for ensuring adequate resources to support the transition.

Providers reported that the SPD transition taxed their staff resources.

Providers' offices reported an increase in uncompensated staff hours to handle authorizations and appeal denials for recently transitioned SPDs. SPD beneficiaries have complex care needs that require longer appointment times, more frequent appointments, and more urgent care appointments than many other Medi-Cal populations. Providers that were used to seeing up to 40 relatively healthy patients per day were no longer able to do so when SPD beneficiaries were added to their panels. Informants reported that some SPD patients had to wait 2-3 months for their first appointments in clinics that were over-burdened before the SPD transition. Provider clinics reported that to ameliorate the strain on their resources, they needed to restructure appointment scheduling to provide more urgent care appointment availability and longer appointment slots for SPD beneficiaries. Providers reported seeking grant funding to cover additional care coordination activities, collaborating with CBOs to provide additional care coordination, and redirecting care coordination tasks to non-physician office staff.

Providers reported providing unreimbursed care during the transition to prevent potentially dangerous disruptions in care.

Due to patient safety concerns, many providers reported providing care to SPD patients despite the fact that they would no longer be reimbursed by the patients' new managed care plan. To ensure that patients made it to and from appointments, dialysis centers paid for medical transportation services for SPD who were denied that service in their new managed care plan. A cancer center reported that when patients were defaulted to non-affiliated plans during their cancer treatment, it continued to provide treatment without reimbursement. County mental health clinics in Los Angeles County reported absorbing the cost of routine labs to monitor medication levels at on-site laboratories that were not reimbursed under MMC. Key informants suggested that the state grant automatic medical exemption requests or delays in transition for beneficiaries in active treatment. They also suggested that non-network providers who provide care during the transition for patient safety reasons should be reimbursed for care retroactively.

Some plans reported that Medi-Cal capitation rates for SPDs do not account for the much higher utilization rates of the population. Many health plans felt unprepared for the higher needs of the SPD beneficiaries and reported that Medi-Cal payment rates did not account for the higher utilization of this population. One health plan said that rates were based on the utilization experience of SPD beneficiaries who voluntarily enrolled before the mandatory transition. According to this health plan, SPD beneficiaries enrolled in MMC on a mandatory basis are

“We used to predominately serve moms and kids, and now 1 out of 5 is an adult or senior with a disability. It changes the organization. Everything has changed.”
– Health plan

“Our system was not ready... If I do it again, I would reserve a certain amount of slots and give an appointment immediately and not 2-3 months.”
– County Health Department

using a much higher level of care. Key informants suggested a reassessment of payment rates for SPD enrollees on actual utilization rates of the mandatory population.

Community-based organizations (CBOs) used resources to assist SPDs with the transition to managed care. Organizations such as Independent Living Centers, advocacy groups, and Regional Centers for people with developmental disabilities are organizations with a great deal of direct contact with certain segments of the SPD population. Though they were rarely officially engaged by the state or health plans to assist beneficiaries, CBOs reported that they were often enlisted by beneficiaries to assist with decision support during the plan choice process, filing, and appealing Medical Exemption and emergency disenrollment requests, helping beneficiaries switch plans or change providers, and generally advocating for beneficiaries to help them to get the services they needed in managed care. Some CBOs reported that they were paying for unreimbursed care for their SPD clients. Though most CBOs said that they were generally not compensated for this additional assistance to beneficiaries, some reported receiving grants or staff trainings from health plans. Many CBOs indicated that they would like to be officially engaged in Medical expansion efforts for SPD in the future.

LOOKING AHEAD

Today, states are increasingly shifting higher-need Medicaid populations, including people with disabilities and dual eligibles, into managed care organizations (MCOs). In addition, states are expected to rely largely on MCOs to serve millions more low-income adults who will gain Medicaid coverage under the ACA, many of whom have significant health needs. The findings from this study, which examined one such transition to managed care, may be instructive for Medicaid agencies, health plans, providers, and CBOs as they prepare to meet the challenges they may face as Medicaid expands and seek successful strategies to do so. As California's managed care program for SPDs matures, the state's experience will continue to be a bellwether for other states moving in a similar direction. These study findings related to the transition per se are especially timely now, as they serve to orient states that are currently planning transitions to fundamental system readiness issues and strategies that may help address them.

Results of this study show that collaborations across entities and settings can improve health plan and provider readiness for large transitions of high-need beneficiaries into managed care delivery systems. In California, new collaborations among health plans, providers and CBOs have been one of the most important successes of the SPD transition and have contributed to system readiness for the transition of dually eligible beneficiaries to managed care in 2014. Stakeholder collaboration has expanded opportunities to share responsibilities for care coordination, notification for beneficiaries who are often hard to reach, and support for beneficiaries who are often inexperienced in navigating a managed care delivery system. Collaboration and partnerships among plans, providers, county mental health, and CBOs/advocacy organizations were also

“Utilization has gone up 4 times...We get higher reimbursement but not enough to offset their utilization. Reimbursement rates were based on data for SPD who voluntarily enrolled in MMC, but the ones mandated into MMC have higher utilization rates.”

– Health plan

“We trained our employees on our new procedures. Our relationships with the health plans have been most effective. They came in and embraced our population...They provided great information and their contacts help us solve a lot of problems.”

– Regional center

instrumental in expediting information-sharing across settings. In the future, health plans and providers can leverage opportunities to engage and collaborate with community-based organizations that already serve SPD to provide enrollment assistance, decision support, and education for beneficiaries about navigating the managed care system.

Findings from this research provide evidence that the transfer of beneficiary information to plans requires more time than anticipated, suggesting a need for more deliberate staging of implementation. The importance of efficient and timely transfer of beneficiary medical history data across entities was a key finding of this study. The HIPAA was enacted to safeguard the privacy of beneficiaries, but it also poses barriers to quick and efficient transfer of protected health information, such as FFS utilization data. To ensure health plan and provider readiness to care for new managed care enrollees, medical records and prescription histories should be transferred to plans before beneficiaries are required to seek care in the plans. Modifying the timeline for transition to provide a window of up to 60 days between the time the beneficiary enrolls and the time he or she begins using the plan could improve readiness by allowing plans to pre-authorize services, assign beneficiaries to appropriate primary care providers, and use utilization and other data to inform recruitment of specialists already working with the SPD population. In addition, many key informants supported allowing automatic delays or exemptions for beneficiaries undergoing active treatment at the time of transition.

The development of adequate networks to prepare for an expansion of Medicaid managed care is challenging. A key success for many health plans was their ability to expand their provider networks through delegation to medical groups, independent physician practices, or to federally qualified health centers in neighboring counties that already specialized in certain segments of the SPD population. At the same time, health plans also report that independent providers may be reluctant to join managed care networks because of their perceptions of increased oversight, paperwork, reimbursement challenges, or lack of familiarity with managed care delivery systems in general. To effectively expand networks, health plans need timely and accurate patient records to target providers for recruitment. Health plans also need to be afforded some means of incentivizing providers through increased reimbursement or streamlined paperwork. Health plans can leverage opportunities to market the benefits of managed care to providers and beneficiaries.

Though managed care delivery systems may provide more seamless care and increased access to care in the long run, the initial disruptions in care for transitioning beneficiaries can be substantial. While MMC offers the same basic benefits as FFS Medi-Cal, and some additional benefits, beneficiaries who are required to change delivery systems are likely to experience some care disruptions. They may be required to change doctors, pharmacies, prescription medications, laboratories, and durable medical equipment suppliers. Treatments and prescriptions that were approved through

“All organizations who serve SPDs are now working together, from different sectors. This has never happened before. It’s the first time we’re all working together to provide health care to the same population. We can utilize fewer resources collectively to provide higher quality care. We’re all thinking, ‘Why haven’t we been working together all along? This could really work for us.’”

– Health plan

“Take your time, slow it down, get local organizations... churches, local senior centers... engage them, hire, contract with local community-based organizations as information dissemination. ...Get down in the trenches, in the community, don’t hover at 30,000 feet. Address the people where they are.”

– PACE provider

FFS, may be denied or approved in different brands or doses in their managed care plan. Established relationships with providers can be disrupted, especially for those beneficiaries who do not actively choose a plan and those who had previously received care directly through specialists. Beneficiaries with mobility challenges may struggle to establish new transportation routes to unfamiliar provider offices. Changing providers may be particularly difficult for beneficiaries with intellectual disabilities, emotional problems, or mental illness for whom provider continuity and trust may be especially important. Beneficiaries who utilize high levels of care may be more likely to experience disruptions, which can range from merely inconvenient to life threatening for some beneficiaries.

The transition of a large number of high needs beneficiaries will impact the organizational structure and resources of health plans, clinics and community-based organizations that serve SPD.

Staff burnout and resource strain can be challenges for organizations that serve transitioning populations. Serving beneficiaries who are facing disruptions in necessary care, whose conditions are complex and urgent, and who may be inexperienced in navigating managed care, can require additional resources from organizations. This resource strain is likely to be greatest during and immediately following the months of transition. Findings from this study provide insights into how clinics can restructure appointment scheduling and care coordination resources. Ongoing training for staff (office staff, providers, member services representatives) and collaborating with organizations that serve SPDs can help ameliorate resources strain and staff burnout.

Opportunities to improve care delivery can continue after the transition.

The impact of managed care transition may be greatest for beneficiaries and organizations during or immediately following the transition. But there are continued opportunities to improve care systems after the transition is complete. Some key findings include the importance of continued support and education for beneficiaries, especially regarding plan navigation, filing complaints, and their rights to change plans and providers; continued staff and provider training; continued efforts to fill gaps in provider networks and prescription formularies; ongoing monitoring of both beneficiary outcomes and organizational metrics; and ongoing input from stakeholders after the transition.

Looking ahead to the duals transition (Cal MediConnect) in California. Policymakers in California have used the lessons learned from the transition of Medi-Cal-only SPD beneficiaries to inform planning for the transition of dual eligible beneficiaries to managed care in California. The Memorandum of Understanding between the Center for Medicare & Medicaid Services and the California Department of Health Care Services (DHCS) outlines changes to the original plan for the duals transition timeline and scope.¹⁶ To allow more time for necessary outreach and planning, the implementation of Cal MediConnect has been delayed by 10 months. So as not to overwhelm provider networks, the number of enrollees has been limited to less than half a million. Additionally, the number of counties was limited to eight and there are now enrollment caps in place for Los Angeles, the largest county. Unlike the SPD transition, in which enrollment in managed care was mandatory, the Cal MediConnect program allows beneficiaries to opt-out and continue using Medicare FFS, although they are required to enroll in MMC for Medi-Cal services. Unlike Medi-Cal-only beneficiaries, dual eligible beneficiaries with developmental disabilities (receiving services through a

“For a lot of my clients with intellectual disabilities, transition and change can be very difficult for them...having to go to a physically different place can be very anxiety-producing. Having to deal with new doctors and new providers is very difficult for a lot of my clients”

– Advocacy organization for developmental disabilities

“Expanding our provider network was a huge part of getting ready for the SPDs and [we’ve been] continuing to do that over the past year and a half.”

– Health plan

California Regional Center or State Developmental Center) will not be required to participate in the demonstration. Furthermore, substantial funds have been set aside for community outreach and assistance to beneficiaries for Cal MediConnect enrollment support and options counseling. In addition to engaging CBOs to assist beneficiaries, the California Department of Managed Health Care will provide additional oversight and monitoring of Cal MediConnect health plans and will provide assistance to dual eligible beneficiaries through its help center.

While Cal MediConnect will require that network providers (and those who participate in the continuity of care provision) accept managed care rates, the state legislation specifies that providers will be paid at Medicare rates for Medicare services and Medi-Cal rates for Medi-Cal services.¹⁷ While specialty mental health will continue to be carved out, this will exclude psychiatry and psychology services for which Medicare is the primary payer. Most plans will contract with behavioral health managed care plans to provide those services. Furthermore, DHCS has worked with county mental health services to create a shared accountability platform, which is intended to incentivize the plans and county mental health services to work more closely together.¹⁸

The state is working to improve the efficiency of data transfers between DHCS and health plans. CMS has provided technical assistance to speed up the transfer of beneficiary FFS medical and prescription histories. DHCS reports that they will be able to provide plans with utilization data 60 days prior to their active date, which will permit sharing of member specific information for care coordination in a more comprehensive way.¹⁹ In addition, plans have already received a file containing FFS Medicare provider information so they can identify providers to expand their networks. Finally, the reluctance of independent practice FFS providers to join MMC plans has been a major barrier to network expansion since California began using managed care to deliver Medicaid, and may also be a challenge for Cal MediConnect plans. That said, DHCS has been working closely with Independent Physician Associations and large group practices in the planning for Cal MediConnect and anticipates that, similar to the MMC plans, group practices will be a primary vehicle for expanding MediConnect plan networks to meet the needs of the new dually eligible enrollees.

CONCLUSION

California was one of the first states in the country to execute a large-scale transition of beneficiaries with complex care needs into managed care arrangements. Given the high costs of care, utilization, and complex care needs of the SPDs and of similar populations, both within California and across the country, new care delivery models, such as managed care, present significant opportunities to both improve care access and control costs. The usage of Medicaid managed care delivery models have been increasing nationally, a trend which is likely to continue due to the coverage expansion under the ACA. Even when steps are taken to mitigate anticipated issues and concerns prior to the transition, as was the case with California, unanticipated challenges are likely to arise. Learning from California's experience with their SPD transition, this brief presents considerations for states, health plans, CBOs, and providers as they prepare for managed care expansions. Particularly salient are the findings around timing, communication, and coordination, including the establishment of partnerships that enable plans and providers to deliver efficient and effective care that meets beneficiaries' health care needs.

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APPENDIX: KEY INFORMANT ORGANIZATIONS BY TYPE

TYPE OF ORGANIZATION	NUMBER OF REPRESENTATIVES INTERVIEWED
Health Plans	
Commercial Health Plan	5
Local Initiative Health Plan	5
PACE provider	1
Delegated Health Plan	2
Medical Care Providers	
Specialty Practice/Clinic	4
County Hospital	2
FQHC	8
Home & Community Based Services / County Services	
County Adult and Aging Services	1
County Mental Health	1
County Department of Public Health	1
County Department of Health Services	1
IHSS	1
Regional Center for people with Developmental Disabilities	4
Adult Day Health Care	1
HIV/AIDS	2
Homeless Services	2
Other Social Services (non-County)	1
Ancillary Services	
Pharmacy	3
Dialysis Center	3
Durable Medical Equipment supplier	2
Transportation	1
Advocacy Organizations	
Independent Living Center	3
Advocacy Organization	4
Other	
Contractor- Provided Health Plan Admin Support	1
TOTAL	59

Endnotes

- ¹ Kaiser Commission on Medicaid and the Uninsured. *The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of Recession. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010* (Kaiser Family Foundation, September, 2009), <http://www.kff.org/medicaid/event/the-crunch-continues-medicaid-spending-coverage-and/>.
- ² California Department of Health Care Services. *The Transfer of Medi-Cal Seniors and Persons with Disabilities to the Managed Care Delivery Model*, power point presentation (August, 2011).
- ³ California Department of Health Care Services. Data extracted 7/02/2010. The aid codes for Medi-Cal only SPD include: Aged: 10,14,16, 1E, 1H. Blind: 20, 24, 26, 2E, 2H, 6A, Disabled: 36, 60, 64, 66, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V.
- ⁴ Terri Coughlin and Sharon Long. *Impacts of Managed Care on SSI Medicaid Beneficiaries: Preliminary results from a National Study*, powerpoint presentation, Academy Health Annual Research Meeting (Urban Institute, June 2004), <http://www.academyhealth.org/files/2004/coughlin.pdf>.
- ⁵ Carrie Graham, Elaine Kurtovich, Susan Ivey, and Linda Neuhauser. "Fee-for-Service and Managed Care for Seniors and People with Disabilities on Medicaid: Implications for the Managed Care Mandate in California," *Journal of Health Care for the Poor and Underserved* 22, 4 (November 2011): 1413-23, doi: 10.1353/hpu.2011.0141.
- ⁶ Brenda Premo, June Kailes, Erin Schwier, and Curtis Richards. *Adults with Disabilities in Medi-Cal: The Beneficiary Perspective* (California HealthCare Foundation, September 2003), <http://www.chcf.org/publications/2003/09/adults-with-disabilities-in-medical-the-beneficiary-perspective>.
- ⁷ Samantha Artiga and Andy Schneider. *California's 'Bridge to Reform' Demonstration Waiver* (Kaiser Family Foundation, October 2011), <http://www.kff.org/health-reform/fact-sheet/californias-bridge-to-reform-medicaid-demonstration-waiver/>.
- ⁸ California Department of Health Care Services. *Managed Care Implementation for Seniors and Persons with Disabilities: Monitoring Dashboard* (January 2013), http://www.dhcs.ca.gov/individuals/Documents/MMCD_SPD/ChartsRptsData/SPD_Dashboard_Jan2013.pdf.
- ⁹ Though over 400,000 Medi-Cal only SPD were originally targeted for transition to managed care, many were subsequently exempted due to approved Medical Exemption Requests, Emergency Disenrollment Requests, and aid code changes.
- ¹⁰ Over 85% of new LIHP enrollees are in managed care counties.
- ¹¹ California Department of Health Care Services. *LIHP February 2013 Monthly Enrollment (April 2013)*, <http://www.dhcs.ca.gov/provgovpart/Documents/LIHP/Reports/February%202013%20Enrollment.pdf>.
- ¹² Cal MediConnect Memorandum of Understanding (MOU): Centers for Medicare & Medicaid Services. *California Demonstration to Integrate Care for Dual Eligible Beneficiaries*, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf>.
- ¹³ Cal MediConnect will be implemented beginning January 2014 in the following counties: including Alameda, Los Angeles, San Bernardino, San Diego, San Mateo, Santa Clara, Orange, and Riverside
- ¹⁴ California Department of Health Care Services. *Managed Care Implementation for Seniors and Persons with Disabilities: Monitoring Dashboard* (January 2013).
- ¹⁵ Data compiled by the California Department of Health Care Services Research Analytic Studies Branch. *SPD sample summaries* (California Department of Health Care Services, January, 2013).
- ¹⁶ Cal MediConnect Memorandum of Understanding (MOU).
- ¹⁷ California Senate Bill SB 1008, Introduced by the Committee on Budget and Fiscal Review and filed with the Secretary of State (June 27, 2012), http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1001-1050/sb_1008_bill_20120627_chaptered.html.
- ¹⁸ California Department of Health Care Services. *Description of Changes to California's Proposal to Integrate Care for Dual Eligible Individuals* (June 2012), <http://www.calduals.org/wp-content/uploads/2012/06/DemoChangeAttachment1.pdf>.
- ¹⁹ Personal communication with Jane Ogle, Deputy Director, California Department of Health Care Services on June 25, 2013.



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