



**SEMI-ANNUAL REPORT  
TO THE LEGISLATURE**

**MANDATORY ENROLLMENT OF SENIORS AND  
PERSONS WITH DISABILITIES INTO  
MEDI-CAL MANAGED CARE**

**Covering July through December 2011**

**Department of Health Care Services  
Medi-Cal Managed Care Division**

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# **MANDATORY ENROLLMENT OF SENIORS AND PERSONS WITH DISABILITIES INTO MEDI-CAL MANAGED CARE**

## **I. INTRODUCTION**

Senate Bill (SB) 208 (Steinberg, Chapter 714, Statutes of 2010) permits the Department of Health Care Services (DHCS) to mandatorily enroll Medi-Cal eligible seniors and persons with disabilities (SPDs) into Medi-Cal managed care plans (MCPs) in counties operating under this model of care. The mandatory enrollment of SPDs does not apply to SPDs with Medicare coverage (Duals), SPDs with other health coverage, or SPDs in the fee-for-service (FFS) Medi-Cal system with a share-of-cost.

By delivering health care services to this high-risk population through a MCP model, DHCS will be able to provide SPD beneficiaries with a high-quality system of care that improves access and care coordination.

Welfare and Institutions (W&I) Code Section 14182(s)(1) requires DHCS to provide semi-annual reports to the Legislature that provides details of the activities undertaken for the identification, notification, education, and enrollment of SPDs into a Medi-Cal MCP. These reports include the key milestones for mandatory SPD enrollment into MCPs, discuss DHCS' progress toward the objectives of SPD enrollment, and assess issues related to the care management and care coordination of SPDs. This report is the third semi-annual report to the Legislature covering the period of July 1, 2011 through December 31, 2011.

## **II. BACKGROUND**

DHCS contracts with managed care organizations to arrange for the provision of health care services for approximately 4.35 million Medi-Cal beneficiaries in 30 counties. DHCS provides three types of managed care models:

1. Two-Plan, which operates in 14 counties.
2. County Organized Health System, which operates in 14 counties.
3. Geographic Managed Care (GMC), which operates in two counties.

DHCS also contracts with two specialty health plans, AIDS Healthcare Foundation and Family Mosaic.

### III. KEY MILESTONES FOR MANDATORY SPD ENROLLMENT

Key Milestone	Completion Dates
Plan Readiness	January 2011
Sensitivity Training	January 2011
Access/Facility Site Review	January 2011
Outreach and Education	February 2011
Risk Assessment and Stratification	April 2011
Federal Approval of Waiver, Rates, and Contract Language	May 2011
SPD Mandatory Enrollment	June 2011 – May 2012

#### A. Enrollment—June- December 2011

Implementation of mandatory enrollment of the Medi-Cal-only SPD population into the MCPs has not presented any unresolvable medical care situations. As of December 2011, eight phases of the SPD enrollment process have been completed and 166,531 transitional SPDs have enrolled into MCPs. There have been some minor data glitches and an increase of mostly informational calls at the MCP level and to the Medi-Cal Managed Care Division (MMCD) Office of the Ombudsman (OMB). At an administrative level, there has been an increase in medical exemption requests (MERS) from managed care enrollment and fair hearing requests. Most of the SPD-related MERs and fair hearings have been due to a lack of familiarity with the continuity of care provisions in the federal Section 1115 Bridge to Reform Waiver (Waiver). Both beneficiaries and providers received information regarding the provisions of the Waiver. Monitoring of MCPs continues and reviews of health plan progress and member satisfaction is ongoing. Monthly updates on MERS is located on the MMCD website, in a report titled “SPD Monitoring Dashboard,” at:

<http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDChrtsRptsData.aspx>

MMCD is closely monitoring Ombudsman calls, MERs, and fair hearing requests. Any health care issues that arise are being resolved as expeditiously as possible at the MCP level and in collaboration with MMCD staff when necessary.

### IV. PROGRESS TOWARD OBJECTIVES OF SPD ENROLLMENT

#### A. Outreach and Education

1. Prior to enrolling SPD beneficiaries, DHCS developed an extensive outreach and education strategy that includes three separate mailings and two telephone calls according to the following:
  - The first mailing is a 90-day notice intended to inform SPD beneficiaries of the upcoming change to their health care delivery system.

- A telephone call follows the written notice to verbally educate beneficiaries on the upcoming change and assist with questions.
- The second notice is a 60-day enrollment packet that includes a county-specific insert notifying SPD beneficiaries of their MCP choices and additional educational information.
- The final outreach attempt is a second telephone call focused on informing SPD beneficiaries of their ability to choose an MCP, provide assistance in the enrollment process, and address questions.
- The 30-day intent-to-default notice is the final mailing. This mailing is only for those SPD beneficiaries that have not made a MCP selection. The notice informs the SPD beneficiaries that if they do not choose a MCP, DHCS will make the assignment. SPD beneficiaries that enrolled on June 1, 2011, received their first 90-day notice on or before March 1, 2011.

Enrollment of SPDs began on June 1, 2011, and will be completed May 30, 2012. The enrollment and notification process is ongoing and DHCS continues to educate providers and members on working with the health plans.

2. In July 2011, DHCS began a monthly call campaign called the “DHCS Outbound Call Survey,” to Medi-Cal-only SPD beneficiaries who enrolled the previous month. The calls made in July 2011 were to SPD beneficiaries whose enrollment effective date was June 1, 2011. The objective of the survey was and continues to be to determine the beneficiary’s level of satisfaction with their access to providers, as well as their overall level of satisfaction with their MCPs. The calls consist of questions focused on the beneficiary’s ability to obtain timely appointments with providers. Beneficiaries are then asked to rate the MCP on a scale reflecting their satisfaction with the MCP. Initially, the call survey was limited to six health plans. In December, the call campaign expanded to all sixteen Two-Plan and GMC Medi-Cal managed care counties.

The methodology for the telephone survey is one call attempt is made to each randomly selected beneficiary at least 45 days after his or her enrollment effective date. The random sampling method ensures that the results produce an unbiased, statistically valid sample and that the samples are of sufficient size to produce 95 percent confidence intervals with a precision level of plus or minus 2 percent. The random sampling methodology ensures that the size of each sample is a representative proportion of the SPD population for each sampling interval.

The six-plan survey call campaign lasted for six months. Of those who responded to the survey call, an average of 48 percent had made an appointment to see a doctor since enrolling in a Plan. On average, 71 percent were able to get an appointment within three weeks. While only 15 percent of respondents had made an appointment to see a specialist, on

average 68 percent were able to get an appointment within three weeks. Finally, of those who rated their health plan, there was an average score of 4 out of 5.

The results of the DHCS Outbound Call Survey can be located on the MMCD website, in a report titled "SPD Monitoring Dashboard," at:  
<http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDChrtsRptsData.aspx>

## B. Risk Assessment and Stratification

During the period July through December 2011, DHCS provided MCPs with FFS utilization data and current information on Treatment Authorization Requests for new mandatory SPD members. The data sets developed for this process are fully compliant with the State and federal privacy requirements.

W&I Code Section 14182(c)(12)(A) requires MCPs to conduct a risk stratification and risk assessment of new SPD members. The risk stratification determines a member's health status as high risk or low risk followed by a 45 or 105-day requirement to conduct the risk assessment of the new SPD member. The risk assessment allows the MCP to determine health care management needs. From March to May 2011, DHCS reviewed and approved risk stratification and risk assessment tools for all MCPs, using MMCD Policy Letter 11-007 for criteria and minimum requirements for approval (Policy Letter 11-007 replaced Policy Letter 11-001).

## C. SPD Mandatory Enrollment

The Waiver and W&I Section 14182 requires a phased-in enrollment process to transition existing FFS SPDs into Medi-Cal MCPs. The 12-month phased-in process began June 1, 2011, and will continue until May 1, 2012. SPDs who become eligible for Medi-Cal benefits and meet the criteria for mandatory enrollment into a MCP on or after June 1, 2011, are not eligible for the phased-in enrollment process and are required to enroll into a MCP within 30 days.

With input from the Stakeholder Advisory Committee (SAC), DHCS developed an SPD Linkage Default Protocol to use when the SPD beneficiary does not make an affirmative MCP choice during the enrollment period. The protocol attempts to link each SPD beneficiary with a MCP that contracts with the FFS provider most utilized by the beneficiary.

If an SPD beneficiary cannot be linked to a MCP that contracts with their current provider, DHCS follows the current default algorithm. This algorithm considers quality of care along with available provider choices. The default protocol applies to existing SPD beneficiaries during their birth month, if they fail to make a MCP choice during the enrollment period. The default protocol also applies to new Medi-Cal SPD beneficiaries who are required to enroll in a MCP within 30 days

following establishment of their Medi-Cal eligibility. DHCS modified the existing enrollment broker system to identify the affected FFS SPD beneficiaries and new SPD eligibles on and after June 2011.

## **V. SUBMITAL OF FEDERAL SPAs and WAIVERS**

The Waiver incorporated DHCS' Medi-Cal managed care population. Inclusion of the entire managed care program under the Waiver eliminates the need to submit State Plan Amendments to CMS during the term of the Waiver.

## **VI. HEALTH OUTCOMES OF ENROLLEES**

In accordance with federal quality assurance requirements, DHCS requires contracted MCPs to report performance measurement scores annually. The scores include a number of Healthcare Effectiveness Data Information Set measures related to quality of care, access to care, and timeliness of care provided to Medi-Cal MCP members.

In August 2011, DHCS announced the required performance measures for 2012 and subsequently published the Quality and Performance Improvement Program Requirements for 2012 in MMCD All Plan Letter 11-021. This letter reflected DHCS' work to include measures relevant to SPDs and the intention to begin stratified reporting for SPDs. The objective is for MCPs to eventually report scores for some measures for both their entire population and specifically for SPDs.

However, stratified reporting for SPDs will not begin until 2013 as the new mandatory SPD members will not be enrolled in MCPs long enough in 2011 (the "measurement year" for 2012 performance measure rates) to be reflected in MCP scores. The new SPD members will need to participate in their MCPs long enough for MCPs to collect data to generate statistically significant performance scores. It will take several years before the performance measurement scores fully reflect member health outcomes.

In December 2011, DHCS presented a draft of proposed performance measures for 2013 and began discussions with MCPs and other stakeholders to determine the best SPD stratification methodology. DHCS plans to finalize the measures and SPD stratification methodology by May 2012.

DHCS is continuing development work related to the CMS-required utilization data reporting for the new mandatory SPDs in the following areas: avoidable hospitalizations; hospital readmissions; emergency room utilization; and outcome measures related to person-centered care planning and delivery.

## **VII. CARE MANAGEMENT AND COORDINATION**

Primary Care Providers (PCPs) must manage the care of patients with chronic

health conditions, serious and complex medical needs, multiple co-morbidities, and care of the elderly and disabled. Current contract language requires MCPs to support PCPs in their case management and care coordination activities. MCPs are responsible for coordination activities for members who receive health care services within the MCP provider networks and when members receive services outside of the networks.

DHCS has completed modifications of the MCP contract language to further define and strengthen MCP requirements for case management and care coordination across the continuum of care for SPD members. New language specifies that MCPs must provide case management and care coordination through basic or complex case management activities. Basic case management services are provided by the PCP and include the following: health and behavioral assessments; identification of appropriate providers and facilities (including those out of the network) to meet patient care needs; coordination of care through direct communication; patient and family education; and coordination of carved out and linked services.

Complex case management services include all of the above basic components and further require management of acute or chronic illnesses, including emotional and social support issues, intense coordination of resources to ensure members regain optimal health or improved functionality, and development of specific individual care plans that are updated at least annually.

## **VIII. OTHER SPD INFORMATION**

### **A. Data Stakeholder Workgroup**

During June through August 2011, DHCS worked on the development of data submission standards and methodologies for effective measurement. Upon consultation with legal counsel, DHCS received the opinion that the standards and penalties referenced in Section 14182.1 of the W&I Code would be applicable only to data specifically related to the mandatory SPD population and could not be enforced for all encounter, claims and financial data submissions.

In September 2011, the Data Workgroup reconvened to discuss the impact of the legal opinion and available options for moving forward. Most MCPs agreed that separating the data submissions was not feasible as the population is not readily identifiable. The Workgroup determined that improving the quality of all data submissions would positively affect the subset of data for the SPD population. The Workgroup agreed that the preferred option to reach the goal of improved data submissions is to strengthen and strictly enforce existing language in contracts, including the use of sanctions.

DHCS developed and shared draft contract language with the Workgroup in November 2011. Workgroup members provided feedback, which DHCS

incorporated into a revision currently undergoing legal review. DHCS anticipates contract amendment execution in 2012.

#### B. Stakeholder Advisory Committee (SAC), Section 1115 Waiver

The purpose of the SAC is to advise DHCS on the development and implementation of the Waiver. The chairperson is the Director of DHCS and the committee includes several technical workgroup groups comprised of individuals chosen for their expertise in the following areas:

- Seniors and persons with disabilities (SPDs)
- California Children's Services (CCS) program
- Behavioral health
- Health Care Coverage Initiatives
- Dual eligibles

The technical workgroups identify issues, develop options, and inform DHCS of issues affecting the Waiver. The most recent SAC meeting was held on November 3, 2011, which included an update on the transition of SPDs into Medi-Cal Managed Care. The update included the following:

- Community presentations
- Internal/external trainings
- Network access reviews
- Contracts and deliverables
- Risk stratification/health assessments
- DMHC/DHCS Interagency Agreement
- Data sharing; stakeholder data workgroup
- Webinars held
- Letters of interest
- Adjustments

#### C. Medi-Cal Managed Care Office of the Ombudsman

The OMB uses a Microsoft Customer Relationship Management System (CRM) that tracks incoming beneficiary phone calls. In June 2010, the OMB added "SPD Access" as a tracking sub-category. The OMB reviews the CRM's "Case Detail by Issue Type" report and the "Sub-Issues and Referrals by Primary Issue" report to identify trends. The OMB tracks SPD access on an ongoing basis. For the months of July through December 2011, there were 8,180 calls regarding the mandatory enrollment of SPDs, which is 39 percent of all calls made to the Ombudsman's Office (21,068). Calls regarding mandatory enrollment has steadily decreased every month from 68 percent in July to 30 percent in December. While the number of calls regarding access issues from SPDs (421) is more than non-SPD members (300), it is not a concern since this represents 2 percent and 1 percent respectively of all calls made to the Ombudsman's Office.

Information on calls made to OMB related to mandatory enrollment of SPDs can be found on the MMCD website, in a report titled "SPD Monitoring Dashboard," at: <http://www.dhcs.ca.gov/individuals/Pages/MMCDSPDChrtsRptsData.aspx>

D. Monitoring Activities

During the first quarter of 2011, DHCS solicited stakeholder input for CMS before finalizing the report elements that are to be used to track and report on the transition of SPDs into MCPs. The monitoring elements will include: enrollment patterns; outreach results; continuity of care requests; risk assessment and stratification results; member concerns and grievances; utilization data; and care coordination data. In February 2011, DHCS presented a fully developed outline for monitoring reporting via a conference call with the SAC. The DHCS is now developing the monitoring report format and data collection tools.

E. DHCS/DMHC SPD Related Interagency Agreement (IA), per SB 853 (Committee on Budget and Fiscal Review, Chapter 717, Statutes of 2010).

DHCS and DMHC initiated a required IA on June 1, 2011. The purpose of the IA is to facilitate provider network reviews, medical audits, and financial audits relative to the SPD member population, on behalf of DHCS. Quarterly network adequacy reports are due 120 days after the close of each calendar quarter. Medical survey reports do not have a specific timeframe for completion, but they must be completed for each MCP at least once every three years. The reports are provided by DMHC and submitted to DHCS.

F. During the first quarter of 2011, DHCS solicited stakeholder input and comments for CMS before finalizing the report elements that are to be used to track and report on the transition of SPDs into MCPs. The monitoring elements will include: enrollment patterns; outreach results; continuity of care requests; risk assessment and stratification results; member concerns and grievances; utilization data; and care coordination data. In February 2011, DHCS presented a fully developed outline for monitoring reporting via a conference call with the SAC. The DHCS is now developing the monitoring report format and data collection tools.

G. Rate Development

Mercer utilized a number of assumptions within the rate development process. The first assumption is that it generally takes three months for a beneficiary to enroll in a MCP and begin using services; therefore, excluded from rate development are the FFS costs for the first three months. FFS costs during the first few months of eligibility are typically higher than during subsequent months. An additional assumption when translating FFS costs into managed care rates is

that there will be shifts in utilization patterns under managed care as compared to FFS. These shifts in utilization patterns include the following:

- There will be a reduction in inpatient utilization, resulting in savings for inpatient costs over FFS. Inpatient unit costs will increase slightly.
- Emergency Room (ER) utilization will lower and ER unit costs will increase.
- Utilization for PCPs and specialist providers will increase and unit costs will lower for PCPs; the assumption is that efficiencies will result from the managed care contracting process.
- Pharmacy utilization and mix will change, with the expectation that the MCPs will be aggressive in the utilization of generic drugs.

The following website location gives a summary of the utilization and cost adjustment factors:

[http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD\\_Fin\\_Rpts/All-PlanMtgPresentation\\_01-25-2011.pdf](http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/All-PlanMtgPresentation_01-25-2011.pdf)

In addition, the proposed SPD rates include an additional 0.5 percent for the MCPs to cover the new administrative requirements for care coordination of the SPD population.

DHCS received considerable feedback at the December 2010 meeting and worked with the MCPs to address concerns, which centered on primary care unit costs; inpatient utilization reductions; and the pharmacy mix between name brand and generic drugs. DHCS and Mercer specifically re-examined assumptions and made appropriate adjustments.

#### H. Rates - Risk Analysis

The California Health Care Foundation contracted with Mercer to conduct a risk analysis of the SPD population. The objective was to determine whether the population of SPDs without Medicare coverage currently served by MCPs in Two Plan Model counties differs from the Medi-Cal SPD population in the FFS program. Mercer's report, developed in April 2010 and released in September 2010, is available on the following DHCS website:

[http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD\\_Fin\\_Rpts/SPD\\_Study\\_Final\\_092810.pdf](http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/SPD_Study_Final_092810.pdf)

DHCS utilized this study as a preliminary assessment of the risk of the SPD population in FFS Medi-Cal. It is important to emphasize that the objective of the study was strictly to gather information on the SPD population and not intended for rate setting purposes.

The study used Medicaid Rx (version 5.0) risk adjustment software developed by the University of California, San Diego, to develop risk scores from pharmacy

utilization data to assess the acuity level of each of the populations. The software classifies each beneficiary into one of 43 disease categories and 10 age/gender categories based on pharmaceutical utilization patterns. The study compared the results for beneficiaries in Medi-Cal FFS and Two Plan managed care populations. The initial study indicated that overall, the acuity levels between the two populations were very similar. In six of the 12 Two Plan model managed care counties, managed care beneficiaries had a higher acuity level than those beneficiaries in FFS, whereas the opposite was true in the remaining six managed care counties.

I. Other Rate Related Issues

SB 208 (Steinberg, Chapter 714, Statutes of 2010) requires DHCS to work with designated public hospitals (DPHs) and their stakeholders to develop an intergovernmental transfer mechanism to account for certified public expenditure (CPE) funding that will be lost because of the transition of the SPD population into MCPs. Additionally, the legislation allows DHCS and LA Care (the local initiative in Los Angeles County), to develop a risk sharing mechanism for a three-year period. The intent is to mitigate the risk for Los Angeles County, which had the largest differential between the normalized FFS Risk Score and the normalized Managed Care Risk Score. This occurred when Mercer conducted the initial study of the risk differentials between managed care and FFS.

Discussions are continuing with the DPHs to determine the appropriate amounts for the CPE replacements. DHCS has continued the process to gather and analyze the data to validate the concerns of the DPHs.

DHCS requested a proposal from Los Angeles County to address the risk mitigation legislation, but as of the date of this report, Los Angeles County has not sent a response.

## Attachment A

### Abbreviations and Acronyms

CMS	Centers for Medicare and Medicaid Services
CPE	Certified Public Expenditures
CRM	Microsoft Customer Relationship Management System
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
DPH	Designated Public Hospitals
ER	Emergency Room
FFS	Fee-For-Service
GMC	Geographic Managed Care (Model of Medi-Cal managed care)
MCP	Medi-Cal Managed Care Plan
Mercer	Mercer Health and Benefits LLC
MER	Medical Exemption Request
MMCD	Medi-Cal Managed Care Division
OMB	Office of the Ombudsman
PCP	Primary Care Provider
SB	Senate Bill
SAC	Stakeholder Advisory Committee
SPDs	Seniors and Persons with Disabilities
Waiver	Federal Section 1115 Medicaid Demonstration Waiver: A Bridge to Reform