

Meeting Notes from 2/28/11 Conference Call with  
Stakeholder Advisory Committee on Monitoring SPD Implementation

Rita Marowitz (Chief of Program Data and Performance Measurement in DHCS's Medi-Cal Managed Care Division) presented the revised draft of the proposed report elements for monitoring the implementation of mandatory enrollment of Seniors and Persons with Disabilities (SPDs). See handout.

Enrollment

- Rita: "Newly eligible" means new SPDs enrolled on a monthly basis to health plans. Will track SPDs moving into managed care program wide and also by plan and county.
- Q: Can we also track exits/switches? A: DHCS will check to see how easily they can track movement from one plan to another.
- Q: What question does this answer? A: DHCS wants to see what percent are default-enrolled. Want to see success of outreach.
- Q: What is the breakdown of age bands? A: DHCS will follow up with specific numbers.
- Q: Can DHCS track enrollment based on accessibility? A: Can't track the choosers, but if people call to switch or with a complaint, they will track the reason.
- Q: One reason for calls is "Doctor did not meet my needs." Could DHCS track more finely? A: Should be able to add this to tracking process.
- Comment: Folks require more outreach. They may not understand how to access fair hearings.

Outreach

- Rita: Under this category, DHCS is tracking administrative functions: packets sent out and returned; SPDs reached vs. attempted; returned Health Information Forms (HIFs). Goal is to measure how successful outreach is, and how involved the population is in completing the HIF.
- Q: How does HIF compare to risk self-assessment? A: From the member's perspective, the HIF indicates health status and chronic conditions and the member's special needs. It's on the DHCS website, but will share again after call. HIF is included in enrollment packet, scanned and provided to health plan in a secure file.
- Q: Will there be a way a member can get help to fill out HIF? A: Yes, HCO can assist with that. (DHCS will check if that instruction is on the form.)

Continuity of Care Approvals, MERs and EDERs

- Rita: For assistance with continuity of care (i.e., continuing to get care from a FFS provider not in the plan's network), members must work with health plan. DHCS will track denials of continuity of care requests by plans by category. Will work with plans if there are concerns that requests are being denied for incorrect reasons.
- Q: Is there coordination between DHCS and DMHC? A: If member went to DMHC, they coordinate with DHCS to resolve the issue. Generally, members go to the MMCD Office of the Ombudsman, and DHCS is tracking the new SPD members' calls to see if the outreach process and plans' support of new SPD members are working. DHCS and DMHC have an interagency agreement related to ongoing monitoring of provider network adequacy, but DMHC should not be making decisions about moving people out of managed care.

- Q: Are there separate requirements for pediatrics? A: Provider network standards apply to all specialties, but these indicators provide real-time monitoring.
- DHCS has added a new reason code for continuity of care/provider access. Will share categories once they are developed.

### Risk Stratification and Assessment

- Rita: Tracking according to the DHCS-specified timelines for risk stratification and assessment. DHCS is tracking the total number of records (re: utilization data) to show the magnitude of data shared with plans. Also will track number/percentage identified as high risk and among those who completed the risk assessment survey; the number/percentage in both risk categories who were misidentified.
- Q: Is risk assessment based on data? A: Yes, and the information the member provides in the HIF. The Policy Letter with the risk stratification and assessment requirements was just modified to include a definition of what constitutes high risk.
- Rita: DHCS is giving plans all data requested within HIPAA limits (most recent 12 months), except the paid amount per claim.
- Q: Does data include psychiatric complexities? A: Mental health drugs will be included, as well as outpatient visits with diagnosis codes indicating mental health conditions.
- Rita: The CMS Standard Terms and Conditions and SB 208 require these activities on risk stratification. DHCS is monitoring the process to see if adjustments are necessary to the process if too many or too few people are being put into high risk category.
- Q: Are you able to share risk assessment data with high volume providers? A: Some plans already do this. Related to facility site review for physical accessibility, plans are required to develop a method for identifying specialty and ancillary providers treating a high volume of SPDs.
- Q: Are plans required to do an in-person assessment within 90 days? A: Yes. DHCS will look at reporting the percentage of SPDs who receive an assessment within 90 days.
- Rita: Reporting on change in risk category was requested by clinical staff. If this information does not prove useful, DHCS can drop it as a monitoring measure.
- Q: Can DHCS or plans track if member requested/needs home and community-based services? A: This need should be identified on HIF or through the risk assessment process.
- DHCS: Will try to figure out how to track those who do NOT complete an assessment.

### Member Concerns

- Q: What is the universe of calls? A: Any questions that come in will be tracked. **Access to care** is a broad category (e.g., unable to get service from a specialist). **Physical accessibility** tracked separately.
- Q: How do you track grievances filed with plans? A: Plans submit quarterly grievance reports to DHCS. DHCS expects that access may be a primary concern for SPDs, so if calls come in to DHCS regarding access concerns, the issues will be triaged quickly to plans.
- Comment: Tracking calls and grievances is not about making new categories, but whether definitions are understood when calls come in. For deaf persons and those with other disabilities, access to communication is critical, along with access to needed specialists, access to doctor's office, appropriate exam table, etc. Important for ombudsman and plans to understand what the access issue is. A: DHCS will look at

- Comment: Lots of people will not reach out to state. UC Berkeley has proposal to collect information from beneficiaries about problems and satisfaction with care and advocates support that.

#### Utilization Data

- Utilization data is a snapshot and will not reflect complete experience for some time due to data lag. Later, DHCS will track more expanded data (as required by CMS), including avoidable hospitalization, readmits, Rx use, person-centered care planning and delivery. Outcomes based on disease are reflected in performance measure results, e.g. – do diabetics receive recommended care?

#### Performance Measures

- Rita shared the timeline/development process for performance measurement work.
- Comment: Make sure measures include pediatric measures. May need non-standard approach.

DHCS: Reminded attendees to send additional comments and questions to e-mailbox – [mmcdpmb@dhcs.ca.gov](mailto:mmcdpmb@dhcs.ca.gov).

Minutes prepared by Alice Lind, CHCS.