



CALIFORNIA
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A First Look: Mandatory Enrollment of Medi-Cal's Seniors and People with Disabilities into Managed Care

Prepared for

CALIFORNIA HEALTHCARE FOUNDATION

by

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About the Foundation

The **California HealthCare Foundation** works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

Contents

2	Executive Summary
5	I. Introduction and Background
6	II. Assessment Purpose and Approach
7	III. Overview of the Transition Process
9	IV. Findings
	1. Activities to Prepare Provider Community
	2. Most Effective Outreach Strategies to Engage Provider Network
	3. Challenges Affecting Outreach to Providers
	4. Activities to Prepare Beneficiaries
	5. Most Effective Outreach Activities to Engage Beneficiaries
	6. Strategies Used to Improve Communication with Beneficiaries
	7. Challenges that Affected Outreach to and Contact with Beneficiaries and Their Representatives
	8. Experiences with State-Sponsored Activities
21	V. Discussion
25	VI. Looking Ahead
26	VII. Conclusions
27	Endnotes
28	Appendices
	A: Summary Choice Rate Table for Health Plans
	B: CHCF SPD Transition Report Advisory Group Members
	C: Health Plan Survey Questions
	D: Provider and Advocate Survey Questions
	E: County Site Visit Discussion Guides
	F: County Site Visit Participating Organizations

Executive Summary

These lessons could improve the experience of SPD beneficiaries and inform current and future DHCS initiatives, including planned expansions of managed care for dual eligibles (SPDs with Medicare and Medi-Cal) and children with special health care needs.

CALIFORNIA RECENTLY COMPLETED A YEARLONG transition of hundreds of thousands of low-income seniors and people with disabilities who have Medi-Cal coverage from fee-for-service to managed care plans. It was an ambitious undertaking, and state officials and stakeholders learned many valuable lessons in the effort—lessons that can inform and improve similar efforts in California and other states.

On November 1, 2010, the federal Centers for Medicare and Medicaid Services (CMS) approved California’s “Bridge to Reform” waiver request, authorizing the state to expand mandatory managed care to seniors and people with disabilities (SPDs) who are covered by Medi-Cal.¹ This expansion of Medi-Cal managed care affected over 380,000 beneficiaries in 16 counties. Nearly 141,000 of these beneficiaries had voluntarily enrolled in managed care prior to the expansion, so the immediate impact on them was limited: It removed their option to return to the fee-for-service system. For nearly 240,000 beneficiaries, however, the waiver approval meant they had to choose a health plan or be assigned to one by the state. Some had to change one or more of their health care providers. The goal of the managed care expansion was to broaden access, increase care coordination, improve health outcomes, and save the state money.

This report examines the implementation of the expansion and its effect on those Medi-Cal-only SPDs who were required to transition from fee-for-service to managed care. It documents the activities conducted by health plans, providers, community-based organizations, and advocates to prepare for and carry out the transition to managed care, including the challenges they experienced.

Sources for this analysis included web-based surveys of these stakeholders in all 16 counties, interviews with stakeholders in five counties, and data provided by the California Department of Health Care Services (DHCS). Analyzing the effectiveness of transition activities and the experience of beneficiaries was not in the scope of this project.

After California’s waiver request was approved in November 2010 by CMS under authority of Section 1115 of the Social Security

Act, DHCS began sending notices to beneficiaries four months later. The first group of beneficiaries was mandatorily enrolled on June 1, 2011, and the transition process was completed at the end of May, 2012. Before and during the yearlong transition, DHCS and its enrollment contractor worked closely with managed care plans, held informational meetings, collaborated with community-based advocates, and developed an information and assistance infrastructure to support beneficiaries.

Findings

Informing and Assisting Beneficiaries

- Many stakeholders reported that beneficiaries had trouble understanding the complex written notices they received. Although DHCS and its contractor distributed written materials to beneficiaries and the majority of health plans conducted informational meetings in communities, fewer than half of the health plans offered individual counseling or support to beneficiaries by telephone.
- Health plans reported out-of-date contact information for many beneficiaries.
- All types of stakeholders experienced challenges in answering questions directly from beneficiaries.

Providing Care

- Stakeholders reported that beneficiaries experienced anxiety due to confusion and concern about continuity of care. For the SPD population, continuity of care means not just the ability to remain with a primary doctor but continued access to specialists and ancillary providers, including mental health providers, and providers of durable medical equipment and prescription medications.

- Most plans reported that they trained staff to work with beneficiaries to provide information, support, and care coordination, but stakeholders said this service should have been offered earlier in the transition period, rather than the point at which beneficiaries were enrolled and needed care.
- Many stakeholders reported that the managed care system was not prepared for the SPD beneficiary population, specifically for complex cases involving mental illness, homelessness, and developmental disability.
- Providers who accepted new SPD beneficiaries as patients reported that they did not receive patient-specific information in a timely fashion.
- Many health plans reported difficulty recruiting fee-for-service providers to join their networks. Their challenges included difficulty getting a response from providers and a shortage of adequate information regarding home health, durable medical equipment (DME), and pharmacy providers.

Measuring Performance

- There were no performance goals established at the outset of this policy change, making it impossible to evaluate the effectiveness of the transition to mandatory managed care.
- Choice rates (the share of beneficiaries who selected a plan versus those who were assigned to a plan by default) averaged 40% during the 12-month transition period, with some variation by county. However, choice rates may not be a good indicator of performance.

Implications

The experience of stakeholders in this transition raises important considerations for Medi-Cal and for Medicaid programs in other states. Specific lessons suggested by the research in this report include:

- Allow more than seven months to plan and implement an expansion of this magnitude, particularly given the complexity of needs among SPD beneficiaries and the challenges they face.
- Establish simple and clear policies and processes for Medical Exemption Requests (MERs), continuity of care, and notification of disruption in the provision of DME and pharmaceuticals. Vet these policies and processes with stakeholders to identify potential points of confusion.
- Conduct extensive outreach to providers and target high-volume fee-for-service medical, DME, and pharmacy providers.
- Conduct intensive personal education and outreach to beneficiaries and develop easier-to-understand, culturally relevant materials in alternative formats, such as Braille and audio.
- Provide accurate beneficiary data to health plans before they take on the responsibility of managing new members.
- Leverage trusted community resources for more personalized communication with beneficiaries.
- Develop outreach, engagement, and care management strategies for specific populations and target high-volume users of care.
- Build the care-coordination process before the transition begins.
- Consider instituting a grace period after enrollment or default assignment.

- Establish quality-improvement benchmarks for processes such as MERs, measure changes in utilization, health outcomes, and patient satisfaction, and assess the connection between health outcomes and choice rates.

These lessons could improve the experience of SPD beneficiaries and inform current and future DHCS initiatives, including planned expansions of managed care for dual eligibles (SPDs with Medicare and Medi-Cal) and children with special health care needs.

I. Introduction and Background

IN JUNE 2011, THE CALIFORNIA Department of Health Care Services (DHCS) began transitioning seniors and persons with disabilities (SPDs) covered by Medi-Cal from fee-for-service to managed care plans. This yearlong process, which affects nearly 400,000 beneficiaries in 16 counties, is intended to expand access to healthcare services, increase care coordination, and improve health outcomes. Before the transition began, DHCS anticipated savings of approximately \$2.1 billion over five years.²

Mandatory enrollment into managed care of Medi-Cal-only SPDs (excluding those also covered by Medicare) had been under consideration since 2003. The path for this policy change was cleared in November 2010, following federal approval of California's request for a Medicaid waiver under Section 1115 of the Social Security Act, which permits the mandatory enrollment of Medi-Cal only seniors and persons with disabilities into Medi-Cal managed care.³ The counties involved in the managed care transition process are: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

This report examines the early activities and experiences of local stakeholders as they prepared for and implemented the expansion of managed care. These stakeholders include managed care plans, health care providers including physicians, clinics, durable medical equipment (DME) providers, pharmacies, advocacy organizations, and community-based organizations. The work was carried out under the guidance of an Advisory Group composed of individuals representing the diverse range of stakeholders involved in and affected by the SPD managed care transition (see Appendix B for Advisory Group members).⁴

II. Assessment Purpose and Approach

THE GOALS OF THIS STUDY INCLUDED:

1. Assessing and understanding the activities and experiences of local stakeholders (i.e., health plans, providers, community-based organizations, and advocates) in preparing for and implementing the mandatory transition of SPDs to Medi-Cal managed care.
2. Documenting challenges experienced during the transition.
3. Identifying lessons that can improve the experience of SPDs transitioning to managed care and inform upcoming initiatives that target dual eligible (Medicare-Medicaid) beneficiaries and children with special health care needs.

To address these goals, the study used several data sources, including:

- Web-based survey of participating health plans in the 16 counties (14 of the 16 health plans responded).
- Web-based survey of providers, community-based organizations (CBOs), and advocates in the 16 counties (98 organizations responded).⁵
- In-person group and individual telephone interviews with stakeholders in five counties: Alameda, Fresno, Los Angeles, Riverside, and San Diego. (Group interviews in each county were conducted by group type, e.g., health plan, provider, advocate, or community-based organization.)
- Available data from DHCS, including SPD Dashboard, COPS-43 SPD Telephone Call

Center Report, 90/30-Day Beneficiary Letter, and Health Plan Training Curriculum.

Tables 1 and 2 show the organizational affiliation of the web survey respondents. Survey and interview instruments are listed in Appendices C, D, and E.

Table 1. Organizational Affiliation of Health Plan Respondents (n=14)

Local community or public plan	64% (9)
Commercial plan	29% (4)
Other (Geographic Managed Care)	7% (1)

Table 2. Organizational Affiliation of Stakeholder Respondents (n=98)

Primary care provider	10% (9)
Specialty care provider	13% (13)
Community clinic or FQHC	14% (14)
Adult day health center	2% (2)
Independent living center	2% (2)
Regional center	8% (8)
Area Agency on Aging	10% (9)
Advocacy organization (e.g., legal, mental health, homeless)	21% (21)
Other health care provider (e.g., SNF, home health, residential treatment)	10% (10)
Other agency/provider (e.g., human services, mental health)	10% (10)

It is important to note that assessing the effectiveness and impact of transition activities, as well as documenting the experience of beneficiaries, are not in the scope of this project.

III. Overview of the Transition Process

THE ENROLLMENT OF SPDs INTO managed care was phased over the 12-month period from June 1, 2011 through May 2012. Beneficiaries were required to transition from fee-for-service to managed care according to their birth month. The process began with beneficiaries born in May. Approximately 90 days before their birth month, DHCS notified beneficiaries that they would be required to make this transition. This was the start of an informing process that included notification letters, choice packets, informational materials, and phone calls from Health Care Options, the state’s Medi-Cal enrollment broker. For nearly 141,000 of the 380,000 SPDs impacted by the expansion of mandatory managed care, services did not change because they had previously enrolled into a Medi-Cal managed care plan voluntarily.

Several months before the transition was launched, DHCS, the managed care plans, providers of all types, community-based organizations, and advocates for people with disabilities and seniors

began a period of transition planning and preparation that included data review, rate discussions, training, provider and beneficiary outreach, materials modification, and other local activities. As a condition of the waiver, DHCS was required to assess and ensure the readiness of the county plans to meet the needs of transitioning SPDs. DHCS was also required to augment its existing Facility Site Review (FSR) tool, which plans must use to assess and report on the physical accessibility of the buildings and offices of providers in their networks to people with disabilities. Managed care plans were required to assure continuity of care, assess beneficiary needs using a Health Risk Assessment (HRA), and develop individual care plans for new enrollees. DHCS clarified its existing Medical Exemption Request (MER) policy and process during the transition year and developed a “dashboard” that provided ongoing month-by-month data on the progress of the transition.

DHCS Transition Timeline

November 1, 2010	CMS approved California’s waiver request
January 2011	DHCS authorized 40 temporary positions for enrollment broker Health Care Options (HCO)
February 1, 2011	HCO sent 90-Day notification letter to beneficiaries
March 1, 2011	HCO sent 60-Day enrollment packet to beneficiaries
March–April 2011	DHCS held community presentations in 16 counties
April 2011	DHCS participated in webinars for beneficiaries
June 1, 2011	SPD beneficiaries with May birthdays enrolled in managed care
May 31, 2012	Transition of SPDs into managed care completed

DHCS initiated numerous activities to provide information to beneficiaries, health plans, and providers (Table 3).

The state’s Medi-Cal enrollment broker, Health Care Options (HCO), was responsible for developing and disseminating a comprehensive enrollment package to promote a smooth transition.⁶ The package included informational materials, letters, and enrollment forms to make SPDs aware of the enrollment process, the timeline, and the health plans from which they could choose. HCO implemented procedures and systems, in 13 languages, to ensure the timely processing of enrollments and disenrollments. HCO attempted to reach SPD

beneficiaries five times before proceeding with an “auto-assignment” process that automatically enrolled beneficiaries into a health plan. The process included steps to foster continuity of care for beneficiaries with their providers. In addition, HCO provided in-person presentations for SPDs at 120 enrollment sites across California. Individual beneficiaries could also request presentations in their home or living facility if they were not able to travel. HCO added 40 new staff members to its outreach program specifically for enhanced SPD outreach services. However, HCO was not able to implement services and materials in alternative formats, such as Braille and audio files.

Table 3. DHCS Informational Activities

BENEFICIARIES	HEALTH PLANS	PROVIDERS
Targeted Activities		
<ul style="list-style-type: none"> • Sent an informational mailing 90 days in advance of enrollment. • Sent an information and enrollment packet 60 days in advance of enrollment. • Mailed an “Intent to Default Letter” 30 days in advance of enrollment. • Authorized additional staffing—40 temporary full-time customer service representatives—from January 11, 2011, through April 30, 2012, to assist in contacting beneficiaries prior to the enrollment date of each individual. Placed an average of 30,000 calls each month—two calls (plus three follow-ups if no answer) were placed to each beneficiary following the 90-day and 60-day letters. • Conducted an in-person presentation for beneficiaries at 120 enrollment sites. • Created and disseminated “My Medi-Cal Choices” informational booklet designed to inform SPDs about Medi-Cal managed care. 	<ul style="list-style-type: none"> • Hosted multiple planning meetings and teleconference calls. • Worked with health plans to update contracts to reflect new requirements. • Provided ongoing communication on all aspects of the transition, including plan readiness and provider network development. • Sponsored training for health plan staff. • Released multiple All-Plan and Policy Letters to provide specifics of the SPD transition. 	<ul style="list-style-type: none"> • Prepared and disseminated multiple informational notices to Medi-Cal FFS providers via the Medi-Cal Provider Bulletin system.
Common Activities		
<ul style="list-style-type: none"> • Conducted one public presentation in each county (March and April 2011). • Participated in five webinars for beneficiaries, providers, and consumer advocates.* • Created an email account to which beneficiaries, providers, and community advocates could submit questions (mmcdpmb@dhcs.ca.gov). • Provided updates on the DHCS website. 		

*These webinars were organized by the Center for Health Care Strategies with funding from the California HealthCare Foundation.

IV. Findings

1. Activities to Prepare Provider Community

The majority of health plans engaged in a range of similar activities (Table 4). They included: conducting Facility Site Reviews (FSRs); sending staff to DHCS community meetings; training health plan staff at both DHCS-sponsored events and at health plan-specific sessions; sending informational materials and holding informational meetings and trainings for providers in the community; collaborating with other community-based advocates and community stakeholders; and developing informational materials for providers. Most plans also established an information and assistance infrastructure to support beneficiaries and often collaborated with other Medi-Cal health plans operating in their community. For example, in Riverside County, both Inland Empire Health Plan and Molina Healthcare of California hired additional disability coordinators, did extensive staff training, and made it a priority to keep their existing collaborative of relevant community-based organizations and advocates well informed regarding the transition process and changes to it.⁷

In addition to initiating specific outreach activities to educate their provider networks, plans conducted network adequacy assessments and recruited fee-for-service providers to expand their networks where necessary. For example, L.A. Care Health Plan wanted to ensure that its provider network is capable of serving members with complex medical and social needs, so the health plan developed quality-based evaluation criteria for contracted medical groups and independent physician associations. According to L.A. Care representatives, groups that met quality standards

Table 4. Health Plan Activities to Prepare Provider Networks for Managed Care Transition

Conducted new FSRs of provider offices	100%
Sent staff to DHCS-sponsored informational meetings in the community	100%
Held education and training sessions with staff	100%
Held education and training sessions for health care providers in the community	100%
Collaborated with other stakeholders (e.g., CBOs, advocates)	93%
Developed and disseminated written materials	93%
Established infrastructure to conduct direct outreach to beneficiaries to provide information and assistance once they were enrolled	86%
Collaborated with other health plans serving Medi-Cal beneficiaries	86%
Developed and disseminated FAQs for health care providers	64%
Established telephone support lines	43%
Other*	21%

*Examples of other responses from the health plans: "We contracted with a consultant who specializes in disability advocacy to assist in plan development and implementation recommendations." "We modified our drug formulary to transition members on nonformulary medications and increased staffing in various areas, including our triage nurse team that assists members with medical issues." "The telephone support line is our customer service line, but we set up a special phone number for SPD-related calls."

(e.g., low avoidable emergency room visit rates and financial-soundness indicators) were invited to remain in the health plan network, while a few medical groups that did not meet the criteria were terminated.

Compared to the health plans, there was much more variability in preparation activities reported by the other stakeholders surveyed, especially between health care providers/community clinics

and other provider/community-based organizations (Table 5). A higher proportion of other provider organizations compared to health care providers and clinics reported conducting outreach to beneficiaries (74% vs. 35%), holding staff education and training sessions (58% vs. 45%), sending staff to DHCS-

sponsored informational meetings (63% vs. 40%), developing and disseminating written materials (58% vs. 35%), and collaborating with other stakeholders (53% vs. 35%). Ten percent of the health care providers reported not implementing any specific preparation activities.

Table 5. Stakeholder Activities to Prepare for the Transition, by Type*

	HEALTH CARE PROVIDERS AND COMMUNITY CLINICS	OTHER PROVIDER AND COMMUNITY-BASED ORGANIZATIONS
Outreached directly to beneficiaries to provide information and assistance	35%	74%
Held education and training sessions with their staff	45%	58%
Sent staff to DHCS-sponsored informational meetings in the community	40%	63%
Developed and disseminated written materials	35%	58%
Collaborated with other stakeholders (e.g., CBOs, advocates)	35%	53%
Developed and disseminated FAQs for health care providers	15%	16%
Held educational training sessions and informational meetings for health care providers in the community	15%	26%
Established telephone support lines	0%	11%
No preparation	10%	0%

*Health care providers include primary care providers, specialists, community clinics and health centers, and ancillary providers, such as durable medical equipment providers and pharmacies. Other provider and community-based organizations include Adult Day Health Centers, Residential Care Centers, Area Agencies on Aging, and legal services, among others.

Multistrategy Approach. Many CBOs used a multistrategy approach to leverage existing community resources and infrastructure to support stakeholders involved in the transition.

“We executed an MOA with the health plans to facilitate access to Area Agency on Aging programs and services and established a secure email account to provide a response within 24 hours to any questions or concerns posed by the health plans,” one CBO explained. The CBO provided health plans with access to refer their members via the web to in-home supportive services and case-management programs. Area Agency on Aging staff joined the county health plan group and quality-improvement subcommittee.... We also hosted a Long Term Care Integration Project meeting in May to discuss the transition of SPDs into managed care. All of the health plans were present and addressed community stakeholders’ questions and concerns.”

2. Most Effective Outreach Strategies to Engage Provider Network

According to the majority (86%) of health plans, the key to effectively communicating with providers was to actively engage them through in-person meetings, in-service training sessions, and informational sessions at the providers’ offices. While nearly two-thirds (64%) of the plans developed provider-specific FAQs and other written materials, only 40% found this more passive strategy effective. But given the brief time frame for planning and the limited experience that some plans had with the diverse fee-for-service provider community used by the SPD population, many plans said they had no choice but to rely on a more passive outreach strategy to reach

“[Continuity of care] changed at least three times. The final MMCD All Plan letter 11-019 9-21-11, which the providers could use as a concrete tool for members, was made available two and a half months after the SPD transition began.”

— HEALTH PLAN

providers. It is not known how many additional providers working with the SPD population have been contracted in each county since the start of the transition.

3. Challenges Affecting Outreach to Providers

Health plans and other stakeholders reported numerous challenges in effectively communicating with the provider community prior to and during the transition (Tables 6 and 7). The challenge reported by the majority of health plans was lack of responsiveness from providers (64%). Half of the plans reported challenges stemming from unclear or changing DHCS policies, such as continuity of care. Plans also reported a need for better information regarding home health, durable medical equipment (DME), and pharmacy providers.

Other stakeholders, particularly health care providers, reported that they incurred a burden from beneficiaries asking questions related to confusing and incomplete information communicated by the state. More than 80% of the specialty providers reported this issue. Three-quarters (75%) of community clinics and health centers and half (50%) of primary care providers reported challenges related to unclear Medical Exemption Request (MER)

Table 6. Health Plan-Identified Challenges Affecting the Effectiveness of Outreach and Education Activities

Lack of responsiveness from providers	64%
Unclear DHCS policies and procedures that were confusing to interpret and communicate	50%
Changes in DHCS policies and procedures (e.g., MERs)	50%
Lack of DHCS reproducible training materials to educate providers	21%
Lack of coordination across state agencies and entities (e.g., DHCS, HCO, Ombudsman, DMHC, etc.)	21%
Difficulty identifying which providers to target	21%
Ensuring patients would be assigned to current provider/clinic	21%

Table 7. Other Stakeholder-Reported Challenges Affecting the Effectiveness of Outreach and Education Activities to Health Care Providers

Confusing or incomplete information communicated to beneficiaries that created questions providers had to answer	52%
Changes in DHCS policies and procedures (e.g., MERs)	41%
Unclear DHCS policies and procedures related to the transition that were confusing to communicate	39%
Lack of coordination across state agencies and entities (e.g., DHCS, HCO, Ombudsman, DMHC, etc.)	39%
Difficulty collaborating with health plans	36%
Difficulty knowing where to get answers at the state level	35%
Ensuring patients would be assigned to current provider/clinic	32%
Lack of DHCS reproducible training materials to educate providers	21%
Difficulty identifying which providers to target	17%
Lack of responsiveness from providers	17%
Experienced no challenges or barriers	8%

policies. Nearly half (48%) of the responding health care providers reported difficulty collaborating with health plans. Similarly, more than half (53%) of the nonmedical provider organizations reported that they incurred a burden associated with questions due to confusing information communicated to beneficiaries, 41% identified challenges associated with MERs, and more than a third (37%) did not know where to get answers to questions at the state level. These experiences reflect the lack of consistent access to information across the diverse provider community serving the SPD population.

Many of the health plans reported experiencing significant issues in recruiting fee-for-service providers to join their networks. They reported that this was a result of delayed and difficult-to-use beneficiary fee-for-service claims data provided by DHCS, as well as reluctance by fee-for-service providers to take part in managed care. For example, L.A. Care Health Plan used state-supplied data to identify high-volume fee-for-service providers, and

worked with its contracted independent physician associations and medical groups to conduct outreach, but its efforts did not result in a significant increase in fee-for-service physicians joining its network. L.A. Care also solicited the seven Regional Centers in Los Angeles County serving individuals with intellectual and developmental disabilities for lists of providers with strong reputations for delivering quality care to their clients. While this led to some critical providers being added to the network, it did not result in a large increase in the number of new providers.

Across the state, health plans reported similar experiences — fee-for-service providers generally were not responsive to limited outreach to join health plan networks and receive health plan payments, although many noncontracted providers were willing to continue to see beneficiaries under continuity-of-care provisions and receive payments from health plans. It will be important to examine and understand the approaches health plans take in assisting members to identify a network provider

once the continuity-of-care period ends, after a year of enrollment, at which time beneficiaries must choose a provider who is contracted with their health plan. At this time, there is no evidence of significant efforts to work directly with beneficiaries and assist them in this process.

4. Activities to Prepare Beneficiaries

Health plans and other stakeholders were asked to report their activities to prepare and support beneficiaries and their representatives for the transition to managed care (Tables 8 and 9). The majority of health plans reported collaborating with other stakeholders (86%), training health plan staff (79%), disseminating written materials (79%), developing cross-organizational workgroups to solve problems (71%), and conducting informational meetings in the community (64%) to prepare beneficiaries for the transition. Fewer than half (43%) offered telephonic counseling or support.

Healthy San Diego engaged in a collaborative, intensive effort to work with its health plans to educate beneficiaries, as did Health Net, which developed a statewide consumer group to advise the health plan. Inland Empire Health Plan and Molina Healthcare used an existing collaborative of hundreds of community, state, and local providers of services to individuals with disabilities to get the word out to their clients regarding the changes. In Riverside County the health plans started preparing for the managed care transition prior to 2007, recognizing the necessity to better understand the complex needs of the SPD population. Both Inland Empire Health Plan and Molina Healthcare hired an expert consultant to advise on various efforts, including strategies to better communicate with and meet the needs of the SPD population. As a result, the plans have worked to educate beneficiaries about managed care and how to engage more effectively with their

providers. Inland Empire Health Plan now sponsors a collaborative focused on people with disabilities with over 300 member organizations. Inland Empire and Molina both hired an additional staff member as a disability coordinator to work with internal staff and in the community as a liaison to the plans, answering questions and providing information for SPD beneficiaries about the transition and health plan services.

Table 8. Health Plan Activities to Prepare Beneficiaries and Their Representatives for Managed Care Transition

Collaborated with other stakeholders (e.g., CBOs, advocates)	86%
Held education and training sessions with health plan staff	79%
Developed and disseminated written materials	79%
Developed workgroups across organizations to identify systemic problems and advocate for fixes	71%
Conducted informational meetings in the community	64%
Provided telephonic or in-person counseling sessions (e.g., benefits counselor, care manager, etc.)	43%
Operated telephone support lines	43%
Disseminated FAQs for beneficiaries	43%
Other (e.g., relied on DHCS to inform beneficiaries)	14%

Compared to the health plans, significantly fewer health care providers and other providers reported conducting activities to prepare beneficiaries for the transition (Table 9 on page 14). There also were differences between the health care providers and other providers, which illustrate the respective roles these stakeholders played in the transition. A higher proportion of other provider organizations compared to health care providers and clinics reported holding education and training sessions with their staff (58% vs. 50%), collaborating with health plans (58% vs.

Table 9. Other Stakeholder Activities to Prepare Beneficiaries and Their Representatives for Managed Care Transition

	HEALTH CARE PROVIDERS AND COMMUNITY CLINICS	OTHER PROVIDER ORGANIZATIONS
Held education and training sessions with their staff	50%	58%
Provided beneficiaries telephonic or in-person counseling sessions with staff (e.g., benefits counselor, care manager, etc.)	35%	53%
Collaborated with health plans	35%	58%
Collaborated with other stakeholders (e.g., CBOs, advocates)	25%	47%
Developed and disseminated written materials	30%	42%
Disseminated answers to FAQs specifically for beneficiaries	20%	32%
Conducted informational meetings/public forums in the community	10%	37%
Developed workgroups across organizations to identify systemic problems and advocate for fixes	5%	11%
No preparation	0%	5%

35%), providing telephonic or in-person counseling (53% vs. 35%), disseminating FAQs for beneficiaries (32% vs. 20%), and conducting informational meetings in the community (37% vs. 10%).

5. Most Effective Outreach Activities to Engage Beneficiaries

Health plans and especially other stakeholders, such as CBOs and advocates, reported that “high-touch” and personalized outreach and communication, including in-person, one-on-one counseling and phone support, were the most effective strategies for engaging beneficiaries. The least-effective strategies included mailings and written materials dissemination, as well as community meetings, due to the impersonal nature of these forums and the limited mobility of many disabled beneficiaries in the target population.

Similarly, the other stakeholders identified high-touch engagement with beneficiaries through in-

person, one-on-one counseling and phone support and outreach using dedicated information lines as the most effective beneficiary-outreach activities, along with collaboration with health plans, CBOs, and other stakeholders.

6. Strategies Used to Improve Communication with Beneficiaries

Health plans and other stakeholders were asked to identify what they did to improve beneficiaries’ access to and comprehension of information about the transition (Tables 10 and 11 on the following pages). All health plans reported that they supported staff training to ensure their staff understood policies and procedures, and most (86%) sent staff to trainings to understand beneficiary needs. Most plans also focused on managing language-access issues and ensuring the availability of information in alternative formats. Many plans hired new staff to address the increased demand from beneficiaries for information,

support, and care coordination (64%). However, many stakeholders noted that the plans built their care-coordination capacity during implementation rather than integrate it into the planning process, which limited its effectiveness.

Other stakeholders also engaged in staff training and provided staff to assist beneficiaries in understanding the enrollment process and choices. Nearly a quarter of these providers and advocacy organizations addressed language-access issues or disseminated answers to FAQs. These stakeholders also provided trainings and sponsored educational meetings with other organizations in the community.

“[During the planning period] we had limited ability to reach large numbers of beneficiaries, since they were not yet our members. We held community presentations, with DHCS-approval, but large numbers of beneficiaries did not attend. We often used those presentations to train CBO staff to work with their clients.”

— HEALTH PLAN

Table 10. Steps Taken by Health Plans to Ensure Information Provided to Beneficiaries Was Accessible and Understandable

Trained staff on new policies and procedures	100%
Ensured language was appropriate for limited literacy levels	93%
Translated information into multiple languages	86%
Attended state-sponsored trainings to better understand beneficiary needs	86%
Informed prospective members of information available in alternative formats and other support to promote accessibility	71%
Provided information in alternative formats (e.g., Braille, audio, large print, text-only electronic, etc.)	64%
Provided staff to assist potential members with understanding enrollment materials	64%
Hired new staff to implement and support activities during the transition	64%
Collaborated with CBOs and other organizations to sponsor educational meetings in the community	64%
Provided training to CBOs on the managed care transition	50%
Established telephone support lines	43%
Provided information through a website tested for accessibility	43%
Other (e.g., provided sign language interpretation at community meetings)	7%

Table 11. Steps Taken by Other Stakeholders to Ensure Information Provided to Beneficiaries Was Accessible and Understandable

Trained staff on new policies and procedures	46%
Provided staff to assist individuals with understanding enrollment materials	44%
Attended state-sponsored trainings to better understand the needs of beneficiaries	28%
Ensured language was appropriate for limited literacy levels	27%
Disseminated FAQs and answers	24%
Translated information into multiple languages	23%
Established telephone support lines	18%
Provided training to CBOs on the managed care transition	14%
Sponsored educational meetings in the community in conjunction with CBOs and other community organizations	10%
Informed potential members of available alternative formats, sign language interpreters, and other support to promote accessibility	10%
Provided information through a website tested for accessibility	8%
Provided information in alternative formats (e.g., Braille, audio, large print, text-only electronic, etc.)	5%
Hired new staff to conduct and support activities during the transition	4%
No change from standard practices	4%
Other (pushed state to provide better information, set up training for Health Care Options to come to the agency and provide information to managers and service coordinators)	3%

7. Challenges that Affected Outreach to and Contact with Beneficiaries and Their Representatives

Health plans and other stakeholders reported numerous challenges to providing effective outreach to and communication with beneficiaries (Tables 12 and 13). Inaccurate and incomplete contact information presented the greatest challenge for most health plans (86%), while the short timeframe for communication, unclear DHCS policies, and inaccurate information challenged many of the other stakeholders. In one county, the Program of All-Inclusive Care for the Elderly was omitted from the list of health plan options in the DHCS enrollment packet provided to beneficiaries. Providers also expressed concerns regarding the increased burden they experienced due to beneficiaries not understanding the information communicated in the enrollment packets and a lack of available patient-specific information.

Other stakeholders also reported a shortage of communication avenues to counsel beneficiaries with complex issues in a timely fashion.

While very few health plans or other stakeholders cited a lack of alternative formats (e.g., Braille and audio) as a challenge, there were suggestions that formats need to be culturally responsive to individuals with complex conditions, such as mental health issues, developmental disabilities, and homelessness.

Table 12. Health Plan Challenges Affecting the Effectiveness of Outreach and Education Activities for Beneficiaries

Incorrect or incomplete contact information	86%
Incorrect telephone numbers	79%
Lack of responsiveness from beneficiaries	71%
Short timeline for communication	50%
Unclear DHCS policies and procedures concerning the transition	29%
Limited alternative formats (e.g., Braille, audio, etc.) to communicate with beneficiaries	7%
Lack of information support lines to counsel beneficiaries with the most complex problems	7%
Resistance from community advocates and CBOs to help with communication	7%

Table 13. Other Stakeholder Challenges Affecting the Effectiveness of Outreach and Education Activities for Beneficiaries

Unclear DHCS policies and procedures concerning the transition	46%
Short timeline for communication	41%
Lack of information support lines to counsel beneficiaries with the most complex problems	32%
Inaccurate telephone numbers for beneficiaries	31%
Lack of responsiveness from beneficiaries	30%
Inaccurate addresses for beneficiaries	24%
Limited alternative formats (e.g., Braille, audio, large print, etc.) to communicate with beneficiaries	10%
Resistance from community advocates and CBOs to help with communication	10%
Lack of resources to conduct outreach, education, or other activities to support population	8%
Other	10%

In Their Own Words: Stakeholders Speak of Their Experiences

“We never knew anything beyond, ‘Some of your patients will be forced into managed care plans,’ so all we’re doing is waiting until they call for information or appointments, then, depending on their issue, redirecting them.”

— COMMUNITY ADVOCATE

“We have been put in the position of having to be detectives and trying to determine what conditions a patient has, where they were getting treatment before, their previous workups, etc. And we have to hear our patients cry for an hour in the office because their stress levels have been so high, working with case managers to get their specialty care reinstated, etc.”

— PROVIDER

“New patients with complex and confusing chronic medical, social, and mental problems came to my office, having left familiar providers, with no transition or continuity in care. They belonged to managed care organizations with slow-to-respond patient-assistance systems, changing and often absent specialty providers, formulary refusal of prior meds, and treatment providers often more than 30 miles away from patient’s home. Thus each patient required huge amounts of my staff time.”

— PROVIDER

“Alternative formats to reach those with complex conditions (i.e., homelessness) do not currently exist unless the managed health plan has implemented policies for reaching out to this population. Health plans have admitted that they are not accustomed to serving this population and, while some are interested in developing programs and policies to do so, intensive education and communication is required.”

— COMMUNITY ADVOCATE

“There was a lack of understanding of the complex needs of this population and the high percentage of SPDs with significant mental health issues and/or developmental disabilities. The expectation that this population will be informed by a mailer or even a phone call is unrealistic.”

— COMMUNITY-BASED ORGANIZATION

“This is a complex, needy population. There needs to be support at the primary care provider level. Community outreach and education, both in groups and individually, is important as well. Primary care providers could do more to directly outreach to those patients already at their practice but they need resources to do that.”

— PRIMARY CARE PROVIDER

8. Experiences with State-Sponsored Activities

Health plans and other stakeholders were asked to provide specific feedback on their knowledge of and use of key state-sponsored activities (Tables 14 and 15). Overall, and especially compared to the other stakeholders, the health plans reported a high rate of participation in these activities. Among the other stakeholders, nonmedical providers and advocates were more likely than medical providers, particularly specialists, to know about and participate in DHCS-sponsored activities. The most common reason given for the shortage of participation and use was a lack of awareness of the availability of these activities and materials and the fact that providers were not targeted for outreach by the state.

Overall, the health plans reported that the DHCS-sponsored activities were useful, particularly the DHCS website and webinars. Slightly more than half of the other stakeholders reported that the website and webinars were useful, especially

the medical providers and specialists. Both health plans and other stakeholders found the county presentations and beneficiary mailings to be less useful than the website and webinars.

Health plans and other stakeholders were asked if they contacted the state’s managed care enrollment broker, Health Care Options, to assist in the transition process. Half (50%) of the plans and about a quarter (27%) of the other stakeholders reported contacting Health Care Options, with nonhealth care providers more likely than medical providers to have engaged with the enrollment broker. The most common information that health plans and other stakeholders sought when they contacted Health Care Options included: when beneficiaries needed to enroll in the plan; copies of enrollment materials, including alternative formats, that were unavailable; and instructions on how to file Medical Exemption Requests. When asked to rate the effectiveness of the enrollment broker, all the health plans that used Health Care Options rated its services “effective”

Table 14. Health Plan and Other Stakeholder Participation in DHCS-Sponsored Activities

	HEALTH PLANS	PROVIDERS/ ADVOCATE ORGANIZATIONS
Staff attended DHCS-sponsored county presentation	100%	55%
Used materials on the DHCS website	93%	48%
Staff participated in DHCS webinars	86%	56%

Table 15. Health Plans’ and Other Stakeholders’ Perceived Usefulness of DHCS-Sponsored Activities in Informing and Preparing Providers and Beneficiaries

	HEALTH PLANS	PROVIDERS/ ADVOCATE ORGANIZATIONS
Website “Somewhat” or “Very useful”	93%	57%
Webinars “Somewhat useful”	78%	53%
County presentations “Somewhat” or “Very useful”	64%	39%
Mailings to beneficiaries “Somewhat” or “Very useful”	62%	37%

or “very effective.” In contrast, among the other stakeholders that used the enrollment broker, more than half (60%) rated its services “not very effective” or “not at all effective.”

In Their Own Words: Stakeholders Speak of Their Experiences

“The County presentations were well presented and informative. They were, however, poorly attended and only offered on one date in most counties.”

— COMMUNITY ADVOCATE

“The barrier in the mailings seems not to have been language but comprehension. The concepts are difficult, in part, because many in my population do not manage their own insurance but depend on family members or care providers to do it. So, in a way, educating those persons was a more critical need. The mailing, though simple, assumed clients know what they are currently doing about insurance and, in the case of my clients, their knowledge was very poor to begin with.”

— COMMUNITY-BASED ORGANIZATION

“The support was not as effective, in that the staff there were rigid in their understanding and efforts to assist. The support felt like it was only, ‘Follow the script.’ There was very little independent thinking to address special cases.”

— PROVIDER

V. Discussion

THE ONLINE SURVEYS AND INTERVIEWS conducted with stakeholders involved in the process of expanding mandatory Medi-Cal managed care to seniors and people with disabilities reveal many early insights regarding the transition process. These include:

- The ratio of beneficiaries who actively choose a health plan is important to monitor, but may not be the best measure of success at this stage of the managed care transition.** Promoting choice of plans by beneficiaries was a key goal of the SPD managed care transition because actively choosing a plan can increase enrollee satisfaction, and having a choice is an important component in promoting independence and empowerment. Although health plans and local stakeholders in different counties conducted a wide array of activities during the planning and implementation phase of the transition, the impact of these activities is difficult to discern, as positive choice rates show limited variation across counties over the course of the transition year. During any given month, choice rates did vary by county (e.g., during a 28-day period in January and February 2012, the average choice rate across counties was 47%, ranging from 32% in Kern to 51% in Santa Clara — see Table 16). However, the overall choice rate among the 239,731 beneficiaries who transitioned from fee-for-service to managed care during the 12-month period was slightly less than 40% (see Appendix A). This is not surprising in light of the experience of other states that have transitioned populations to managed care. It is common for positive

Table 16. Choice Rate Data, by County, Jan/Feb 2012

COUNTY	ENROLLMENT		TOTAL
	CHOICE	DEFAULT	
Alameda	579 (43%)	778	1,357
Contra Costa	301 (43%)	401	702
Fresno	392 (40%)	583	975
Kern	329 (32%)	697	1,026
Kings	57 (45%)	71	128
Los Angeles	5,872 (50%)	5,783	11,655
Madera	54 (38%)	89	143
Riverside	609 (42%)	833	1,442
Sacramento	901 (45%)	1,123	2,024
San Bernardino	719 (43%)	953	1,672
San Diego	1,213 (49%)	1,254	2,467
San Francisco	500 (43%)	676	1,176
San Joaquin	397 (45%)	476	873
Santa Clara	582 (51%)	553	1,135
Stanislaus	233 (44%)	293	526
Tulare	202 (41%)	286	488
Total	12,940 (47%)	14,849	27,789

Source: COPS-40 – SPD Enrollment Activity Report: Data for 1/25/2012 through 2/21/2012.

choice rates to be low initially and improve as the program matures.

Many factors have been identified as influencing choice rates among beneficiaries, including program maturity and visibility, and characteristics of the enrolled population.⁸ Fraser et al note that states with the highest choice rates have designed their systems specifically to achieve this outcome by implementing aggressive information campaigns or investing in educators and advocates to provide direct support to beneficiaries.

- **Implementation challenges during the initial transition period were predicted well by health plans, providers, community-based organizations, and advocates, given the diversity and complexity of the SPD population and the aggressive implementation timeline.** The SPD population is diverse, with complex health and living situations and specialized needs, not all of which are medical. Working under the ambitious transition timeline, advocates, community-based organizations, and health plans identified many issues in advance regarding the ability of beneficiaries to transition smoothly and the ability of health plans and providers to meet beneficiaries' wide-ranging needs. Significantly more data and analysis are needed to better understand the magnitude of problems experienced by beneficiaries and providers, and to assess the impact on the various SPD subpopulations.

Moreover, it is important to acknowledge that the task of evaluating and selecting a health plan can be difficult for anyone, and especially so for members of the SPD population, where there is a prevalence of cognitive issues, low literacy, and

language-access issues. Improving the experience of beneficiaries navigating the transition process is going to take time and requires attention to specific subpopulation needs to ensure parity in understanding the options available, as well as the appropriateness, responsiveness, and quality of services accessed.

- **Efforts to engage providers and beneficiaries were limited and many problems surfaced.** Within the ambitious implementation timeline, there were limited efforts by DHCS and the health plans to engage fee-for-service providers, including ancillary providers (e.g., durable medical equipment suppliers and pharmacies). While outreach to beneficiaries created a number of potential contact opportunities for them, stakeholders reported that the actual impact and penetration was limited, with only one community meeting per county and only a few webinars. Health Care Options did conduct in-person presentations for beneficiaries at 120 enrollment sites across the state, however attendance data were not available to assess participation and the sessions did not mitigate the concerns of stakeholders regarding sufficient access to clear information by beneficiaries, particularly given the lack of materials and presentations in alternative formats. More important, telephone outreach by HCO and the health plans was severely constrained by inaccurate contact information. Feedback from stakeholders encourages the state and health plans to develop and disseminate additional information and instructions for beneficiaries and providers, spend more time engaging with them at the local level, and leverage CBOs that understand the needs of SPD subpopulations and that are trusted by them.

- **Although health plans invested in ensuring network adequacy for persons with physical disabilities, there was often insufficient training of health plan staff and the provider community in the needs of persons with mental illness and developmental disabilities.**

A variety of stakeholders, from advocates to providers, identified significant gaps in knowledge among health plan staff and the provider community regarding the needs of persons with mental illness and developmental disabilities. Stakeholders noted that the absence of specific training materials to address the needs of this population negatively affected their health and mental health due to increased anxiety and inadequacy of provider response. While some of the health plans recognized the need for this kind of training for their staff in the wake of their experience with voluntary Medi-Cal SPD beneficiaries, training efforts were not encouraged or widespread in all of the health plans.

- **Issues with Medical Exemption Requests (MERS) and continuity of care continue to be of concern to advocates, providers, and health plans.** Over the course of the transition, many concerns were raised about the DHCS policy on MERS, including the evaluation process and high volume of denials, and continuity of care requests at the health plan level. Stakeholders expressed significant concerns regarding changes to MERS and continuity-of-care policies made during the transition-implementation period. There were also concerns about the processing time for MER decisions and the lack of information sharing on the status of requests by DHCS. Throughout the transition year, DHCS clarified its explanation of the MERS process. The number of outstanding MERS began to decrease by January 2012, but

this did not change the perception or experience of the many stakeholders that expressed concern about a lack of responsiveness by the state in processing and denying the majority of requests.

Issues pertaining to continuity of care ranged from basic concerns about the ability of enrollees to continue accessing their primary care physicians to very specific concerns regarding network adequacy (access to specialists) and access to durable medical equipment and prescription medication. Stakeholders expressed concern that some health plans lacked enough experience with the diverse and intense needs of this new mandatory population. In addition, advocates expressed concern about their patients not being able to access specific pharmaceuticals not on a plan's formulary.

- **The transition to managed care has created ripple effects across the provider community.** Health plans and other stakeholders in counties like Alameda and Los Angeles noted the impact that the managed care transition is having on the broader system of care for the SPD population, particularly on CBOs and community programs that have traditionally supported the SPD population with enabling services and case management. In Alameda, for example, the Alameda Alliance for Health and Anthem Blue Cross had to decide whether to bring case-management services in-house or contract out this function to CBOs that have traditionally provided these services. Decisions like this can impact the long-term viability of CBOs.

- **Data were not transmitted in a timely way to plans and were often inaccurate; technology is slow to develop and build.**

During planning for the 1115 waiver, there were high hopes for transmission of fee-for-service provider and beneficiary health data to the health plans in advance of outreach to providers and enrollment of beneficiaries. The development and implementation of a Health Risk Assessment (HRA) was anticipated to be an effective tool. Unfortunately, the transmission of data on fee-for-service providers from DHCS to the health plans was slow and the data were often inaccurate. Data on the health status of beneficiaries were limited, often inaccurate, and not timely, and the HRA was only completed on a relatively small number of beneficiaries, often more than 90 days post-enrollment, due to inaccurate beneficiary contact information. In the early stages of the transition, health plans across the counties reported that they were still working on developing the electronic tools to help their staff and providers respond to the needs of SPD enrollees. According to some stakeholders, the state underestimated the lead time necessary to build the technology infrastructure, tools, and data-sharing capacity needed to address the complex needs of the SPD population.

VI. Looking Ahead

AS CALIFORNIA LAWMAKERS AND MEDI-CAL program officials move forward with the enrollment of additional populations into managed care (including SPDs with both Medi-Cal and Medicare, or dual eligibles, and children with special health care needs), the following actions should be considered:

1. Establish a longer planning period before the transition to mandatory enrollment begins. There was a four-month period between CMS's approval of the California waiver request and the point at which DHCS began sending materials to beneficiaries telling them that they would need to choose a health plan, and a seven-month period before mandatory enrollment began. A longer planning period prior to pre-enrollment activities would have given DHCS more time to provide data to the health plans, conduct outreach to beneficiaries and other stakeholders, and finalize enrollment policies.
2. Establish simple and clear policies and processes to ensure beneficiary protection and understanding of Medical Exemption Requests and continuity-of-care policies, and ensure notification of service delays or disruptions, particularly for durable medical equipment and pharmaceuticals.
3. Improve outreach to providers, targeting high-volume fee-for-service providers, including durable medical equipment and pharmacy providers.
4. Develop materials for providers and beneficiaries in alternative formats that are culturally relevant, and easier to read and understand.
5. Improve the availability, accuracy, and timeliness of beneficiary contact and utilization data provided to plans before they assume responsibility for managing new members.
6. Implement approaches for more high-touch (personalized, in-person) beneficiary communication by leveraging trusted community resources to provide outreach/education to the most at-risk populations.
7. Develop strategies for specific populations (e.g., people with mental illness, immigrants/refugees, homeless individuals) and target high-utilizers of care in the process.
8. Ensure that health plans have high-functioning care-coordination processes before starting the mandatory enrollment process.
9. Consider instituting a short (several month) grace period after enrollment in which changes to a beneficiary's prescriptions, durable medical equipment, or other necessary services are not made immediately, similar to the continuity-of-care provision that allows beneficiaries to retain their existing providers for up to 12 months.
10. Establish quality-improvement benchmarks for processes such as MERs and measure changes in utilization, health outcomes, and patient satisfaction, and assess the connection between these outcomes and choice rates. Communicate results to stakeholders at regular intervals to improve transparency and accountability.

VII. Conclusions

CALIFORNIA'S EXPANSION OF MANDATORY managed care to seniors and persons with disabilities enrolled in Medi-Cal was finally set in motion by federal approval of the state's 1115 waiver request in November 2010, after seven years of debate. Since that time, DHCS, the health plans, advocates, beneficiaries, and other stakeholders have engaged in a range of activities to transition the eligible SPD population to managed care.

Feedback from the array of stakeholders involved in the transition reveals mixed expectations and experiences, although there is agreement that the transition has been challenging, particularly given the ambitious timeline. However, because there were no performance metrics established by DHCS at the outset of the process, it is not possible to fully evaluate the success of the process. The only data currently available — choice rates — do not provide a robust enough picture of the experience of beneficiaries to assess the transition's effectiveness. In fact, the experience in other states shows that choice rates tend to improve over time, as the process improves and stakeholders and beneficiaries grow more comfortable with the change. Therefore, to better assess the effectiveness of the SPD transition in California, there is a critical need to employ a variety of short-term and longer-term tools to evaluate beneficiary experiences, including member surveys and focus groups, claims and encounter data analyses, and analyses of HEDIS and CAPHIS results.

While determining the effectiveness of this process was not in the scope of this project, it was possible to identify some important issues and considerations regarding the transition of beneficiaries to managed care. Moving forward to the enrollment of additional populations, including dual eligibles, will require attention to the lessons learned in this recent transition.

Endnotes

1. For many years, California has required mandatory managed care enrollment of all Medi-Cal beneficiaries, including seniors and people with disabilities (SPDs), in counties with a County Organized Health System (COHS). In each county with a COHS plan, all beneficiaries must enroll in a single nonprofit health plan. The first COHS was established in 1983 by Santa Barbara County. As of June 2012, there are six COHS plans operating in 14 counties. California's 2010 waiver gave the state authority to expand mandatory managed care for SPDs to counties where managed care enrollment was already mandatory for most children, parents, and pregnant women.
2. Centers for Medicare and Medicaid Services, California Bridge to Reform Waiver Special Terms and Conditions (Amended Effective April 1, 2012), Attachment K: Reserve Budget Neutrality Projections. An amended waiver, approved by CMS on June 28, 2012, includes updated estimates of savings from the expansion of mandatory managed care. These revised estimates will also be updated as new information about Medi-Cal expenditures for the waiver population becomes available.
3. Medi-Cal beneficiaries with the following aid codes were included in the transition: 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 10, 14, 16, 1E, 1H.
4. An evaluation to determine the impact of the transition of SPD beneficiaries is underway, beginning with a survey of beneficiaries in all 16 counties and targeted focus groups.
5. It was not possible to identify the universe of organizations that supported or participated in the stakeholder transition in the 16 counties. Therefore the authors used a "snowball" sampling approach to connect with appropriate respondents. Invitations to participate in the survey were sent to individuals identified by advisory group members, participants in the 2010 Medi-Cal waiver stakeholder process, and Community Clinic Voice subscribers. The survey instructions encouraged respondents to forward the survey link to other stakeholders with knowledge of and experience in the managed care transition.
6. The Health Care Options Branch, part of the Managed Care Division within DHCS, oversees the enrollment process. Maximus is the firm contracted to conduct mail correspondence with and provide phone support to beneficiaries.
7. All activities in Riverside County were also implemented in San Bernardino County because both counties are served by the same two health plans — Inland Empire Health Plan and Molina Healthcare of California.
8. I. Fraser, E. Chait, and C. Brach, "Promoting Choice: Lessons from Managed Medicaid," *Health Affairs* 17, no. 5 (1998); 165–174

Appendix A: Summary Choice Rate Table for Health Plans, June 2011 to May 2012

ENROLLMENT MONTH	TOTAL ENROLLED	CHOSE PLAN	NON-CHOOSERS
June 2011	23,743	8,763	14,980
July	22,754	9,052	13,702
August	24,345	9,419	14,926
September	20,396	8,129	12,267
October	19,178	7,520	11,658
November	19,429	7,836	11,593
December	18,027	7,229	10,798
January 2012	18,659	7,625	11,034
February	19,227	7,750	11,477
March	16,603	6,767	9,836
April	20,931	8,588	12,343
May	16,439	6,750	9,689
Total Enrollment (12 months)	239,731	95,428	144,303
Average % (over 12 months)		39.81%	60.19%

Appendix B: CHCF SPD Transition Report Advisory Group Members

Anne Cohen	Disability Health Access, LLC
Brad Gilbert, MD	Inland Empire Health Plan
June Kailes	Harris Family Center for Disability and Health Policy
Greg Knoll	Legal Aid Society of San Diego
Lisa Kodmur	L.A. Care Health Plan
Ingrid Lamirault	Alameda Alliance for Health
Marty Lynch	LifeLong Medical Care
Katie Murphy	Neighborhood Legal Services of Los Angeles County
Jane Ogle	California Department of Health Care Services
Bob Prath	AARP
Brenda Premo	Harris Family Center for Disability and Health Policy
Kevin Prindiville	National Senior Citizens Law Center
Bill Walker, MD	Contra Costa Health Services
Silvia Yee	Disability Rights Education and Defense Fund

Appendix C: Health Plan Survey Questions *(administered in Survey Monkey)*

1. **Organizational Affiliation:**
 - Local community or public health plan
 - Commercial health plan
 - Other (please specify):
2. **What position do you hold at the health plan?**
3. **What was your role in the SPD managed care transition?**
4. **Primary Population Served (check all that apply):**
 - Older adults
 - Adults with chronic conditions
 - Adults with disabilities
 - Adults with mental health/substance use issues
 - Adults or children with developmental disabilities
 - Children with special health care needs
 - Other (please specify):
5. **Please indicate the geographic region served by your health plan (check all that apply):**

<input type="checkbox"/> Statewide	<input type="checkbox"/> Sacramento
<input type="checkbox"/> Alameda	<input type="checkbox"/> San Bernardino
<input type="checkbox"/> Contra Costa	<input type="checkbox"/> San Diego
<input type="checkbox"/> Fresno	<input type="checkbox"/> San Francisco
<input type="checkbox"/> Kern	<input type="checkbox"/> San Joaquin
<input type="checkbox"/> Kings	<input type="checkbox"/> Santa Clara
<input type="checkbox"/> Los Angeles	<input type="checkbox"/> Stanislaus
<input type="checkbox"/> Madera	<input type="checkbox"/> Tulare
<input type="checkbox"/> Riverside	<input type="checkbox"/> Other (please specify):
6. **What did your health plan do to prepare your health care provider network for the transition of SPDs to managed care? (check all that apply):**
 - Developed and disseminated written materials (i.e., informational letters, educational materials, etc.)
 - Developed and disseminated answers to Frequently Asked Questions (FAQs) specifically for health care providers
 - Conducted new physical access surveys of provider offices
 - Continued conducting and publishing results of physical access surveys of provider offices
 - Sent staff to Department of Health Care Services (DHCS)-sponsored information meeting in the community
 - Held education and training sessions for your staff within your organization
 - Held educational training sessions and other informational meetings for health care providers in the community
 - Outreached directly to beneficiaries to provide information and assistance
 - Established telephone support line
 - Collaborated with other health plan(s) serving Medi-Cal beneficiaries in your county
 - Collaborated with other stakeholders, such as CBOs or consumer advocates
 - Not applicable
 - Other (please specify):
7. **What ongoing activities is your health plan doing to support your health care provider network throughout the SPD managed care transition period (June 2011 – June 2012)? (check all that apply):**
 - Develop and disseminate written materials (i.e., informational letters, educational materials, etc.)
 - Develop and disseminate answers to Frequently Asked Questions (FAQs) specifically for health care providers
 - Hold education and training sessions for your staff within your organization

- Hold educational training sessions and other informational meetings for health care providers in the community
 - Operate a telephone support line
 - Collaborate with other health plan(s) serving Medi-Cal beneficiaries in your county
 - Collaborate with other stakeholders, such as CBOs or consumer advocates
 - Not applicable
 - Other (please specify):
8. **Of the activities you indicated above that were sponsored by your health plan, which were most effective in reaching and communicating with the health care providers network? Why?**
9. **What challenges or barriers did your health plan experience that affected the effectiveness of your outreach and education activities with your health care provider network? (check all that apply):**
- Experienced no challenges or barriers
 - Difficulty identifying which providers to target
 - Assuring patients would be reassigned to provider/ clinic
 - Unclear Department of Health Care Services (DHCS) policies and procedures related to the transition that were confusing to communicate
 - Changes in DHCS policies and procedures, such as Medical Exemption Requests
 - Difficulty knowing where to get answers at the state level
 - Lack of coordination across state agencies and entities (e.g., DHCS, enrollment broker, Ombudsman, DMHC, etc.)
 - Lack of DHCS reproducible training materials to educate providers
 - Confusing or incomplete information communicated to beneficiaries that created questions providers had to answer
- Lack of responsiveness from providers
 - Not applicable
 - Other (please specify):
10. **What did your health plan do to prepare beneficiaries and their representatives (including community advocates and community-based organizations who work with SPDs) for the transition to managed care? (check all that apply):**
- Developed and disseminated written materials (i.e., informational letters, educational materials, etc.)
 - Conducted informational meetings/public forums in the community
 - Held education and training sessions for your staff within your organization
 - Provided beneficiaries telephonic or in-person counseling sessions with staff (e.g., benefits counselor, care manager, etc.)
 - Established telephone support line specifically to answer beneficiaries' questions
 - Disseminated answers to Frequently Asked Questions (FAQs) specifically for beneficiaries
 - Collaborated with other stakeholders, such as CBOs or consumer advocates
 - Developed workgroups across organizations to identify systemic problems and advocate for fixes
 - Other (please specify):
11. **What activities is your health plan currently doing to support beneficiaries and their representatives in the transition from fee-for-service to managed care? (check all that apply):**
- Develop and disseminate written materials (i.e., informational letters, educational materials, etc.)
 - Conduct informational meetings/public forums in the community
 - Hold education and training sessions for your staff within your organization

- Provide beneficiaries telephonic or in-person counseling sessions with staff (e.g., benefits counselor, care manager, etc.)
- Establish telephone support line specifically to answer beneficiaries' questions
- Disseminate answers to Frequently Asked Questions (FAQs) specifically for beneficiaries
- Collaborate with other stakeholders, such as CBOs or consumer advocates
- Participate in workgroups across organizations to identify systemic problems and advocate for fixes
- Other (please specify):

12. Of the activities you indicated above that were conducted by your health plan, which were the most effective or worked best in reaching beneficiaries and their representatives? Why?

13. Which activities conducted by your health plan did not work well in reaching beneficiaries and their representatives? Why?

14. What challenges or barriers did your health plan experience in providing effective outreach and education activities to beneficiaries and their representatives regarding the transition to managed care? (check all that apply):

- Lack of responsiveness from beneficiaries
- Poor addresses for beneficiaries (lots of returned mail)
- Poor telephone numbers for beneficiaries
- Limited alternative formats (e.g., Braille, audio, large print, etc.) to communicate with beneficiaries
- Lack of information support lines to counsel beneficiaries with the most complex problems
- Short timeline for communication
- Resistance from community advocates and CBOs to help with communication

- Unclear Department of Health Care Services (DHCS) policies and procedures related to the transition

Other (please specify):

15. What steps did your health plan take to ensure that the information provided to beneficiaries and their representatives was understandable and easily accessible? (check all that apply):

- Translated information into multiple languages
- Provided information in alternative formats (e.g., Braille, audio, large print, text-only electronic)
- Ensured language was appropriate for limited literacy level
- Disseminated answers to Frequently Asked Questions (FAQs)
- Established telephone support line
- Made information available on your website and tested site for accessibility
- Sponsored educational meetings in the community in conjunction with CBOs or other community organizations
- Provided training to your staff on new policies and procedures
- Provided training to community-based organizations on the transition to managed care
- Provided staff to assist individuals with understanding enrollment materials
- Hired new staff to conduct and support your activities during the transition
- Attended state-sponsored trainings to better understand needs of beneficiaries
- Informed potential members of availability of alternative formats, sign language interpreters, and other supports to promote accessibility
- Other (please specify)

16. To facilitate the SPD transition to managed care, the California Department of Health Care Services made presentations in each county (during March and April 2011), sent mailings to beneficiaries, conducted webinars (May 2011), and developed a web page (www.dhcs.ca.gov). We would like to know if you attended or used any of these resources.
- Yes, No, Don't know
 - Did you or persons from your organization attend the DHCS-sponsored county presentation?
 - Did you or persons from your organization participate in the DHCS webinars?
 - Did you or persons from your organization access and use materials on the web page?
17. From your perspective, how useful were the following activities in informing and preparing providers, and beneficiaries and their representatives for the transition to managed care:
- Very useful, Somewhat useful, Not useful
 - County presentations
 - Webinars
 - Web page
 - Mailings to beneficiaries
18. In what ways could DHCS have improved its direct communication with health care providers?
19. In what ways could your health plans have improved their direct communication with health care providers?
20. In what ways could DHCS have improved its communication with beneficiaries and their representatives?
21. In what ways could the health plans have improved their communication with beneficiaries and their representatives?
22. What additional DHCS-sponsored or local stakeholder activities would have been useful to support the SPD transition to managed care?
- Suggestions for state
 - Suggestions for local stakeholders
 - Suggestions for CBOs and advocates
23. What were the key contributions of the following groups to the managed care transition in your community?
- Health plans
 - Consumer advocacy organizations
 - Health care providers
 - Community-based organizations
24. Did your health plan contact the state's managed care enrollment broker to assist with understanding the enrollment process?
- Yes, No, Don't know
 - Comment:
25. What information did your health plan receive from the enrollment broker? (check all that apply):
- When someone needs to enroll in the plan
 - Copy of enrollment materials
 - Enrollment materials in alternative formats
 - How to file a medical request
 - Physicians available through a specific plan in this service area
 - Not applicable
 - Other (please specify):
26. If your health plan received information from the enrollment broker, how would you rate the effectiveness of this information?
- Very effective, Effective, Not very effective, Not at all effective, Not applicable
 - Comment:

27. To what extent did your health plan feel prepared for the transition?
- Completely, Somewhat, Not at all prepared, Not sure
 - Comment:
28. What could have improved your health plan's level of preparedness for the transition?
29. What did your health plan do to evaluate your outreach, educational, and enrollment activities? (check all that apply):
- Administered satisfaction surveys to providers
 - Administered satisfaction surveys to beneficiaries
 - Analyzed complaints and complaint rates
 - Analyzed enrollment trends
 - Other (please specify):
30. To what extent do you agree that as a result of the managed care transition process activities focusing on outreach, education, enrollment, and follow-up:
- Agree, Disagree, Strongly disagree
 - Beneficiaries and their representatives understand the managed care transition and their options
 - Beneficiaries received timely and accurate answers to questions about enrollment
 - Beneficiaries can access care in a timely manner
 - Beneficiaries are able to continue to see their regular providers
 - Beneficiaries receive Medical Exemptions in a timely fashion
 - Other (please specify):
31. What advice would you give to state officials and policymakers regarding how to effectively support beneficiaries and health care providers during the transition process to managed care?
32. What advice would you give to other community advocates and community organizations regarding how to effectively support beneficiaries and health care providers during the transition process?
33. What are your ongoing concerns regarding the transition to managed care for the SPD population and other populations?
- Pre-enrollment information materials
 - Ability to ask questions and get accurate information
 - Medical exemptions
 - Health risk assessment
 - Care coordination
 - Continuity of care
 - Issues related to medically necessary transportation requests
 - Issues related to assistance with other state service access (e.g., Adult Day Health, In-Home Supportive Services, etc.)
 - Issues related to identifying health care providers with wheelchair-accessible offices
 - Carve-outs (services and specific beneficiary populations)
 - Unclear DHCS policies and procedures related to the transition
 - Understanding of ongoing enrollment rights (e.g., right to change plans)
 - Other (please specify):
34. What specific recommendations do you have for enrolling children with special health care needs and the dual eligible (Medicare/Medi-Cal) population in the future?
- Dual-eligibles
 - Children with special health care needs

Appendix D: Provider and Advocate Survey Questions *(administered in Survey Monkey)*

1. Organizational Affiliation:

- Primary care provider
- Specialty care provider
- Community clinic or FQHC
- Adult Day Health Center
- Independent Living Center
- Regional Center
- Area Agency on Aging
- Advocacy organization or other health care or human services agency/provider (please specify):

2. Primary Population Served (check all that apply):

- Older adults
- Adults with chronic conditions
- Adults with disabilities
- Adults with mental health/substance use issues
- Adults or children with developmental disabilities
- Children with special health care needs
- Other (please specify):

3. Please indicate the geographic region served by you or your organization (check all that apply):

- | | |
|---------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Statewide | <input type="checkbox"/> Sacramento |
| <input type="checkbox"/> Alameda | <input type="checkbox"/> San Bernardino |
| <input type="checkbox"/> Contra Costa | <input type="checkbox"/> San Diego |
| <input type="checkbox"/> Fresno | <input type="checkbox"/> San Francisco |
| <input type="checkbox"/> Kern | <input type="checkbox"/> San Joaquin |
| <input type="checkbox"/> Kings | <input type="checkbox"/> Santa Clara |
| <input type="checkbox"/> Los Angeles | <input type="checkbox"/> Stanislaus |
| <input type="checkbox"/> Madera | <input type="checkbox"/> Tulare |
| <input type="checkbox"/> Riverside | <input type="checkbox"/> Other (please specify): |

4. What did your organization do to prepare for the transition of SPDs to managed care? (check all that apply):

- Developed and disseminated written materials (i.e., informational letters, educational materials, etc.)
- Developed and disseminated answers to Frequently Asked Questions (FAQs) specifically for health care providers
- Sent staff to Department of Health Care Services (DHCS)-sponsored information meeting in the community
- Held education and training sessions for your staff within your organization
- Held educational training sessions and other informational meetings for health care providers in the community
- Outreached directly to beneficiaries to provide information and assistance
- Established telephone support line
- Collaborated with other stakeholders, such as CBOs or consumer advocates
- Not applicable
- Other (please specify):

5. What ongoing activities is your organization currently doing to respond to the SPD managed care transition period (June 2011 – June 2012)? (check all that apply):

- Develop and disseminate written materials (i.e., informational letters, educational materials, etc.)
- Develop and disseminate answers to Frequently Asked Questions (FAQs) specifically for health care providers
- Hold education and training sessions for your staff within your organization
- Hold educational training sessions and other informational meetings for health care providers in the community

- Operate a telephone support line
- Collaborate with other stakeholders, such as CBOs or consumer advocates
- Not applicable
- Other (please specify):

6. What challenges or barriers did you or your organization experience that affected the effectiveness of your outreach and education activities with health care providers? (check all that apply):

- Experienced no challenges or barriers
- Difficulty collaborating with health plans
- Assuring patients would be reassigned to provider/clinic
- Unclear Department of Health Care Services (DHCS) policies and procedures related to the transition that were confusing to communicate
- Changes in DHCS policies and procedures, such as Medical Exemption Requests
- Difficulty knowing where to get answers at the state level
- Lack of coordination across state agencies and entities (e.g., DHCS, enrollment broker, Ombudsman, Department of Managed Health Care, etc.)
- Lack of DHCS reproducible training materials to educate providers
- Confusing or incomplete information communicated to beneficiaries that created questions providers had to answer
- Difficulty identifying which providers to target
- Lack of responsiveness from providers
- Not applicable
- Other (please specify):

7. What did your organization do to prepare beneficiaries and their representatives (including community advocates and community-based organizations who work with SPDs) for the transition to managed care?

- Collaborated with health plans
- Developed and disseminated written materials (i.e., informational letters, educational materials, etc.)
- Conducted informational meetings/public forums in the community
- Held education and training sessions for your staff within your organization
- Provided beneficiaries telephonic or in-person counseling sessions with staff (e.g., benefits counselor, care manager, etc.)
- Established telephone support line specifically to answer beneficiaries' questions
- Disseminated answers to Frequently Asked Questions (FAQs) specifically for beneficiaries
- Collaborated with other stakeholders, such as CBOs or consumer advocates
- Developed workgroups across organizations to identify systemic problems and advocate for fixes
- Other (please specify)

8. What activities is your organization currently doing to support beneficiaries and their representatives in the transition from fee-for-service to managed care? (check all that apply):

- Develop and disseminate written materials (i.e., informational letters, educational materials, etc.)
- Conduct informational meetings/public forums in the community
- Hold education and training sessions for your staff within your organization
- Provide beneficiaries telephonic or in-person counseling sessions with staff (e.g., benefits counselor, care manager, etc.)

- Establish telephone support line specifically to answer beneficiaries' questions
 - Disseminate answers to Frequently Asked Questions (FAQs) specifically for beneficiaries
 - Collaborate with other stakeholders, such as CBOs or consumer advocates
 - Participate in workgroups across organizations to identify systemic problems and advocate for fixes
 - Other (please specify):
9. **Of the activities you indicated above that were conducted by your organization, which were the most effective or worked the best in reaching beneficiaries and their representatives? Why?**
10. **Which activities conducted by your organization did not work well in reaching beneficiaries and their representatives? Why?**
11. **What challenges or barriers did you or your organization experience in providing effective outreach and education activities to beneficiaries and their representatives regarding the transition to managed care? (check all that apply):**
- Lack of responsiveness from beneficiaries
 - Poor addresses for beneficiaries (lots of returned mail)
 - Poor telephone numbers for beneficiaries
 - Limited alternative formats (e.g., Braille, audio, large print, etc.) to communicate with beneficiaries
 - Lack of information support lines to counsel beneficiaries with the most complex problems
 - Short timeline for communication
 - Resistance from community advocates and CBOs to help with communication
 - Unclear DHCS policies and procedures related to the transition
 - Other (please specify):
12. **What steps did you or your organization take to ensure that the information provided to beneficiaries and their representatives was understandable and easily accessible? (check all that apply):**
- Translated information into multiple languages
 - Provided information in alternative formats (e.g., Braille, audio, large print, text-only electronic)
 - Ensured language was appropriate for limited literacy levels
 - Disseminated answers to Frequently Asked Questions (FAQs)
 - Established telephone support line
 - Made information available on your website and tested site for accessibility
 - Sponsored educational meetings in the community in conjunction with CBOs or other community organizations
 - Provided training to your staff on new policies and procedures
 - Provided training to community-based organizations on the transition to managed care
 - Provided staff to assist individuals with understanding enrollment materials
 - Hired new staff to conduct and support your activities during the transition
 - Attended state-sponsored trainings to better understand needs of beneficiaries
 - Informed potential members of availability of alternative formats, sign language interpreters, and other supports to promote accessibility
 - Other (please specify):

13. To facilitate the SPD transition to managed care, the California Department of Health Care Services (DHCS) made presentations in each county (during March and April 2011), sent mailings to beneficiaries, conducted webinars (May 2011), and developed a webpage (www.dhcs.ca.gov). We would like to know if you attended or used any of these resources.
- Yes, No, Don't know
 - Did you or persons from your organization attend the DHCS-sponsored county presentation?
 - Did you or persons from your organization participate in the DHCS webinars?
 - Did you or persons from your organization access and use materials on the web page?
14. From your perspective, how useful were the following in informing and preparing providers, and beneficiaries and their representatives for the transition to managed care:
- Very useful, Somewhat useful, Not useful
 - County presentations
 - Webinars
 - Web page
 - Mailings to beneficiaries
15. In what ways could the Department of Health Care Services have improved their direct communication with health care providers?
16. In what ways could the health plans have improved their direct communication with health care providers?
17. In what ways could the Department of Health Care Services have improved their communication with beneficiaries and their representatives?
18. In what ways could the health plans have improved their communication with beneficiaries and their representatives?
19. What additional state-sponsored or local stakeholder activities would have been useful to support the SPD transition to managed care?
- Suggestions for state
 - Suggestions for local stakeholders
20. What were the key contributions of the following groups to the managed care transition in your community?
- Health plans
 - Consumer advocacy organizations
 - Health care providers
 - Community-based organizations
21. Did your organization contact the state's managed care enrollment broker to assist with understanding the process?
- Yes, No, Don't know
 - Comment:
22. What information did you or your organization receive from the enrollment broker? (check all that apply):
- When someone needs to enroll in the plan
 - Copy of enrollment materials
 - Enrollment materials in alternative formats
 - How to file a medical request
 - What plans are available in your organization's service area
 - Physicians available through a specific plan
 - Not applicable
 - Other (please specify):

23. If you or your organization had contact with the enrollment broker, how would you rate the effectiveness of this experience?

- Very effective, Effective, Not very effective, Not at all effective, Not applicable
- Comment:

24. What advice would you give to state officials and policymakers regarding how to effectively support beneficiaries and health care providers during the transition process to managed care?

25. What advice would you give to other community advocates and organizations regarding how to effectively support beneficiaries and health care providers during the transition process?

26. What are your ongoing concerns regarding the transition to managed care for the SPD population and other populations?

- Pre-enrollment information materials
- Ability to ask questions and get accurate information
- Medical exemptions
- Health risk assessment
- Care coordination
- Continuity of care
- Issues related to medically necessary transportation requests
- Issues related to assistance with other state service access (e.g., Adult Day Health, In-Home Supportive Services, etc.)
- Carve-outs (services and specific beneficiary populations)
- Unclear DHCS policies and procedures related to the transition
- Understanding of ongoing enrollment rights (e.g., right to change plans)
- Other (please specify):

27. What specific recommendations do you have for enrolling children with special health care needs and the dual eligible (Medicare/Medi-Cal) population in the future?

- Dual-eligibles
- Children with special health care needs

Appendix E: County Site Visit Discussion Guides

Provider Group Discussion Guide

I. Enrollment Planning and Implementation

1. What specific steps did you take to prepare for the SPD transition to managed care? How was this different from how you typically work with your patient population, other providers, and/or health plans?
 - 1a. What were the most effective/least effective strategies you used to prepare your staff? What was the most effective/least effective information communicated?
2. What would you estimate were the time period and resource (staff, etc.) investments for the planning period?
3. Did you develop any new relationships in your community — with community-based organizations, advocates, other providers — as a result of the SPD transition to managed care? What has been the impact of these new relationships?
4. Of your new patients, which types (e.g., older adults, persons with mental illness) were the least challenging to engage in services/treatment? Most challenging? (Probe for population type and complexity.) On what evidence are you basing this assessment?
5. What, if any, issues have you encountered during the transition period? How have you addressed or resolved them? What has been your experience working with the health plan?
 - 5a. Issues related to continuity of care, including specialty providers, tests, prescriptions, previously scheduled procedures, etc.?
 - 5b. Issues related to Medical Exemption Requests?

II. Early Assessment of the Impact of the SPD Transition to Managed Care

6. What is your experience with patient retention during the transition period for your existing fee-for-service patients and new patients assigned to you? (Probe for any evidence/data used to make this assessment.)

III. Role of State and Health Plan in Supporting the Transition

7. DHCS made presentations in each county, sent beneficiary mailings, conducted webinars, and developed a web page to disseminate information about the transition. Did you participate in or use any of these? To what extent were they useful? How could DHCS improve its information-dissemination efforts in the future?
8. In what ways were you supported through the managed care transition by the health plan? What could the health plan do to better support you?
9. If we could redo this managed care transition, what should the health plans do differently?
10. What advice would you give DHCS and the health plans regarding upcoming managed care transitions for dual eligibles (Medicare/Medi-Cal) and children with special health care needs?

Health Plan Group Discussion Guide

I. Enrollment Planning and Implementation

1. What specific steps did you take to prepare for the SPD transition to managed care? (Probe for different strategies used internally at the health plan vs. for providers vs. for beneficiaries and their representatives vs. community-based and advocacy organizations.) How was this different from how you typically work with new beneficiaries, health care providers, and/or advocates and community-based organizations?

(In these questions, probe for distinctions between information and strategies they used vs. strategies of others — state, providers, CBOs/advocates.)

- 1a. What were the most effective/least effective strategies used with your health plan staff?
 - 1b. What were the most effective/least effective strategies used with the provider network? What was the most effective/least effective information communicated? (Any differences in communication with in-network/out-of-network providers?)
 - 1c. What were the most effective/least effective strategies used with beneficiaries and their representatives? What was the most effective/least effective information communicated?
 - 1d. What were the most effective/least effective strategies used with CBOs and advocates? What was the most effective/least effective information communicated?
2. What would you estimate were the time period and resource (staff, etc.) investments for the planning period?
 3. What are you currently doing to facilitate the SPD transition? What have you changed midcourse to improve the process? (Probe: internal to health plan; provider network; beneficiaries; CBOs and advocates.)

4. Did you develop any new relationships in your community — with community-based organizations, advocates, additional health or home-based and community-based providers — as a result of the SPD transition to managed care? What has been the impact of these new relationships?
5. Which populations were the least challenging to enroll? Most challenging to enroll? (Probe for population type and complexity.) On what evidence are you basing this assessment?
6. What, if any, issues have you encountered during the enrollment period? How have you addressed or resolved them? Of these issues, which are due to issues with DHCS and not under the health plan's purview or control?
 - 6a. Issues related to continuity of care, including specialty providers, tests, prescriptions, previously scheduled procedures, etc.?
 - 6b. Issues related to Medical Exemption Requests?
 - 6c. Issues with disenrollment requests and appeals? That remain unresolved?
 - 6d. Issues related to using the state's managed care enrollment broker?

II. Role of State

7. DHCS made presentations in each county, sent beneficiary mailings, conducted webinars, and developed a web page to disseminate information about the transition. Did you participate in or use any of these? To what extent were they useful? How could DHCS improve its information-dissemination efforts in the future?
8. If we could redo this managed care transition, what would you do differently? What could DHCS do differently?

CBOs and Advocates Group Discussion Guide

I. Enrollment Planning and Implementation

1. What specific steps did your organization take to prepare for the SPD transition to managed care? (Probe for different strategies used with different types of beneficiaries and their representatives.) How was this different from how you typically work with consumers, health care providers, and/or health plans?

(For these questions, probe for distinctions between information and strategies they used vs. strategies of others — state, health plan, providers.)

- 1a. What were the most effective/least effective strategies used with beneficiaries and their representatives? What was the most/least effective information communicated?
2. What would you estimate were the time period and resource (staff, etc.) investments for the planning period? What would you estimate is your current time and resource investment during the transition period (June 2011 – June 2012)?
3. Did you develop any new relationships in your community — with community-based organizations, advocates, health care providers, health plans — as a result of the SPD transition to managed care? What has been the impact of these new relationships?
4. What are you currently doing to facilitate the SPD transition? What have you changed midcourse to improve the process? (Probe: beneficiaries; CBOs and advocates; also current resource investments.)
5. Which populations had the most problems understanding the transition? (Probe for population type and complexity.) On what evidence are you basing this assessment?
6. What, if any, issues have you encountered during the transition period? How have you addressed or resolved these issues?

- 6a. Issues related to continuity of care, including specialty providers, tests, prescriptions, previously scheduled procedures, etc.?

- 6b. Issues related to Medical Exemption Requests?

- 6c. Issues with disenrollment requests and appeals? That remain unresolved?

- 6d. Issues related to using the state's managed care enrollment broker?

7. What has experience been like working with the health plans?

II. Role of State, Health Plan, and Providers in Supporting the Transition

8. DHCS made presentations in each county, sent beneficiary mailings, conducted webinars, and developed a web page to disseminate information about the transition. Did you participate in or use any of these? To what extent were they useful? How could DHCS improve its information-dissemination efforts in the future?
9. In what ways did you communicate with the health plans during the planning and transition period? Did you perceive that the health plan heard and was responsive to your communications? What could the health plan do to be more responsive to you and your constituencies?
10. In what ways did you communicate with health care providers during the planning and transition period? Did you perceive that providers heard and were responsive to your communications? What could they do to be more responsive to you and your constituencies?
11. If we could redo this managed care transition, what should DHCS and the health plans do differently?
12. What advice would you give DHCS and the health plans regarding upcoming managed care transitions for dual eligibles (Medicare/Medi-Cal) and children with special health care needs?

Appendix F: County Site Visit Participating Organizations

Notes: Health plans, providers and community advocates met separately in each county. Multiple representatives often attended from each organization

Alameda County SPD Site Visit January 20, 2012

Alameda Alliance for Health
Alameda County Developmental Disabilities Planning and Advisory Council
Alameda County Public Health Department
Alameda County Medical Center
Alameda County Senior Services Coalition
Alameda Health Consortium
Anthem Blue Cross
California Health Advocates
Center for Elders' Independence
Center for Independent Living
Community Health Center Network
Community Resources for Independent Living
Developmental Disabilities Council
East Bay AIDS Center
East Bay Innovations
Kaiser Permanente – Northern California Region
LifeLong Medical Care
Regional Center of the East Bay
Senior Services Coalition

Los Angeles County SPD Site Visit January 30–31, 2012

AltaMed Medical Group
Anthem Blue Cross
Armenian Relief Society Social Services
Care 1st Health Plan
Center for Health Care Rights
Corporation for Supportive Housing
Harris Family Center for Disability and Health Policy at Western University of Health Sciences

Health Net State Health Programs
Kaiser Permanente – Southern California Region
LA Care Health Plan
LA Gay & Lesbian Center
Maternal and Child Health Access
National Health Law Program
Neighborhood Legal Services of Los Angeles County
The Children's Clinic
Universal Care Medical Group
Watts Health Foundation

Riverside County SPD Site Visit February 3, 2012

Autism Society Inland Empire
Community Access Center
Health Net State Health Programs
Inland Empire Adult Day Health Care Center
Inland Empire Health Plan
Dr. Tarek Mahdi
Molina Healthcare of California
Riverside County Department of Public Health
Riverside County Office on Aging
Dr. Stanley Schwartz
Stroke Recovery Center, Palm Springs
United Cerebral Palsy of the Inland Empire
Vantage Medical Group

San Diego County SPD Site Visit February 6, 2012

2-1-1 San Diego
AARP
Care 1st Health Plan
Community Health Group
Council of Community Clinics

County of San Diego, Aging and Independence Services
County of San Diego, Healthy San Diego
Family Health Centers of San Diego
Health Net State Health Programs
Hospital Association of San Diego and Imperial Counties
Kaiser Permanente – Greater San Diego Area
Kaiser Permanente – Southern California Region
Legal Aid Society/Consumer Center for Health Education and Advocacy
Molina Healthcare of California
University of California, San Diego

Fresno County SPD Site Visit February 10, 2012

Anthem Blue Cross
Apria Healthcare
CalViva Health
Central California Legal Services
Clinicas Sierra Vista
Coram Specialty Infusion Services
Deaf and Hard of Hearing Service Center
Fresno County Department of Public Health
Health Net State Health Programs
Resources for Independence Central Valley
Shield HealthCare
United Health Centers of San Joaquin Valley



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