TRANSITIONING BENEFICIARIES WITH COMPLEX CARE NEEDS TO MEDICAID MANAGED CARE: LESSONS FROM CALIFORNIA

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Planning an Evaluation of Cal MediConnect

- **Lessons learned from previous evaluation of Medi-Cal only SPDs into managed care**
  - Focus groups with beneficiaries
  - Telephone survey with 1,521 SPD beneficiaries
  - Key informant interviews in 3 counties.
  - Funded by DHCS, California Healthcare Foundation, and Kaiser Commission on Medicaid and the Uninsured

- **Planning a California-specific evaluation of the transition of duals into Cal MediConnect**
  - 6 month planning period funded by The SCAN Foundation
  - Proposed evaluation design

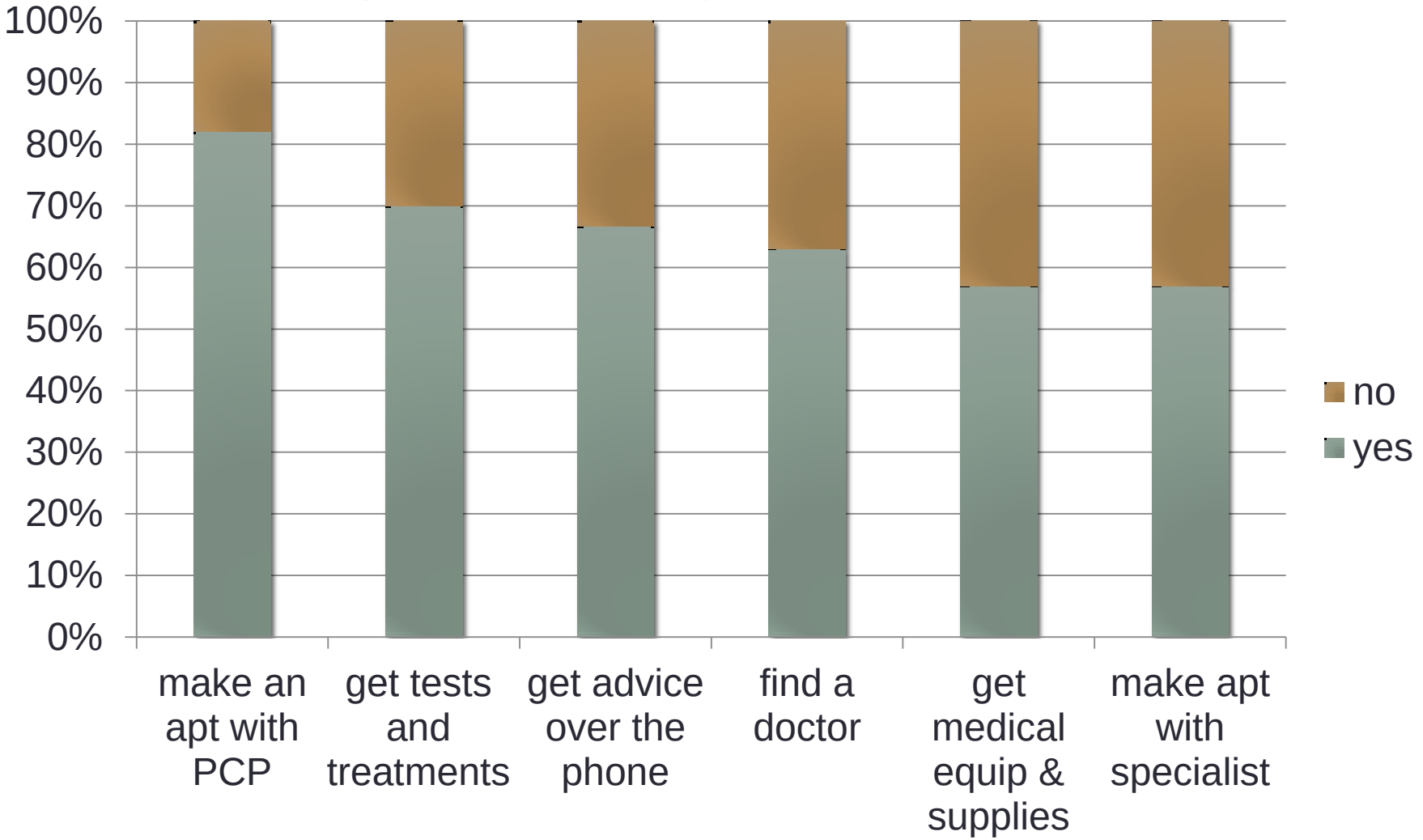
Lessons learned from Medi-Cal only SPD transition evaluation

- **Notification materials**
  - 69% remembered getting the letter but they still had questions…
    - Why is this transition happening?
    - What plan is best for me?
    - Can I still see my…. doctor, go to my preferred hospital, get my prescriptions, medical equipment/supplies and tests/treatments I need.

- **Lack of knowledge about choices and consumer protections**
  - Almost 1/3 of those who received notification letter also did not know they could choose a plan.
  - Only 17% of SPD beneficiaries were aware they could apply for the Continuity of Care Provision

- **Lack of knowledge about how to navigate managed care delivery system**

Plan Navigation: Do you know how to….?



Those less likely to know how to navigate plan: Latino, African Americans, “fair” health, limited health literacy, cognitive deficits, more ER visits since transition

Majority of SPD beneficiaries reported satisfactory experiences

- 63% of beneficiaries were somewhat or very satisfied with benefits in MMC
- 30% of beneficiaries were somewhat or very dissatisfied
- 21% of beneficiaries said care was worse now in MMC.
- 18% said getting PCP appointment more difficult in MMC
- 19% said getting specialist appointments more difficult in MMC
- 21% said getting prescription medication more difficult in MMC
- 20% said they are getting less help finding doctors and getting test/treatments they need in MMC.

Who are the beneficiaries more prone to difficulty?

Groups to target for additional support

- **Beneficiaries who did well with transition to managed care**
  - Those who actively choose a plan
  - Those who live alone
  - Those who have a health care proxy
  - Those who were relatively new to Medi-Cal (less than 2 years)
  - Those who had PCP and specialist visits since transition

- **Beneficiaries who had a harder time with transition to MMC**
  - People who don't actively choose a plan
  - People with "poor" self-rated health
  - Cognitive or functional impairment
  - People who have been continuously eligible for Medi-Cal long term (2-11 years before transition)
  - More acute care visits (ER and Hospitalizations) since transition
  - No PCP or specialist visits
  - People who call member services since transition

Intelligent Assignment…

We compared those who chose a plan vs. those who were "linked" vs. those who defaulted.

- Choosers had the best outcomes
- No significant differences between people linked to a plan compared to those who defaulted on key outcomes

	Choosers	Link	Default
Reported PCP appointment more difficult in MMC	15%*	26%	23%
Reported less help finding providers & services in MMC	18%*	32%	26%
Rated Medi-Cal benefits worse	29%*	44%	40%

* $p < 0.05$ bivariate & multivariate comparisons.

Planning an Evaluation of Cal MediConnect

- 6 month planning period funded by The SCAN Foundation
- 26 key informant interviews with health plans, providers, policymakers, advocates, and CBOs that serve duals
- 2 focus groups with dually eligible beneficiaries, 1 interview
- Stakeholder calls
- Learning from demo evaluations in other states

Duals Transition Evaluation

- Input from key informants…
  - Problems with notification
  - Outreach was better than SPD transition, but still not deep enough
  - Importance of collaboration within counties
  - Still issues with data from the state/CMS
  - Delegation to IPAs and contracting issues
  - Impact on provider organizations: finances, staffing, patient panels

Duals Transition Evaluation

- Input from key informants…
  - Care coordination from health plans
    - How can health plans be gatekeepers AND an ally?
    - Ensuring self direction and patient centered care
  - Need more education about how HPs can help providers
  - Hope that health plans will facilitate increased access to needed care
    - More IHSS hours
    - More non-emergency transportation
    - Optional Direct Services: what will be provided? How to pay?

Focus Groups with Beneficiaries

- Input from beneficiaries
  - Terminology is inconsistent “duals” “medi-medi” “Cal MediConnect”
  - Notification was confusing
  - Few received a health risk assessment
  - Lack of awareness about transportation benefit
  - Lack of awareness about care coordination options
  - Confusion about delegated entities
  - Uncertainty, fear, avoidance as a barrier to access
  - Better coordination in Cal MediConnect
  - Confusion over opting out
    - How to opt out?
    - What am I opting out of?

DESIGNING AN EVALUATION OF CAL MEDICONNECT

RTI evaluation

- CMS funded evaluation focuses on comparing dual alignment demonstrations across 12 states

- In California they will…
  - Describe the demonstration model and compare it to other states
  - Examine policies, procedures, MOUs and other documents
  - Monitor enrollment figures
  - Conduct 2 sets of site visits with state staff and stakeholders
  - 8 key informant interviews per year
  - Conduct 4 focus groups with beneficiaries
  - Analyze changes to healthcare utilization and costs

- RTI recommends “other entities” in the state conduct additional focus groups and representative telephone surveys.

Proposed California Evaluation

AIM 1: Engage meaningful stakeholder and policymaker input

- A project advisory group convened twice yearly to provide input on evaluation design, questionnaires, and interpretation of results
- Feedback loop with advisors, DHCS, and other dissemination

AIM 2: Identify the impact that the transition to Cal MediConnect has had on experiences with access to, quality of and coordination of care for dual beneficiaries.

- 15 focus groups in Year 1 to assess in-depth experiences of diverse duals
- A representative telephone survey with a sample of dual beneficiaries, comparing experiences in CCI versus non-CCI counties and measuring prevalence of experiences.

Proposed California Evaluation

AIM 3: Identify improvements in access to, quality of, and coordination of care that may emerge over time for dual beneficiaries.

AIM 4: Identify problems that may persist over time and require specific course correction.

A follow-up telephone survey with the same dual beneficiaries to assess changes over time.

Proposed California Evaluation

AIM 5: Examine organizational impacts and health system responses to the demonstration

- Key informant interviews with health plans, providers, advocates organizations, & CBOs that serve duals
- Follow up key informant interviews in year 2-3

AIM 6: Identify challenges, promising practices and recommendations to improve the coordination of care across sites for dual beneficiaries.

- County case studies to examine the relationship between beneficiary experiences and system response

Beneficiary experiences to assess…

- Experiences with notification and outreach
- Assistance received with enrollment/decision support
- Interactions with plan: member services, grievances, health risk assessment, and interactions with care team
- Knowledge of key CMC features such as: Continuity of Care provisions, new benefits (transportation, care coordination), right to change plans or opt out
- Beneficiary perceptions of care quality: changes in quality from FFS
- Beneficiary experiences with access to care: changes in access, barriers or facilitators to access
- Experiences with disability access, cultural appropriateness and language services in CMC
- Experiences with LTSS, self-direction and patient-centered planning of care
- Experiences with health plan care coordination services and integration of care
- Opting out: reasons for opting out and implications for care

Subgroups of interest

- Seniors
- Younger adults with disabilities
  - Functional impairment
  - Communication difficulties
  - Chronic conditions
- Those using LTSS
- Those who opted out
- Those using behavioral health
- Those using care navigation benefit
- Non-English speakers (threshold languages, ASL)
- Limited health literacy/limited English proficiency
- Homeless or marginally housed

Inclusive evaluation

- Importance of triangulation: focus groups, telephone survey, key informant interviews with advocates
- Focus groups:
  - Variety of recruitment methods: CBOs, health plans, data from state
- Telephone survey:
  - Excludes people with no phone
  - Offer alternative formats: relay communication, text, PDF, health care proxies
- Document who is NOT included

Thank you for your attention

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