



**SEMI-ANNUAL REPORT
TO THE LEGISLATURE**

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

Covering January through June 2012

**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). This mandatory enrollment of SPDs does not apply to SPDs with Medicare coverage, SPDs with other health coverage, or SPDs in fee-for-service (FFS) Medi-Cal with a share-of-cost.

By delivering health care services to this high-risk population through a MCP, 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 provide details of the activities undertaken for the identification, notification, education, and enrollment of SPDs into a MCP. These reports include key milestones for mandatory SPD enrollment into MCPs, DHCS' progress toward the objectives of SPD enrollment, and issues related to the care management and care coordination of SPDs. This report is the fourth semi-annual report to the Legislature covering the period of January 1, 2012 through June 30, 2012.

Note: All updates since the last semi-annual report are in italics for ease of reference.

II. BACKGROUND

DHCS contracts with MCPs to arrange for the provision of health care services for approximately 4.9 million Medi-Cal beneficiaries in 30 counties. DHCS provides three types of Medi-Cal managed care models:

1. Two-Plan Model (TPM), which operates in 14 counties;
2. County Organized Health System (COHS), which operates in 14 counties; and
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 2011- May 2012

On May 1, 2012, the SPD enrollment process was completed with the transition of 239,731 SPDs into MCPs. At the onset of the transition, there were minor data glitches and an increase of informational calls at the MCP level and to the Medi-Cal Managed Care Division's (MMCD) Office of the Ombudsman (OMB). DHCS continues to monitor MCPs and the review of MCP progress and member satisfaction is ongoing. Monthly updates regarding medical exemptions requests (MERS) are located on the MMCD website, in a report titled "SPD Monitoring Dashboard" at:

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

At an administrative level, there has been an increase in MERS and fair hearing requests. Most of the SPD-related MER and fair hearing requests have been inconsistent with the continuity of care provisions in the federal Section 1115 Bridge to Reform Waiver (Waiver). Prior to enrollment, beneficiaries and providers received information regarding the continuity of care provisions in the Waiver.

MMCD continues to closely monitor OMB calls, MERS, and fair hearing requests. Any health care issues that arise are resolved as expeditiously as possible at the MCP level and in collaboration with MMCD staff when necessary. To date the implementation of mandatory enrollment of the Medi-Cal only SPD population into the MCPs has not presented any unresolvable medical care situations.

IV. PROGRESS TOWARD OBJECTIVES OF SPD ENROLLMENT

A. Outreach and Education

1. Prior to the mandatory enrollment of SPDs, DHCS developed an extensive outreach and education strategy that included three separate mailings and two telephone calls that are detailed below:

- The first mailing was a 90-day notice intended to inform SPD beneficiaries of the upcoming change to their health care delivery system. SPD beneficiaries that enrolled on June 1, 2011, received their first 90-day notice on or before March 1, 2011.
- A telephone call followed the written notice to verbally educate beneficiaries on the upcoming change and assist with questions.
- The second notice was a 60-day enrollment packet that included a county-specific insert notifying SPD beneficiaries of their MCP choices and additional educational information.
- The next outreach effort was a second telephone call that focused on informing SPD beneficiaries of their ability to choose a MCP, provide assistance in the enrollment process, and address questions.
- The 30-day “intent-to-default notice” was the final mailing. This notice was only sent to SPD beneficiaries who did not make a MCP selection. This notice informed the SPD beneficiaries that if they did not choose a MCP, DHCS would assign them to a MCP.

Enrollment of transitional SPDs began on June 1, 2011 and was completed on May 30, 2012. *Although the enrollment and notification process listed above has been completed, DHCS continues to educate providers and beneficiaries on working with the MCPs.*

2. In July 2011, DHCS began the implementation of a monthly call campaign titled “DHCS Outbound Call Survey,” to Medi-Cal only SPD beneficiaries. Calls are made to SPD beneficiaries at least 45 days following their enrollment effective date. The objective of the survey is to determine a beneficiary’s level of satisfaction with their access to providers, as well as their overall level of satisfaction with their MCP. 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 MCPs. In December 2011, the call campaign expanded to all TPM and GMC managed care counties.

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

The January through June 2012 reporting period includes the following results of the DHCS Outbound Call Survey for all managed care counties, including the 16 TPM and GMC counties:

- *Of those who responded to the call survey, an average of 66.12 percent made an appointment to see a doctor since enrolling in a MCP. Of those that made an appointment, 56.25 percent had already received services.*
- *Finally, of those who rated their MCP on a scale of 1-5, with 5 being the highest, 84 percent rated their MCP at a 3 or better.*

B. Risk Assessment and Stratification

W&I Code Section 14182(c)(12)(A) requires MCPs to conduct risk stratifications and risk assessments 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 the health care management needs of its beneficiaries. DHCS approved all MCPs risk stratification and risk assessment tools.

During the months of July through December 2011, DHCS provided MCPs with FFS utilization data and current information on Treatment Authorization Requests for new mandatory SPD members. During the months of June 2011 through March 2012, DHCS provided MCPs with over 25 million FFS claim records. The data sets developed for this process were fully compliant with state and federal privacy requirements.

Since risk assessments can take up to 105 days to complete, statistics on the completed assessments are only available for 2011. During the second, third and fourth quarters in 2011, MCPs successfully contacted 129,427 beneficiaries and identified 61,937 of those as high-risk.

Assessment statistics can be located in the monitoring Dashboard that is available on the MMCD website at the following link:

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

C. SPD Mandatory Enrollment

The Waiver and W&I Section 14182 required a phase-in enrollment process to transition existing FFS SPDs into MCPs. The 12-month phase-in process began June 1, 2011, and was complete on May 1, 2012. As of June 1, 2012, SPDs that become eligible for mandatory enrollment in a MCP are no longer eligible for the phase-in enrollment process and are required to enroll into a MCP within 45 days of eligibility.

With input from the Stakeholder Advisory Committee (SAC), DHCS developed an SPD linkage default protocol to use when a SPD beneficiary does not make an affirmative MCP choice during the enrollment period. The protocol attempts to link the enrollment of each SPD beneficiary with a MCP that contracts with a FFS provider that is most utilized by the beneficiary. If an SPD beneficiary can't be

linked to a MCP with this default protocol, DHCS follows its current default algorithm. The current default algorithm considers quality of care along with available provider choices.

During the phase-in enrollment period, the default protocol was applied to a SPD beneficiary's birth month if they failed to make an affirmative MCP choice. This default protocol is also used for new Medi-Cal SPD beneficiaries not eligible for phase-in enrollment who are required to enroll in a MCP within 45 days following the establishment of their Medi-Cal eligibility. DHCS modified the existing enrollment broker system to identify the affected FFS SPD beneficiaries and new SPD eligibles.

No new updates for this section during the January through June semi-annual reporting period.

V. SUBMITAL OF FEDERAL SPAs and WAIVERS

On January 1, 2012, DHCS submitted an amendment to the Waiver to the Centers for Medicare and Medicaid Services (CMS) to incorporate the Community Based Adult Services (CBAS) Program.

The State Budget Bill for Fiscal Year 2011/2012 eliminated Adult Day Health Care (ADHC) services. DHCS became the defendant in a lawsuit (Darling v. Douglas) to halt the elimination of ADHC. DHCS entered into a settlement agreement with the plaintiffs to establish a new program CBAS that offers some of the same services as ADHC and allows beneficiaries in danger of institutionalization to remain in their communities. However, CBAS has stricter eligibility requirements to achieve cost savings. In Medi-Cal managed care counties, CBAS will be a covered service that is managed by MCPs.

ADHC ended on February 29, 2012, and FFS CBAS began on March 1, 2012. The MCPs operating in COHS counties will begin covering CBAS July 1, 2012, with the exception of the Gold Coast Health Plan (GCHP) in Ventura County. The TPM and GMC MCPs, along with GCHP, will begin covering CBAS on October 1, 2012.

MCPs have contracted with former ADHC centers that are certified as CBAS providers. Once CBAS becomes a Medi-Cal managed care covered service, MCPs will assume two responsibilities: (1) the assessment process to determine eligibility for CBAS; and (2) the reassessment process to ensure that CBAS members continue to receive the level of CBAS services needed, or to determine if CBAS is still necessary. DHCS has executed contract amendments outlining MCP responsibilities in managing CBAS that included rates to cover the daily provision of CBAS services.

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 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 (APL) 11-021. This APL reflected DHCS' work to include measures relevant to SPDs and the intent to begin stratified reporting for SPDs. The objective is for MCPs to eventually report scores for some measures specifically for SPDs as well as their entire population.

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 enough 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 September 2012.*

DHCS continues 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 the coordination activities for members who receive health care services within the MCP's provider network and when members receive services from out-of-network providers.

DHCS 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*

complete risk stratification and risk assessments followed by completion of individual care plans for high-risk members upon enrollment and then regularly updated thereafter.

VIII. OTHER SPD INFORMATION

A. Data Stakeholder Workgroup

With input from the Data Stakeholder Workgroup, DHCS developed draft contract language to incorporate encounter data submission standards and consequences for non-compliance. DHCS is currently reevaluating the requirements, system capabilities, and readiness in the context of the Waiver initiatives.

No new updates for this section during the January through June semi-annual reporting period.

B. Stakeholder Advisory Committee, Section 1115 Waiver

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

- SPDs
- California Children's Services Program
- Behavioral health
- Health Care Coverage Initiatives
- Dual eligibles

The technical workgroups identifies issues, develops options, and informs DHCS of issues affecting the Waiver. The last SAC meeting was held on November 3, 2011, and included an update on the transition of SPDs into managed care. The update included the following:

- Community presentations
- Internal/external trainings
- Network access reviews
- Contracts and deliverables
- Risk stratification/health assessments
- Department of Managed Health Care (DMHC)/DHCS Interagency Agreement (IA)
- Data sharing; Stakeholder Data Workgroup
- Webinars
- Letters of interest
- Adjustments

No new updates for this section during the January through June semi-annual reporting period.

C. Medi-Cal Managed Care Office of the Ombudsman

OMB uses a Microsoft Customer Relationship Management (CRM) system that tracks incoming beneficiary phone calls. In June 2010, OMB added “SPD Access” as a tracking sub-category. OMB reviews the CRM’s Case Detail by Issue Type report and the Sub-Issues and Referrals by Primary Issue report to identify trends. OMB tracks SPD access on an ongoing basis.

For the period of January 1, 2012 through June 30, 2012, there was a total of 9,834 calls received pertaining to the mandatory enrollment of SPDs. This accounted for 42 percent of all calls made to OMB (23,019) during that period. Further, the number of calls regarding access issues for SPDs (126) is less than non-SPD members (142). This is an improvement from the amount of calls reported in the last semi-annual SPD report regarding access.

D. Monitoring Activities

During the first quarter in 2011, DHCS solicited stakeholder input from CMS before finalizing the report elements that are used to track and report the transition of SPDs into MCPs. The monitoring elements 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 SAC.

DHCS has since published the resulting monitoring report, or Dashboard, which is updated on a monthly basis. The September 2012 report contains the monitoring activities through June of 2012 and is available on the MMCD website at the following link:

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

E. DHCS/DMHC SPD Related 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 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.

DHCS expanded its monitoring activities to include surveys. Relative to the SPD transition, two surveys were completed, that included a general survey on beneficiary experiences after joining an MCP (DHCS Outbound Call Survey) and the medical exemption process (SPD MER Survey). The results of both surveys are included in the SPD Dashboard, which is updated on monthly basis, and is available on the MMCD website at the following link (Note: the DHCS Outbound Call Survey results currently in the Dashboard contains the results of the initial six MCP sample. The survey results for all MCPs for the January through June 2012 reporting period are located on pages 4-5 above of this semi-annual report):

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

Attachment A

Abbreviations and Acronyms

ADHC	Adult Day Health Care
APL	All Plan Letter
CBAS	Community Based Adult Services
CMS	Centers for Medicare and Medicaid Services
COHS	County Organized Health System
CRM	Microsoft Customer Relationship Management System
DHCS	Department of Health Care Services
DMHC	Department of Managed Health Care
FFS	Fee-For-Service
GMC	Geographic Managed Care
GCHP	Gold Coast Health Plan
IA	Interagency Agreement
MCP	Medi-Cal Managed Care Plan
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
TPM	Two-Plan Model
Waiver	Federal Section 1115 Medicaid Demonstration Waiver: A Bridge to Reform
W&I	Welfare and Institutions Code