



**SEMI-ANNUAL REPORT  
TO THE LEGISLATURE**

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

**January 2011**

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

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## **I. INTRODUCTION**

Senate Bill (SB) 208 (Steinberg, Chapter 714, Statutes of 2010) permits the Department of Health Care Services (DHCS) to mandatorily enroll Medicaid eligible Seniors and Persons with Disabilities (SPDs) into its Medi-Cal managed care program 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 with a Medi-Cal share of cost.

Providing health care services to this high-risk population through a managed care model provides beneficiaries with an accountable system of care, which improves access and care coordination.

Welfare and Institutions (W&I) Code Section 14182(s)(1), requires the DHCS to provide a semi-annual report to the Legislature that provides details of the activities undertaken with respect to the identification, notification, education, and enrollment of SPDs into the Medi-Cal managed care program. The report will include the key milestones for mandatory SPD enrollment into managed care, 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 first semi-annual report to the Legislature covering the period of July 2010 through December 2010.

## **BACKGROUND**

DHCS contracts with managed care organizations to arrange for the provision of health care services for approximately 4.11 million Medi-Cal beneficiaries in 26 counties. DHCS provides three primary models of managed care: Two-Plan, which operates in 12 counties; County Organized Health System (COHS), which operates in 11 counties; and Geographic Managed Care (GMC), which operates in two counties. DHCS also contracts with a prepaid health plan in one additional county and with two specialty health plans.

Although SPDs are not currently required to enroll into the Two-Plan and GMC Medi-Cal managed care models, SPDs can currently enroll in these plans on a voluntary basis. Of the total Medi-Cal managed care program enrollees served today, 11 percent are SPD members.

## II. 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

## III. PROGRESS TOWARD OBJECTIVES OF SPD ENROLLMENT

### A. Plan Readiness

By January 31, 2011, DHCS will complete a plan readiness review for each Medi-Cal managed care health plan. The purpose of the review is to ensure that each plan can serve eligible Medi-Cal beneficiaries identified as SPDs. The plan readiness review includes three sections: good standing, network assessment, and plan submission of new and revised contract deliverables.

1. *Good Standing:* The good standing review is to certify that each managed care health plan has no current deficiencies that would prevent the plan from providing health services to new SPD beneficiaries. The internal review consists of ensuring health plan compliance with contractual and regulatory requirements, plan financial submissions, and that corrective action resulting from DHCS's monitoring activities were completed and satisfy DHCS standards. The DHCS completed the good standing review in early January and plans operating in the mandatory counties are all in good standing with no deficiencies.
2. *Network Assessment:* DHCS will evaluate each health plan's network to ensure that the network is prepared and able to serve SPD beneficiaries. In anticipation that the SPD population may be more engaged with plan specialty provider networks, DHCS has developed a process to evaluate the ability of its contracted managed care health plans to provide adequate access to specialty care. The DHCS network evaluation is a combination of past and projected utilization data; plan specific projected SPD enrollment; plan input regarding the current utilization of specialty care and use of non-contracted providers in meeting specialty care needs (including plan preparations to meet the increased demands on their network). In October 2010, DHCS shared with the Department of Managed Health Care (DMHC) the network assessment tool for use in the initial network assessment. The DMHC stated the assumptions underlying the development of the tool are both reasonable and beneficial to

enrollees and that they support better access to medically necessary specialty care.

During 2010, DHCS worked with plans to assist them in building their networks. DHCS provided plans with information related to community providers currently serving the fee-for-service (FFS) SPDs. DHCS monitored each plan's progress toward increasing plan networks. As of June 2010, the crosswalk of FFS providers to contracted plan providers indicated a 57 percent overlap. The most recent review in October 2010 indicated a 66 percent overlap.

Plans submitted network information to DHCS in December 2010. DHCS conducted its review and worked with health plans on clarification of their submissions. DHCS will finalize the network assessment for all plans by the end of January, and is on track for a March 1 network certification submission to the Centers for Medicare and Medicaid Services (CMS).

3. *New and revised Contract Deliverables:* DHCS will require that each managed care health plan submit new or revised deliverables consistent with new SPD specific contract language. The new or revised deliverables will include updated policies and procedures for conducting facility site reviews, administering the health risk assessment, enhanced coordination of care requirements and communication, Health Risk Assessments, person-centered planning, accessibility information for beneficiaries, and access to non-network specialty providers.

#### **B. Sensitivity Training**

Under contract with DHCS, the Western University Health Sciences (WUHS) assisted DHCS in the development of an educational module to provide training to State staff and plan health educators relative to the cultural awareness and sensitivity for the SPD populations. In developing the curriculum, DHCS and WUHS obtained input from stakeholder work groups and DHCS has approved the final version. WUHS conducted two "Train-The-Trainer" workshops. Workshops were held in Oakland on January 19-20, 2011 and the second in Los Angeles on January 26-27, 2011.

#### **C. Access/Facility Site Review**

DHCS's contract with WUHS includes the revision to DHCS' Facility Site Review (FSR) tool to assess the level of physical access of provider sites that will serve the SPD population.

In August and September 2010, DHCS and WUHS worked with advocates, stakeholders and plans to create workgroups to provide revisions to the FSR tool. In November and December 2010, DHCS worked with the Medi-Cal

Managed Care Division (MMCD) Advisory Group and its plans to develop a Policy Letter instructing on the purpose and use of the revised FSR tool. DHCS released Policy Letter 10-016 in December 2010. In January, staff conducted a webinar to train the plans in the use of the revised FSR tool. Hands-on training sessions will occur in February in Pomona and Sacramento.

#### *D. Outreach and Education*

DHCS has developed an extensive outreach and education strategy that includes three separate mailings and two telephone calls to the affected SPD beneficiaries. The first mailing will be a 90-day notice intended to inform SPD beneficiaries of the upcoming change to their health care delivery system. This notice is followed by a telephone call intended to educate beneficiaries on the upcoming change and assist with questions. The second notice will be a 60-day enrollment packet that will include a county-specific insert notifying SPD beneficiaries of their health plan choices and additional educational information. The final outreach attempt is a second telephone call focused on informing SPD beneficiaries of their ability to choose a health plan, 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 plan selection. The notice informs the SPD beneficiaries that if they do not choose a plan, DHCS will assign them to a health plan. SPD beneficiaries will receive the first 90-day notice no later than March 1, 2011. The process thereafter will occur monthly for twelve months, for the phasing in of the SPD members.

Additionally, DHCS, in collaboration with the University of California, Berkeley (UCB), will conduct one community presentation in each Two-Plan and GMC County on SPD enrollment. The development of the community presentation has included stakeholder input and review. DHCS will finalize the presentation content in January. UCB will complete the community presentations by April 2011. Stakeholders have voiced concerns that one presentation per county is insufficient therefore DHCS staff will be available to conduct additional presentations and are actively seeking Community Based Organizations (CBO) support for additional outreach and training opportunities.

#### *E. Risk Assessment and Stratification*

In June 2010, DHCS sought input from plans regarding the provision of member-specific FFS utilization data that would allow plans to assess members' health needs. DHCS provided the data set to Medi-Cal Managed Care plans in November 2010, including the format for the member-specific data set and preliminary information about how plans will access the data on a monthly basis via a secure website. Beginning in February 2011, DHCS will provide test files to plans to test the file transfer process and respond to questions from plans

regarding the data files. The data set developed is fully compliant with the State and federal privacy requirements.

W&I Code Section 14182(c) (12) (A) requires plans to conduct a risk stratification and risk assessment of new SPD members. The risk stratification will determine a member's health status as high risk or low risk followed by a 45 or 105 day (respectively) requirement to conduct the risk assessment of the new SPD member. The risk assessment will allow the plan to determine care management needs. W&I Code Section 14182 requires the use of a health plan-developed and DHCS-approved risk stratification and risk assessment tool. Plans are required to solicit and consider stakeholder and consumer input into the development of the tools.

Beginning in August 2010, DHCS solicited input from plan medical directors regarding the processes plans will use to conduct the risk stratification and risk assessment of new SPD members and in the development of the Policy Letter.

In December 2010, DHCS provided the MMCD Advisory Group a draft of the Policy Letter for comment and input. DHCS made revisions to incorporate input received. In January 2011, DHCS released Policy Letter 11-001 to plans providing the criteria and minimum requirements necessary for DHCS approval and the required submission by plans to DHCS in March 2011.

In addition, DHCS has developed a Member Evaluation Tool (MET) that allows beneficiaries to complete a self-assessment of their health status. The MET will be included in the 60-day enrollment packet. Completion of the MET by the beneficiary is voluntary and those returned will be sent to the member's assigned health plan. The purpose of the MET is to obtain additional, and in some cases the only, member information for plan use in the risk stratification/risk assessment process.

#### *F. Federal Approval of Waiver, Rates, and Contract Language*

On November 2, 2010, DHCS received approval from CMS for California's five-year Section 1115 Medicaid Demonstration Waiver: A Bridge to Reform (Waiver). CMS approved the Waiver for the period November 1, 2010, through October 31, 2015.

DHCS anticipates CMS approval of rate certification and health plan's contract approval in May 2011 in order to implement the mandatory enrollment of SPDs starting in June 2011. DHCS rate certifications and contract language for health plans are currently under development for submission to CMS in April 2011. Upon submission, DHCS anticipates CMS contract approvals will be received no later than May 2011. DHCS and CMS are in constant communication on SPD related activities and maintain a standing bi-weekly call.

In August 2010, DHCS started the process of contract language development. DHCS is working with health plans and CMS to ensure developed language is clear and meets the requirements of SB 208 and the 1115 Waiver Special Terms and Conditions. DHCS will submit final contract amendments to CMS for federal approval no later than April 1, 2011.

In August 2010, DHCS and plans discussed the rate development process for the SPD population. Mercer Health & Benefits LLC (Mercer), DHCS' actuarial services contractor, developed preliminary capitation rates for the SPD population. DHCS provided plans the preliminary rates in November 2010 and in December 2010, held a meeting to discuss and obtain feedback on the preliminary rates. Based on input received, DHCS and Mercer are re-examining assumptions. In January 2011, DHCS will have recalculated rates and will hold another meeting with plans to discuss updates in the rate development process and obtain feedback prior to finalizing rates. DHCS intends to finalize rates in February 2011 for inclusion in new contracts and submit rate certifications to CMS in March 2011. Please refer to section VII E of this report for additional information on the rate development process.

#### **G. SPD Mandatory Enrollment**

The 1115 Waiver and W&I section 14182 requires a phased-in enrollment process for the transition of existing FFS SPDs into Medi-Cal managed care. The staggered enrollment process for existing FFS SPD beneficiaries is a 12-month phase-in process, based on the beneficiary's birth month. Los Angeles (LA) County had the option, with DHCS approval, to phase-in using an alternate process. LA County has opted not to exercise this flexibility but rather join the birth-month phase-in process. The 12-month phase-in process will begin June 1, 2011, and continue until May 1, 2012.

SPD beneficiaries who become eligible for Medi-Cal benefits and meet the criteria for mandatory enrollment into the managed care program on or after June 1, 2011, are not eligible for the staggered enrollment process and will be required to enroll into a health plan within 30 days.

DHCS has developed an SPD Linkage Default Protocol to use when the SPD beneficiary does not make an affirmative health plan choice during the enrollment period. Through input from a stakeholder advisory committee, DHCS has developed a default protocol that will attempt to link each SPD beneficiary with a plan that contracts with the FFS provider most utilized by the beneficiary. If a SPD beneficiary cannot be linked to a plan, DHCS will follow the current default algorithm, which includes consideration of quality of care and traditional and safety net providers. The default protocol will apply to existing FFS SPD beneficiaries in their birth month if they fail to make an affirmative health plan choice during the enrollment period. New Medi-Cal SPD beneficiaries will be required to enroll soon after Medi-Cal eligibility is established.

DHCS has modified the existing enrollment broker system and processes to clearly identify the affected FFS SPD beneficiaries to be phased-in. Additional system modifications, for the process of identifying new SPD Medi-Cal eligibles on and after June 2011, have occurred.

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

Through the 1115 Waiver, California will receive approximately \$10 billion in federal funds through 2015 to invest in the health delivery system to prepare for national health care reform. These investments are designed to help slow the rate of growth in healthcare costs within the Medi-Cal program. The key element of the waiver is establishing organized delivery systems that ensure better coordination of care. The Waiver permits the State to mandatorily enroll SPDs into Medi-Cal managed care plans for primary and acute care services and includes numerous safeguards and protections to ensure SPD-specific network readiness and access to quality care.

DHCS's Medi-Cal managed care population has been incorporated in the 1115 Waiver. Inclusion of the entire program eliminates the need for State Plan Amendment submissions to CMS during the term of the waiver.

#### **V. HEALTH OUTCOMES OF ENROLLEES**

In accordance with federal quality assurance requirements, DHCS currently requires contracted plans to report annually performance measurement scores for a number of Healthcare Effectiveness Data Information Set (HEDIS) measures related to the quality of care, access to care, and timeliness of care provided to Medi-Cal managed care plan members. HEDIS measures are established by the National Committee for Quality Assurance and are the "gold standard" performance measures used nationally to assess the quality of care provided by commercial, Medicaid and Medicare plans. The HEDIS measures for which DHCS currently requires plans to report annual scores focus on access to care provided to women, children and adolescents; ambulatory care services provided to members of all ages; screening for diseases such as breast and cervical cancer; and care provided to members with chronic diseases such as diabetes and asthma and serious conditions, such as upper respiratory infections in children and acute bronchitis in adults.

DHCS has begun development work to make initial changes to the required measures for 2012; both adding more measures relevant to SPDs and providing for stratified reporting so that plans will report scores for their entire population and specifically for SPDs.

In addition, the DHCS will specifically require plans to report utilization data 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. DHCS will develop and require utilization reporting in these areas as soon as the technical specifications are developed.

It is important to highlight that the new SPD members must be enrolled in their managed care plans long enough for plans to collect enough data to generate statistically significant performance scores, so it will take several years before the performance measurement scores will be fully reflective of these members' health outcomes.

## **VI. CARE MANAGEMENT AND COORDINATION**

Providers must manage the care of patients with chronic health conditions, serious and complex medical needs, multiple co-morbidities and the elderly and disabled. The coordination of medically necessary care can be a challenge for patients and their primary care physicians (PCPs). Current contract language requires Managed Care health plans to support PCPs in their case management and care coordination activities and maintain procedures for monitoring. Plans are responsible for these coordination activities for members who receive health care services within the plan provider networks and when members receive services outside of the plan provider networks. Case management, care coordination, and care management are terms which are often used interchangeably.

The DHCS will modify contract language to further define and strengthen plan requirements for case management and care coordination across the continuum of care for SPD members. New language specifies that plans will provide case management and care coordination through basic or complex case management activities. Basic case management services are provided by the Primary Care Provider (PCP) and include health and behavioral assessments; identifying appropriate providers/facilities (including out of network) to meet patient care needs; coordinating care through direct communication; patient and family education and coordination of carved out and linked services. Complex case management services include all of the basic components and further require management of acute or chronic illness, 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.

## **VII. OTHER SPD INFORMATION**

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

In December 2010, DHCS began planning to implement the stakeholder workgroup mandated by SB 208 "to review the existing encounter, claims, and financial data submission process" currently required of Medi-Cal managed care plans. This data workgroup will provide input regarding new data standards to be

included in health plan contracts to improve the overall quality of data submitted to DHCS by contracted plans and to provide for financial penalties on plans that do not meet the new standards. The workgroup will meet in March 2011. DHCS anticipates finalizing a Policy Letter in October 2011. The new quality standards will become effective January 1, 2012.

**B. Medi-Cal Managed Care Advisory Committee**

DHCS is working with the MMCD Advisory Group to review and provide feedback on all communication to health plans and beneficiaries. The advisory committee includes representatives from health plans, advocate groups and other stakeholders.

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

The Office of the Ombudsman (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 sub-issue for tracking in the CRM. The OMB reviews the CRM's "Case Detail by Issue Type" and "Sub-Issues and Referrals by Primary Issue" reports to identify trends. The OMB will track SPD access as an ongoing monitoring activity.

**D. Monitoring Activities**

In November 2010, DHCS began developing the data elements and performance measures for use in monitoring and reporting on the transition of SPDs into managed care plans. Areas to be included in the monitoring reports will include enrollment patterns, outreach results, medical exemption requests and continuity of care approvals, risk assessment results, members concerns and grievances, utilization data and care coordination data. In December 2010, preliminary concepts for the monitoring reports were discussed with the Stakeholder Advisory Committee (SAC). During the first quarter of 2011, DHCS will solicit additional stakeholder input and comment from CMS before finalizing the report elements. DHCS will present a fully developed outline for monitoring reporting at the February 2011 SAC meeting.

**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 are required to initiate and maintain an IA. The purpose of the IA is to facilitate an agreement by which DMHC will conduct provider network reviews, medical audits, and financial audits relative to the SPD member population, on behalf of DHCS.

Network assessment reviews will occur quarterly. Medical audits will occur at least once every 36 months. Financial audits will occur once every 36 months.

DHCS and DMHC have collaborated to develop a framework for the IA that reflects the key issues including roles and responsibilities. In early January 2011, DMHC submitted a revision to the DHCS draft IA and it is currently under DHCS review. DHCS and DMHC will meet to discuss outstanding issues and anticipates IA finalization in February 2011.

#### *F. Rate Development*

DHCS and Mercer held All Plan Rate Development meetings in August and December 2010, and an All Plan Conference Call in November 2010 to discuss the rate development process for the SPD population. DHCS released to the plans preliminary capitation rates for the SPD population in November 2010 to initiate discussions with the plans concerning the methodology. The preliminary rates are based on FFS claims data adjusted for services carved out under managed care and on county average managed care rates adjusted for risk factor differences between FFS and managed care.

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 managed care plan and begin using services; therefore, excluded from rate development 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 made when translating FFS costs into managed care rates is that there will be shifts in utilization patterns under managed care as compared to FFS. Specifically:

- Inpatient utilization will reduce, resulting in a 40 percent savings factor for inpatient costs over FFS. Inpatient unit costs will increase slightly.
- Emergency Room (ER) utilization will reduce and ER unit costs will increase.
- Utilization for primary and specialist providers will increase and unit costs will reduce for primary care providers; it assumes that efficiencies are obtained through the managed care contracting process.
- Pharmacy utilization and mix will change, with the expectation that the plans will be fairly aggressive in the utilization of generic drugs.

A summary listing of the utilization and cost adjustment factors can be found at:

[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, an additional 0.5 percent was built into the proposed SPD rates to address new administrative requirements such as care coordination being placed on the plans for the SPD population.

DHCS received a great deal of feedback at the December 2010 meeting and is working with the plans to address concerns, which centered around primary care unit costs, inpatient utilization reductions, and the pharmacy mix between name brand and generic. DHCS and Mercer are specifically re-examining assumptions and may make adjustments. DHCS anticipates Mercer's recalculated SPD rates in January 2011, to be followed by a meeting with the plans at the end of January, 2011 to discuss updates in the rate development process and obtain feedback prior to the February 2011 finalization of rates.

### **G. Rates - Risk Analysis**

The California Health Care Foundation contracted with Mercer to conduct a risk analysis of the SPD population with the objective of determining whether the population of SPDs without Medicare coverage currently served by managed care plans 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 DHCS website at: [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. It is important to emphasize that the study conducted 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 upon 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.

In June 2010, results were updated using the most recent Medicaid Rx model (version 5.2) and more recent pharmacy utilization data. The updated results reflect that managed care members have a higher acuity level in the majority of the Two-Plan model counties (10 of 12), indicating that FFS may not be serving the higher risk members as effectively as managed care.

A reason for the risk shift to managed care in the updated study was due to several large contracting managed care plans not submitting completed pharmacy data for the initial study, thus skewing a comparison. Submission of

plan pharmacy data was much more complete for the updated study. In counties where the measured acuity of the managed care population is lower than FFS, the managed care penetration rate is also lower.

In the updated study, Mercer performed an analysis of the two GMC counties and results show that the risk scores for managed care are lower than the corresponding FFS populations. DHCS is analyzing the reason for the difference. In November 2010, DHCS presented the updated study to plans and conducted a follow-up meeting in December 2010.

#### *H. Other Rate Related Issues*

SB 208 requires that DHCS work with Designated Public Hospitals and their stakeholders to develop an Intergovernmental Transfer mechanism to account for Certified Public Expenditure funding to be lost because of the transition of the SPD population into managed care. Additionally, the legislation allows DHCS and LA Care (the local initiative in LA County), to develop a risk sharing mechanism for a three-year period. The intent is to mitigate the risk for LA County, which had the largest differential between the normalized FFS Risk Score and the normalized Managed Care Risk Score when Mercer conducted the initial study of the risk differentials between managed care and FFS. As of the date of this report, discussions have occurred with the various stakeholders but significant action is pending until the base rates for the SPDs are finalized in February 2011.