CALIFORNIA HEALTHCARE FOUNDATION

April 2014

Issue Brief

In Transition: Seniors and Persons with Disabilities Reflect on Their Move to Medi-Cal Managed Care

Introduction

In 1994, California began transitioning large segments of its Medi-Cal (Medicaid) population from traditional fee-for-service (FFS) to special Medi-Cal managed care (MMC) health plans. By 2013, 30 counties administered Medi-Cal to most beneficiaries through mandatory managed care. In 16 of these counties, including nine of the state's 10 most populous counties, seniors and people with disabilities (SPD) were originally exempted from this mandate and allowed to stay in FFS Medi-Cal.[1] In November 2010, California received federal approval for a Section 1115(a) "Bridge to Reform" waiver that allowed the state for the first time to require Medi-Cal-only SPDs in all counties with Medi-Cal managed care to receive their Medi-Cal coverage through these managed care health plans.[2]

The California Department of Health Care Services (DHCS) implemented the transition of Medi-Cal SPDs to managed care in the 16 counties in June 2011.[3] Each of these counties offered a choice of at least two health plans. Beneficiaries were notified by mail that they were required to choose an MMC plan or they would be assigned to a plan. By May 2012, approximately 240,000 Medi-Cal-only SPDs were enrolled in mandatory MMC plans.[4] DHCS records show that approximately 40% of beneficiaries made an active choice, while the other 60% were either defaulted to a plan or assigned to a plan based on a previous relationship with a network provider.[5]

Some evidence suggests that managed care might ultimately improve care coordination and access. But the transition of seniors and beneficiaries with disabilities to managed care poses numerous challenges and risks, such as disruptions in care that could be particularly difficult to overcome for this population which has high levels of disability, multiple chronic conditions, and high care utilization.[6] As part of a multi-faceted approach to assess the transition, DHCS, with the support of the California HealthCare Foundation, engaged researchers from the University of California, Berkeley to conduct an evaluation of beneficiaries' experiences during and immediately following their move to managed care.

The primary objectives of this evaluation were threefold. The first objective was to examine beneficiary experiences with the transition, including notification, choice of plans, and enrollment processes, and to identify opportunities for supporting SPD beneficiaries and improving the transitions of other Medi-Cal populations to managed care, such as enrollees in rural counties and those dually eligible for Medicare and Medi-Cal. The second objective was to examine beneficiary experiences accessing care in their new managed care health plan, including continuity of care and access to providers, medical equipment, mental health care, and prescription medications. Several survey questions asked beneficiaries to compare their experience (e.g., access to appointments) in their managed care plan with their prior experience in fee-for-service Medi-Cal; for other questions (e.g., plan navigation), a comparison was not relevant. The third study objective was to identify subgroups of beneficiaries who had greater difficulty with the transition than others, so that they could be targeted for additional assistance or new approaches.

To achieve these study objectives, researchers conducted a representative telephone survey with 1,521 SPD beneficiaries or their health care proxies in the 16 transition counties.[7] The survey was conducted in English and Spanish and accommodations were offered to encourage participation by those with communication challenges. To identify characteristics of beneficiaries who reported negative experiences, DHCS provided a dataset that included chronic disease claims data for the telephone survey participants, and analysis was conducted to identify associations between beneficiary health conditions and their experiences with MMC. Additionally, 54 beneficiaries or caregivers participated in qualitative focus groups or qualitative interviews. These were conducted specifically with individuals who were not included in the telephone survey, including beneficiaries who were homeless or marginally housed, those on dialysis, and those who spoke Armenian, Cantonese, or Vietnamese. Focus group responses are not reflected in the percentages shown throughout this issue brief, which represent only survey responses.

There are several limitations to this study. The experiences reflect self-reported responses by beneficiaries. Complementary evaluation methods, such as analysis of utilization data prior to and after the transition, would have been valuable but were beyond the scope and time frame of this study. Also, the study was conducted when beneficiaries had been enrolled in managed care for only six to 16 months; therefore, responses reflect a period when many beneficiaries were relatively new to their managed care plan. Other study limitations and a detailed discussion of this project's methodology, findings, and conclusions, are available in the report *Transitioning Seniors and People with Disabilities to Medi-Cal Managed Care: The Beneficiary Perspective* [www.healthresearchforaction.org] which can also be found on the website of the Health Research for Action Center of the University of California, Berkeley, School of Public Health [www.healthresearchforaction.org].

Beneficiaries' Experiences Enrolling in a Plan

Transition Notification

DHCS notified beneficiaries that they would be required to transition to an MMC plan through a series of letters and follow-up phone calls. The first notification letter was sent 90 days before a beneficiary's enrollment deadline (based on birth month), followed by a second letter and information packet 60 days prior to the deadline, and a final written notification 30 days before the deadline for those who had not yet actively chosen a plan. Beneficiaries who had not enrolled as their deadline approached were also called on the telephone to encourage an active choice.

Most beneficiaries (69%) responding to the survey recalled receiving a notification letter or packet in the mail, 13% heard about the transition from someone at a doctor's office, clinic, or hospital, and 5% learned through a phone call. Less than a tenth (9%) of beneficiaries said that they received no notification information at all. Beneficiaries who were more likely to say they were not notified of the transition included those in "poor" self-rated health and those who enrolled in the later months of the transition.[8] Beneficiaries who were more likely to rate the information they received as "not useful" were those with self-reported functional impairment or mobility difficulty, and those who had been on Medi-Cal FFS longer-term (for at least two years before the transition).

Beneficiary Choice of Plans

Generally, beneficiaries who make an active choice of health plans during a coverage transition have better experiences accessing care and higher satisfaction with their plan. In the case of the SPD transition to MMC, beneficiaries were offered a choice of at least two managed care plans in their county. Approximately half of the beneficiaries in the study said they chose a plan, and almost all (96%) of those said that they got the plan they chose. Beneficiaries who did not choose plan by the deadline were assigned to a plan. The beneficiaries who were most likely to say they were assigned to a plan included those with self-reported cognitive impairment, those who had visited an emergency department (ED) since the transition, those who were enrolled into MMC in the later months of the transition, and those who had been continuously enrolled in Medi-Cal for over two years prior to the transition.

Beneficiaries who were notified of the transition but did not choose a plan reported the barriers that prevented them from making an active choice. About a third (34%) of this group said they did not choose because they did not understand from the notification materials that they had a choice between plans. Groups who were less likely to know they could choose included African Americans, people taking prescription medications, those who reported visiting the ED since the transition, and those with limited health literacy.

Other reasons cited by beneficiaries who did not choose a plan were:

- 22% did not realize that they could not stay on original Medi-Cal FFS.
- 15% believed they did not have enough information to choose.
- 11% believed the plans all seemed the same.
- 9% let Medi-Cal choose for them, some reporting that "it didn't matter that much."
- 8% reported that their doctors were not on either/any of the plans.
- 7% worried about making a bad choice.
- 7% reported that they did not have enough time to choose.
- 6% could not read or understand the information.
- 6% reported that they were ill, hospitalized, or in personal crisis at the time.

Over a third (35%) of those who understood they could choose said that it was "very" or "somewhat" difficult to find information about the plans from which they had to choose.

Only 17% of beneficiaries said that the information in the notification packet was "not at all useful." Nonetheless, slightly over half (51%) of beneficiaries reported that the notification materials left unanswered one or more questions they had about the transition. The most common unanswered questions were: "Why is this transition happening?" "Can I stay on regular Medi-Cal?" and "How will this transition affect my benefits, costs, medications, or physicians?"

Beneficiaries "Linked" or "Defaulted" to a Plan

In the transition of SPDs to managed care, DHCS anticipated that many beneficiaries would not actively choose a plan. DHCS attempted to ameliorate the effects of non-choosing by "linking" beneficiaries, where possible, to plans in which past utilization data showed that the beneficiary had some relationship with an affiliated provider. To do this, DHCS attempted to identify one top provider for each beneficiary based on number of visits and total reimbursed expenses for that beneficiary. Those beneficiaries for whom a top provider could not be identified, or whose top provider was not affiliated with a plan or was affiliated with both plans in the county, were assigned ("defaulted") to a plan based on a default algorithm.[9]

To determine whether the linking intervention was successful, researchers compared linked beneficiaries to choosers and defaulters. If the intervention had been successful, linked beneficiaries' results would have been similar to active choosers and significantly different than the experiences of defaulters. Unfortunately that was not the case. Instead, the comparison revealed that those who were linked had worse self-reported outcomes in almost all areas compared to those who chose. In particular, those who were linked had less knowledge about how to navigate their plan, were more likely to report being "very dissatisfied" with their MMC benefits, and rated their quality of care as worse than those who chose a plan. Though "linkers" and "choosers" were similar in their rates of having to switch doctors, linkers were more likely than choosers to report difficulty accessing appointments with providers in MMC. Moreover, beneficiaries linked to a plan reported that their experiences on most measures were similar to those who were defaulted into a plan.

Consumer Protections

As the transition was planned, certain mechanisms were implemented to help protect beneficiaries. The Continuity of Care Provision (COCP) was one of these. This protection allowed beneficiaries who were transitioning to managed care to request to continue seeing a non-network FFS provider for up to 12 months, if the provider agreed to accept the managed care plan's rates. However, it turned out that during the transition there were very few applications for COCP — telephone survey results showed that only 17% of SPD beneficiaries were even aware that they could apply for this protection.

A Medical Exemption Request (MER) was another form of consumer protection. Unlike the COCP, in which the beneficiary actually transitioned to an MMC plan, an MER would allow a beneficiary to stay on FFS Medi-Cal if a medical condition warranted an exemption. Contrary to the experience with COCP, a high number of individuals applied for an MER.[10] Analysis showed that beneficiaries who filed and were denied MERs were different than non-MER-filing beneficiaries in that they were more likely to:

- Be female, white, and have a high school education
- Be in "fair" or "poor" self-rated health
- Have at least one chronic condition
- Use specialty care
- Have a functional impairment that impedes access to medical care

Another provision designed to protect consumers allowed beneficiaries to switch managed care plans at any time. However, less than half (45%) of survey respondents reported that they knew of this provision, and only 6% reported that they had changed plans in the six to 16 months after transition. Those beneficiaries more likely to have switched plans included those who reported at least one specialty care appointment since they transitioned, those with self-reported cognitive impairment, those who reported they called the managed care plan's member services since transition, and those using In-Home Supportive Services.[11]

Consumers are offered several avenues for filing complaints within their new MMC plan. However, there were low levels of knowledge about these complaint processes. A little over half (53%) of beneficiaries knew they could file for a state hearing if they had a problem with their care — the same complaint process they would have used previously in the FFS system. Less than a third (30%) of beneficiaries knew that they could contact the MMC ombudsman, while 45% knew they could file a grievance with the plan itself. Those who used specialty care or called member services were the most likely to know about the available complaint processes. People who were less likely to know how to file complaints included African Americans, those with functional impairment, and those with limited health literacy. Not surprisingly, given these low knowledge levels, very few (8%) beneficiaries reported that they had filed a complaint of any kind since the transition. Those who filed complaints tended to be those who were in the poorest health.

Care Coordination and Access

Overall Satisfaction and Perceived Quality

Overall, two thirds (66%) of beneficiaries said they were "very" or "somewhat" satisfied with their care in their new plan. However, 10% said they were "somewhat dissatisfied" and 21% said they were "very dissatisfied." Though basic benefits in FFS and MMC are considered comparable, 20% of beneficiaries reported that their overall benefits in MMC were better and 32% said the benefits were worse than in FFS. Some of the negative response may have been due to the suspension of Medi-Cal dental care benefits, which were discontinued at approximately the same time as the transition.

Similar results were found when comparing beneficiaries' perceived quality of care in MMC compared to FFS. About 20% said quality of care was better in MMC and an equal proportion (21%) said quality was worse. The beneficiaries who were the most dissatisfied and who perceived benefits or quality of care as worse were more likely to be African American, in "poor" self-rated health, have functional or cognitive impairment, or had ED visits since the transition. Further, longer-term Medi-Cal enrollees (continuously enrolled for over two years before the transition) were more likely to say that their quality of care was worse than those who were newer to Medi-Cal.

One of the factors highly related to satisfaction with managed care in general is lower out-of-pocket expenses.[12] Though MMC theoretically should result in fewer out-of-pocket expenses for Medi-Cal beneficiaries (since there are no co-pays for medications as there are in FFS), 19% of beneficiaries in this study reported that their out-of-pocket expenses were higher in MMC, whereas 11% reported they were lower. Beneficiaries reported that the increase in expenses was often due to factors such as Medi-Cal no longer covering a specific prescription medication brand or dosage which the beneficiary continued to use, or a beneficiary continuing to see a familiar provider who did not participate in the new MMC plan, resulting in the beneficiary paying out of pocket. Some beneficiaries also reported paying increased transportation costs to reach providers who were farther away.

Plan Navigation and Care Coordination

A primary reason to transition beneficiaries from FFS to managed care is that health plans feature care coordination services that can facilitate beneficiaries' access to care and reduce duplication of services. As an initial step toward increased care coordination for SPDs, MMC health plans were required to call each new beneficiary after enrollment to conduct a health risk assessment. This assessment, designed by each individual plan, asked questions intended to identify beneficiaries who were in need of immediate or specialized medical care. However, only slightly more than one third (37%) of beneficiaries reported receiving a call from their new plan. Beneficiaries with the highest self-reported specialty care and acute care utilization since the transition were more likely than those with lower utilization to remember getting an assessment call from their plan.

Plans also offer support to beneficiaries through member services phone lines. Overall, 33% of beneficiaries reported that they had called their plan's member services since the transition. Women, those who live alone, those who use medical equipment, and those who reported visiting the ED since the transition were among the most likely to report calling member services. Not surprisingly, beneficiaries who had negative experiences with care were more likely to call member services. It is important to note, however, that certain groups were less likely to call member services, including Latinos and those with limited health literacy. The low rate of contact with member services by these groups is especially concerning because these same populations also report negative experiences with managed care which might have been ameliorated through health plan support. Focus group results showed that experiences with member services varied from county to county. In some focus groups, participants expressed frustration with push-button menus, recorded messages, long hold-times to reach a human being, and being cut off.

Accessing care through a managed care delivery system often requires a different set of skills and knowledge than accessing care through FFS. Having been in their managed care plan for six to 16 months at the time of this study, a large majority of beneficiaries reported that they knew how to get a prescription filled (90%) and how to make an appointment with their primary care physician (82%). However, knowledge about access to care dropped steadily with other access tasks. Only 70% of beneficiaries reported that they knew how to get the tests and treatments they need, 66% knew how to get health advice from a nurse or doctor over the phone, 63% knew how to find a doctor, and 57% knew how to make an appointment with a specialist in the plan or how to get medical equipment and supplies. Even more concerning are results that show that many of the groups with the highest health care needs — including seniors, Latinos, African Americans, those in "poor" self-rated health, those with functional or cognitive impairment, and those with limited health literacy — are also those less likely to report that they know how to navigate their care.

Care coordination provided through managed care plans has the potential to provide beneficiaries with more assistance in finding doctors and facilitating access to appointments, tests, and treatments. The results of this study, however, indicate that MMC did not meet that potential for SPDs during the transition period examined. Only 16% of beneficiaries reported that they got more help accessing appointments, tests, and treatments in MMC than they did in FFS, 56% reported that the help they got was about the same, and 21% reported getting less help in MMC. Beneficiaries who reported using specialty care since the transition were the most likely to say they were receiving more help through the MMC plan. However, results also suggest that those likely to be most in need of assistance were the ones least likely to report receiving more help, including those with "poor" self-rated health, functional limitations, or limited health literacy, as well as long-time Medi-Cal beneficiaries (those who had been continuously enrolled in Medi-Cal for two years or longer before the transition).

Primary and Specialty Care

A big concern when transitioning a population with complex care needs to a new delivery system and provider network is the potential for disruptions in care. At the same time, there is recognition that defined provider networks can be an important tool for managed care plans to ensure quality and control costs. Overall, 36% of participants in the MMC transition reported that they had to change primary care providers from those they saw in FFS and 62% said they had to change some or all specialists.

Theoretically, managed care health plans should facilitate beneficiaries' access to appointments, especially considering that many regions have a shortage of providers who accept FFS Medi-Cal. However, results of this study show that very few beneficiaries reported that access to appointments for primary or specialty care (about 17% for both) was easier in MMC than it had been in FFS.[13] About two thirds (63%) of beneficiaries rated access to primary care in MMC as "about the same" as in FFS while a smaller proportion (54%) said accessing specialty care was about the same. On the other hand, 29% of beneficiaries said that accessing specialty care was "more difficult" in MMC and 20% said the same of primary care. Those with cognitive deficits, high ED use, and longer-term Medi-Cal enrollees (those who had been on Medi-Cal two years or more before the transition) were the most likely to say that accessing appointments in MMC was more difficult than in FFS. Focus groups identified the required authorization process as one of the factors impeding access to specialty care. This process was new for many beneficiaries, and many experienced delays in referrals to specialists.

Medical Equipment and Supplies

Over one third (38%) of this study's respondents relied on medical equipment such as wheelchairs, commodes, and lift equipment in order to live independently in the community. Many also used medical supplies for incontinence and blood sugar testing. Disruptions in access to medical equipment or supplies can result in detriment to the comfort and quality of life of beneficiaries who rely on them, and even create serious health hazards. Approximately a third (36%) of those using medical equipment and supplies said that access to these items had become more difficult in their new MMC plan. About half (53%) said access was the same under both systems, and 11% said it was easier to get equipment since the transition.

Prescription Medication

Most beneficiaries in this study relied on prescription medications to manage their conditions. Over half (59%) of those using prescription medications were able to keep all their medications the same after the transition, while 41% had to change some or all medications. Only 15% reported having to change pharmacies. Most beneficiaries (59%) said accessing medications was the same in MMC as it had been in FFS, while 18% said it was easier, and 21% said it was more difficult. In the focus groups, there was much dissatisfaction expressed about being made to switch from brand to generic drugs.

Emergency Department Visits

In general, it is believed that better access to primary care can reduce the frequency of more expensive ED visits, especially for non-emergencies. In this study, approximately half (54%) of beneficiaries reported that their ED use had not changed since the transition while almost a third (31%) said that they had used the ED less since the transition. In particular, Latinos, those using In-Home Supportive Services, and those who use medical equipment reported using the ED less since the transition. Approximately 11% said they used the ED more since the transition, including those with diabetes and those with functional impairment.

Mental Health Care

Many SPDs have multiple diagnoses, including not only physical but also mental health and substance abuse disorders. Though specialty mental and behavioral health services are "carved out" (provided not through Medi-Cal but through county mental health clinics), many common "non-specialty" mental health conditions such as depression and anxiety are often treated by primary care doctors and thus may have been affected by the transition to MMC. Of the 36% of beneficiaries in the telephone survey who self-reported using any mental health care, 23% said that the transition affected that care, most often negatively in ways such as changes to medications, changes to providers, and more limited or lower quality of care.[14]

Researchers also received a dataset with Mental Health (MH) and Serious Mental Illness (SMI) claims covering calendar year 2010. Those with such claims were more likely to say they knew how to get medical advice over the phone in MMC than those with no claims. And while those with SMI claims said they had more trouble in MMC getting access to primary care appointments, they were less likely to have to change primary or specialty doctors than those with no claims. Also, those with MH or SMI claims were more likely to say that their providers' understanding of their condition was better or about the same in MMC.

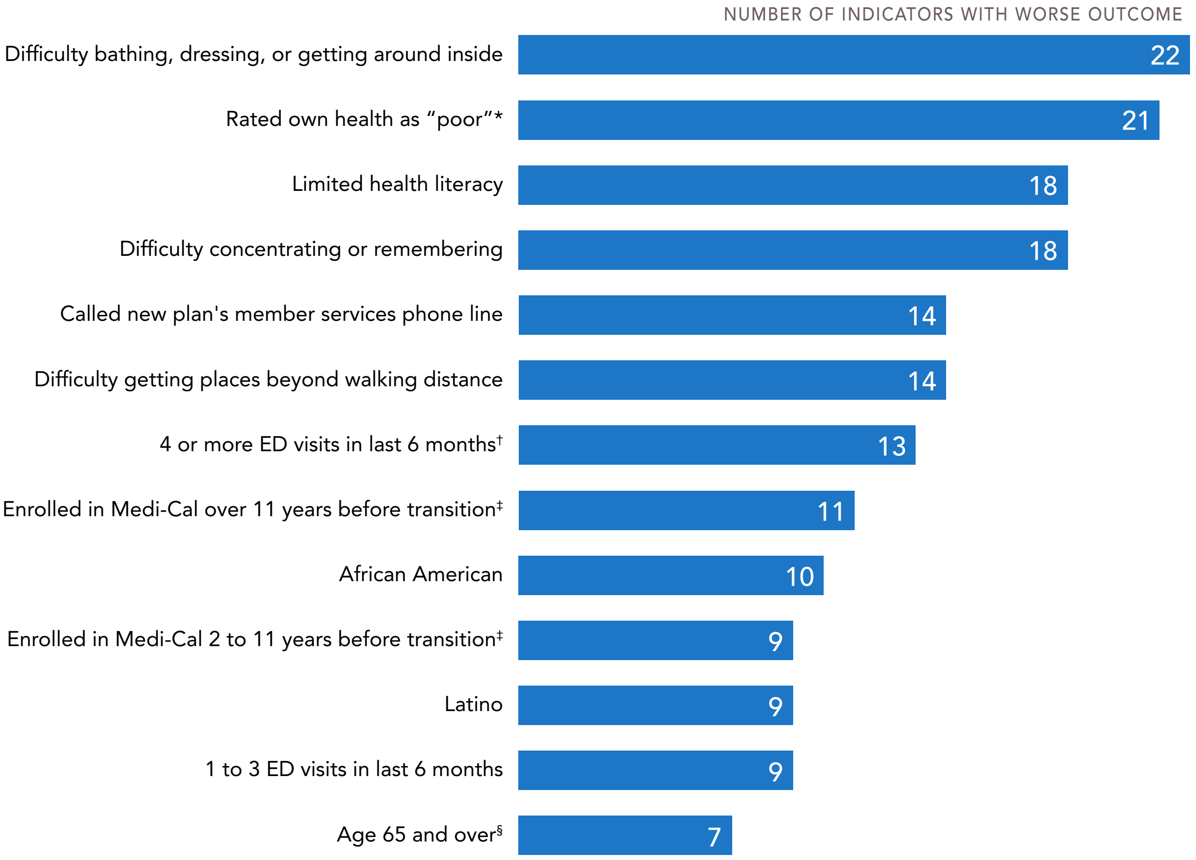
Subgroups' Experiences with the Transition

In order to provide actionable results that allow DHCS, health plans, and other stakeholders to target assistance to beneficiaries who may need additional support during their transition to managed care, this study identified subgroups of beneficiaries who appear to have had more difficulty with the transition and those who had an easier transition. Logistic regression was conducted with 46 dependent variables that were considered indicators of a poor transition. Several independent variables describing beneficiary characteristics (both self-reported and administrative data) were used to identify which subgroups had a higher likelihood of reporting poor transition experiences, and thus should be monitored closely post-transition and in future transition processes. Subgroups that had a lower likelihood of reporting poor transition experiences were also identified.

Subgroups that had a higher likelihood of reporting poor transition experiences on five or more indicators include beneficiaries who:

- Rated their health status poor
- Have activity and mobility limitations
- Have difficulty reading written health care materials
- Were continuously enrolled in FFS Medi-Cal for over two years prior to the transition

Figure 1. Subgroups with Worse Experiences



*Compared to beneficiaries who rate their health as "excellent" or "good".

†Compared to beneficiaries who did not visit the ED in the last six months.

‡Compared to beneficiaries enrolled in Medi-Cal less than two years before transition.

§Compared to adults age 18 to 64.

Notes: Includes subgroups that were more likely to report negative experiences on 5 or more measures. Results of multivariate logistic regression and bivariate chi squared tests. In multivariate analysis, results control for health status and demographics. Subgroups defined as less likely if odds ratio was greater than 1. Findings with a p value less than 0.05 were considered significant.

Source: Health Research for Action Center of the University of California, Berkeley, School of Public Health, *Transitioning Seniors and People with Disabilities to Medi-Cal Managed Care: The Beneficiary Perspective*, www.healthresearchforaction.org.

- Have difficulty concentrating due to physical or emotional conditions
- Called member services after transitioning to managed care
- Had at least one visit to the ED within the previous six months
- Are African American
- Are Latino
- Are age 65 or over

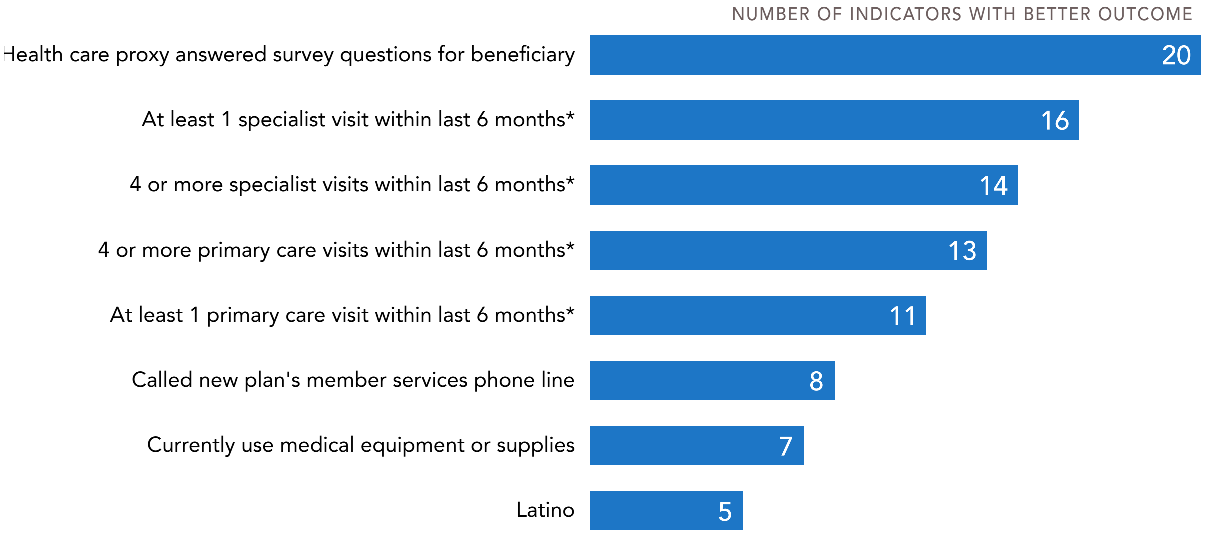
For a graphic representation of these subgroups' experience, see Figure 1 on the previous page.

Subgroups that had a lower likelihood of reporting poor transition experiences on five or more indicators (see Figure 2) include beneficiaries who:

- Had a proxy respond to the survey on their behalf
- Had one or more visits to a primary care physician or specialist in the previous six months
- Called member services after transitioning to managed care[15]
- Use medical equipment
- Are Latino

Findings for these subgroups are discussed below in greater detail.

Figure 2. Subgroups with Better Experiences



*Compared to beneficiaries with no visits in the last six months.

Notes: Includes subgroups that were less likely to report negative experiences on five or more measures. Results of multivariate logistic regression and bivariate chi-squared tests. Significant results with p-values less than 0.05.

Source: Health Research for Action Center of the University of California, Berkeley, School of Public Health, *Transitioning Seniors and People with Disabilities to Medi-Cal Managed Care: The Beneficiary Perspective*, www.healthresearchforaction.org.

More Time in Managed Care Ameliorates Some Negative Experiences

Researchers in this study compared those who had been in MMC the longest versus those who had been in MMC the fewest months at the time of the survey. The self-reported experiences of beneficiaries who had been in MMC the shortest time (only six to nine months at the time of the survey) were generally worse than those of beneficiaries who had been in managed care longer, such as being more likely to report that they did not know how to make appointments with specialists, more likely to change some or all specialists, and more likely to report that quality of care is worse in MMC than it was in FFS.

Conversely, those who had been in their MMC plan longer (between 13 and 16 months at the time of the survey) reported better experiences with the transition in almost all areas. They were less likely than the shorter-term enrollees to report dissatisfaction with specialty care or with quality of care. However, they were more likely to say that they did not know they had a choice of plans and less likely to remember getting a call from the plans, which could be attributed to poorer recall due to a greater number of months since transition. In sum, these results may suggest that problems with access to specialists may be ameliorated and perceptions of quality of care may improve for many beneficiaries the longer they are in their MMC plan. And that, in turn, would suggest that beneficiaries would benefit most from support during, and in the first few months after, transition.

Poor Health/Chronic Conditions

The survey asked beneficiaries to self-report whether the overall quality of their health was "excellent," "good," "fair," or "poor." Those who reported their health as "poor" were more likely than those in better health to respond that they were not notified of the transition, that they lacked knowledge in many areas of plan navigation, and that they receive less help with care coordination in MMC than they did in FFS. Beneficiaries in "poor" health were also more likely than those in better health to report that they changed doctors and prescriptions because of the transition and were more likely to report difficulty making appointments with providers in MMC. They were also more likely to report that their overall benefits and quality of care were worse in MMC. As would be expected, those in poor health were more likely to file a complaint following the switch. Also, beneficiaries with any chronic condition claims (in calendar year 2010) were more likely than those with no chronic condition claims to report negative experiences in the areas of notification, enrollment, and access to care after the transition.

Functional Impairment and Mobility Challenges

Another group that had a difficult time during the transition was people with self-reported functional impairment. Beneficiaries who reported that they needed assistance with bathing, dressing, or getting around inside the home were compared to those who said they did not need such assistance. Beneficiaries with functional impairment had significantly higher odds of saying that:

- The notification material was not useful.
- They did not actively choose a plan.
- They did not know how to access medical supplies, tests, and treatments in MMC.
- They had to change specialty doctors and had difficulty accessing specialty appointments and medical equipment and supplies in MMC.
- They visited the ED more frequently after the transition.
- Their disability access in doctors' offices and their physicians' understanding of their condition was worse in MMC.
- Though they were less likely to be aware of the health plan grievance process, they were more likely to file a complaint following the switch to MMC.

The subgroup that self-reported having "mobility challenges" — difficulty getting to places beyond walking distance — was more likely than those with no mobility challenges to report that access to physician appointments and getting prescription medications was more difficult after the transition. This group was also more likely than those without mobility challenges to report increased ED use, changing specialty doctors, and increased out-of-pocket expenses following the transition.

Both those with functional impairments and those with mobility challenges were more likely to report that benefits and quality of care in MMC were worse than in FFS and that they were dissatisfied with care in MMC overall.

Cognitive Impairment

Transitioned beneficiaries with self-reported cognitive impairment (difficulty concentrating or remembering) were more likely than those with no cognitive impairment to say that they were assigned to a plan rather than having chosen one. They also reported that they:

- Were more likely to have trouble finding information about their MMC choices
- Had significantly lower knowledge of MMC plan navigation measures
- Were more likely to have changed plans since their original MMC assignment
- Got less help finding the doctors and getting the tests and treatment they needed in MMC
- Had more difficulty accessing primary care appointments and prescription medications
- Had more out-of-pocket expenses and increased ED use since the transition
- Had worse benefits and quality of care in MMC

Also, beneficiaries with a claim (in 2010) for a developmental disability were more likely to report changing medical equipment suppliers because of the transition and were more likely to say that access to these supplies was more difficult in MMC.

High Health Care Utilization

Outpatient and acute care health services utilization for the six months prior to the survey in this study was self-reported by beneficiaries. Those who had high outpatient care utilization (four or more primary or specialty visits in the six months prior to the survey) reported better knowledge of plan navigation than those with fewer outpatient appointments. Those with at least one specialty visit since the transition were more likely to report positive experiences than those with no specialty care appointments, including getting a call from their MMC plan and getting more help accessing care in MMC than in FFS. Conversely, those with no specialty appointments were more likely to report they had more trouble accessing specialty visits in MMC than in FFS.

Those with high utilization of the ED (at least four visits in the six months prior to the transition) were less likely than those with fewer ED visits to actively choose a plan. Frequent use of the ED after transition was also associated with many negative experiences and perceptions of care. These higher users of the ED were more likely to report that:

- They did not get a call from their plan.
- They got less help with access to care in MMC than they had in FFS.
- They changed primary care physicians, specialists, or prescription medications after the switch.
- Access to outpatient appointments and prescriptions was more difficult after the switch.
- Their use of the ED was greater in MMC than in FFS.
- Their providers' understanding of their condition was worse in MMC than in FFS.
- Their overall benefits and quality of care were worse in MMC than in FFS.

Seniors

Because this study included only those seniors who were not enrolled in Medicare, the over-65 group was a small proportion (11%) of the survey population.[16] In this evaluation, seniors were compared to younger adults (age 18 to 64) with disabilities. Results showed that seniors were more likely to report that they did not understand they had a choice between different MMC plans, less likely to report knowledge of most plan navigation skills, and less likely to know how to get medical advice over the phone or to call member services. On the positive side, however, seniors were less likely to report changing prescriptions after the transition and less likely to report an increase in ED use in MMC.

Longer-Term Medi-Cal Eligibility Before Transition

Those beneficiaries who had been on Medi-Cal FFS for over 24 months before they were transitioned to managed care had worse experiences in many areas than shorter-term enrollees, including reporting that:

- Information on their choices was difficult to find and enrollment materials were not useful.
- They were less likely to make an active choice of plan, and when they did choose, they were less likely to get the plan they chose.
- They got less help with accessing care in MMC than they had in FFS.
- They had to change prescription medications and accessing prescriptions was more difficult.
- They were more likely to be dissatisfied with their MMC benefits and rated their overall

quality of care as worse in MMC than it had been in FFS.

Beneficiaries who had been continuously enrolled in Medi-Cal even longer (over 136 months before transition) had additional negative experiences, including reporting that:

- Getting access to primary care and specialist appointments was more difficult in MMC.
- They got "less help" accessing care in MMC.
- Their physicians' understanding of their condition was not as good in MMC as in FFS.
- They rated their overall benefits in MMC as worse than in FFS.

These results may indicate that longer-term FFS Medi-Cal beneficiaries had learned over time how to use FFS and were doing well accessing care in that system, making the transition to managed care particularly disruptive. Further, beneficiaries who had only been in FFS Medi-Cal less than two years may have had more recent experiences with managed care (through employer-based or private pay insurance) before they became enrolled in Medi-Cal, which may have improved their ability to navigate and access care in that system.

Limited Health Literacy

Health literacy, as defined by the Institute of Medicine, is "the degree to which an individual has the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions."[17] A 2003 national survey showed that approximately 36% of adults in the United States have limited health literacy.[18] Limited health literacy is especially prevalent in Medicaid populations, where a quarter of beneficiaries reads at or below the fourth grade level, compared to the eighth grade average reading level of US adults generally. Limited health literacy is associated with poor compliance with medical instructions, poor health outcomes, and higher health care costs.[19] For this reason, several provisions of the Patient Protection and Affordable Care Act acknowledge the need for greater attention to health literacy and to clear communication of health and health care information.[20]

Health literacy was measured in the telephone survey with a question asking respondents to report how often they have trouble reading or understanding written health-related information. As expected, those respondents with limited health literacy were less likely to understand from the notification materials that they had a choice of MMC plans and were more likely to say that it was difficult finding information about the plans. This group also had fewer plan navigation skills and less knowledge of consumer protections, and were less likely to call their new plan's member services. They reported that they were more likely to have to switch pharmacies, use the ED, have more difficulty communicating with their providers, and have more difficulty with physical access at their provider's office since the transition to MMC.

Managed care delivery systems are designed to provide more assistance to beneficiaries in the form of care coordination and member services supports than people receive with FFS coverage. But those with limited health literacy in this study reported that they actually received less help accessing care in MMC than they had in FFS, a finding that is particularly concerning given that this is a population in particular need of assistance with plan navigation. Given the problems with navigation and access to care reported by beneficiaries with limited health literacy, and the evidence showing the relationship to higher health care costs for this population, greater monitoring and assistance should be provided to beneficiaries with limited health literacy, especially during and after a transition to a new, more complicated health care delivery system.

African Americans

African Americans accounted for approximately 21% of the beneficiaries sampled in the telephone survey. Their experiences with the transition were mixed. With regard to plan navigation, there were many areas where African American respondents reported lower levels of knowledge than White beneficiaries. For example, they were more likely to report they did not know how to find a doctor or make an appointment in MMC. African Americans were also less likely to know that they had a choice of MMC plans. On the other hand, African Americans were more likely to report knowing how to get medical equipment and supplies and medical advice over the phone in MMC than their White counterparts.

African Americans reported that getting an appointment with a specialist in MMC was more difficult than in FFS, disability access at their doctors' offices was worse, and they were more likely than White beneficiaries to say their benefits and quality of care were worse. Also troubling is that African Americans were less likely to know about the various complaint processes available to them and were also significantly less likely to file a complaint of any kind than White beneficiaries. This may suggest that complaint reporting among African Americans was lower than was warranted, given their problems accessing care.

Latinos

About 21% of the sample took the survey in Spanish, a variable that was significantly correlated with being Latino, having fewer years of formal education, and having limited health literacy. Of these respondents, 13% reported that they usually or always have difficulty communicating with a doctor in their MMC plan because of language barriers, while 21% reported they sometimes had difficulty, and 62% said they never had language issues. However, only 11% of Spanish-speakers said that it was more difficult to get a translator in MMC than it had been in FFS, while 22% said it was easier.

Latinos' experiences with the transition were mixed. On one hand, they were less likely to report knowing how to navigate their care in all areas. Despite this, they were less likely to report dissatisfaction with benefits and more likely to report that quality of care was better or about the same in MMC. They were less likely to report increased ED use since the switch and less likely to report that getting prescriptions was more difficult. Despite the fact that they were less likely to report calling their plan's member services, they were more likely to say that the help they received was the same or better in MMC than in FFS, and they were less likely to file a complaint.

Proxy Respondents

Beneficiaries were given the option to have a surrogate or "proxy" respond to the telephone survey or attend a focus group on their behalf if that person was responsible for making their health care decisions. Typically, someone who had a proxy respondent was in very poor health or had a cognitive or intellectual disability that prevented them from making their own health care decisions. Proxies reported that their beneficiaries had better transition experiences in a variety of areas than beneficiaries with no proxy. Beneficiaries with proxies were more likely to choose a plan, know how to navigate their plan, and get medical advice over the phone from their managed care doctor or nurse than those who answered the survey themselves. They were less likely to report problems accessing primary care, specialty care, or prescription medication after the transition. These better experiences are likely due to the fact that the beneficiaries who had a surrogate or proxy respond to the survey also may have received assistance from that proxy, or another, with their transition choices and plan navigation.

Policy Implications

A primary objective of this study was to identify the characteristics of beneficiaries who could benefit from additional support during delivery system transitions. Results suggest that special attention be paid to a number of matters with regard to both monitoring the current SPD population in MMC and assisting future vulnerable populations transitioning to managed care for the first time. DHCS has already used a number of these findings to inform planning for other transitions (see "DHCS Uses Lessons to Improve Transitions" on page 13).

Additional Support and Monitoring for Specific Vulnerable Groups

As discussed in the sections immediately above, groups in the worst health are in need of the most support. In this study, beneficiaries with "poor" self-rated health, chronic illness, functional impairment, mobility barriers, and cognitive impairment had more negative experiences in almost all areas of the transition and subsequent access to care than their counterparts in better health. Also, seniors and people with limited health literacy needed additional assistance with managed care plan notification, plan choices, and initial plan navigation.

Most enrollees in these groups can be easily identified through administrative data or by simple, self-reported responses to questions that could be added to a health risk assessment conducted by plans. Since specific groups, such as those with limited health literacy and those who do not make an active plan choice, are also likely to experience barriers in contacting plans for assistance, DHCS and health plans can be proactive in contacting these individuals to offer them help.

DHCS Uses Lessons to Improve Transitions

When early findings from this study were made available to DHCS, the department reports that it began to act upon them to inform and improve the:

- Transition to Medi-Cal managed care of people enrolled in the Low Income Health Program (LIHP)
- Transition to Medi-Cal managed care of children enrolled in Healthy Families
- Expansion of Medi-Cal managed care to 28 additional counties
- Transition of dual-eligible SPDs to Cal MediConnect plans
- Inclusion in Medi-Cal of a new mental health benefit

In response to findings that many beneficiaries were not aware of their continuity of care rights during the SPD transition, DHCS created a continuity of care web page that includes helpful information for both beneficiaries and providers [www.dhcs.ca.gov]. A flyer also has been developed which informs beneficiaries of their continuity of care rights and explains how they and providers can obtain additional information.

Further, DHCS acted upon study findings that indicated it should provide health plans with data on their new members' past health care utilization (in Medi-Cal FFS) before the date of enrollment in managed care (while ensuring that all privacy rights were protected). When provided in this more timely manner, health plans and providers can use these data to more expeditiously identify higher-risk and/or harder-to-reach beneficiaries.

With a better understanding from the survey that the provider office is where many beneficiaries are reached with information about transitions and other changes, DHCS designed a new outreach strategy that targets providers. This strategy features webinars and in-person meetings to strengthen relationships between DHCS and participating providers.

DHCS has also created a more robust stakeholder feedback process to elicit information from stakeholders regarding notices to beneficiaries. Through meetings and comment solicitation, stakeholders have had unprecedented input on notices and other education materials. This is just one aspect of a larger stakeholder consultation effort by DHCS that has involved frequent educational webinars and consultation meetings.

DHCS is committed to an ongoing effort to apply lessons learned from this study as the department strives to ensure the use of innovative and best practices across all aspects of its Medi-Cal managed care program.

Source: California Department of Health Care Services.

Improved Contact Information

Medi-Cal beneficiaries are most likely to learn about a transition through the written notification that is mailed to them from the state. Incorrect or missing beneficiary contact information can be an impediment to written notification. In this study, only beneficiaries with complete addresses on file were included in the telephone survey, yet only about 30% of respondents reported that they recall receiving mailed notification materials about the transition. On the other hand, 13% learned about the transition through a provider. Community-based organizations and the health clinics who are already serving these populations may be effective partners through which to directly distribute informational materials to those who may have barriers to receiving notification through the mail, with special outreach efforts made to those who are homeless or marginally housed.

Better Notification Materials

This study identified the most common questions that beneficiaries felt were not answered through the notification materials. Among the most common, beneficiaries want to know why the transition to managed care is happening and need a clearer message that the transition is mandatory and that therefore they cannot stay in FFS. Further, there are major gaps in knowledge about consumer protections such as appropriate use of Medical Exemption Requests, awareness of the option to submit a Continuity of Care Request, and complaint processes that should be highlighted in notification and enrollment materials. Beneficiaries also need access to individual counseling about how the change will affect their specific benefits, including their doctors and prescriptions, and the hospitals they can go to.

While Internet-based decision tree programs or other applications may be useful for some populations, results of this study show that the overwhelming majority of SPD beneficiaries want information in written form, with the option of in-person or telephone counseling. Individual counseling through community-based organizations or the health clinics that are already serving these beneficiaries could very helpfully supplement simple mail notification for beneficiaries who may have difficulty receiving information or understanding their choices.

Improving the Transition for Those Who Do Not Choose a Plan

As discussed above, the approximately 40% of transitioning beneficiaries who actively chose a plan had significantly better experiences in almost all areas than those who did not choose a plan. Although DHCS made an effort to "link" each non-choosing beneficiary to a plan in which the beneficiary's previous utilization data showed a relationship with one "top" MMC provider, this intervention proved unsuccessful in ameliorating the effects of not choosing. When comparing linked beneficiaries with those who were defaulted (i.e., randomly assigned to a plan), analysis showed that linked beneficiaries did not have better experiences. To improve the effectiveness of linking in future transition efforts, it may be useful to increase the robustness of the intervention by identifying multiple "top providers" and then linking beneficiaries based on the plan with which the highest proportion of providers are affiliated.

Close Attention to Specialty Care

The SPD population has high levels of chronic disease and disability and thus relies more heavily than the general population on specialty care to meet its health care needs. Required authorizations for specialty care under MMC is one of the most problematic issues for beneficiaries switching from FFS, where they had the freedom to self-refer to specialists. In this study, those beneficiaries who reported visiting a specialist since switching to managed care also reported better access to care in many areas, compared to those who had no specialty visits. For example, beneficiaries who reported using specialist care since the transition not only reported better access to specialty care itself through their new plan, they also reported that they had more assistance getting appointments, tests, and treatments, and were less likely to have trouble getting prescriptions and medical equipment. This may indicate that assistance from MMC specialist providers is facilitating access in these areas.

Likely as a result of this better access, those with specialty care visits reported higher satisfaction with their benefits and quality of care under their MMC plan. Furthermore, those with visits to specialists were more likely than those who did not have specialist appointments to say that their current physicians' understanding of how to care for them was the same or better in managed care. And while they were more likely to know how to file complaints or grievances, they did not actually file complaints more often. Finally, those with at least one specialty care appointment were more likely to have switched plans since their initial assignment, possibly indicating a greater ability to proactively access the care they need.

With regard to navigating their managed care plan, those beneficiaries who had specialty visits were more knowledgeable, including how to find doctors, make PCP appointments, and get medical equipment and supplies. This was true of these beneficiaries regardless of their health status. On the other hand, there was evidence that those with no specialty appointments were more likely to report they had more trouble accessing specialty visits in MMC than in FFS. These results strongly suggest that SPD beneficiaries in MMC are experiencing barriers to accessing the specialty care they believe they need. Thus, care coordination efforts should focus on facilitating access to specialists for these beneficiaries, with additional assistance provided to those who have limited skills in navigating their own care. Further, rates of specialty care use by SPDs should be closely monitored as a proxy for access to care, with special attention paid to those who have not accessed any specialty care within the first six months after transition.

Conclusion

In summary, between 70% and 80% of Medi-Cal-only SPD beneficiaries reported that their experiences with the transition to MMC resulted in care that was the same or better than it had been in FFS Medi-Cal. But given the fact that this is a population with complex care needs, high rates of disability, and consequent high care utilization, those who had negative experiences may be at risk for care disruptions that could seriously compromise their health, quality of life, and ability to live in the community. Findings from this study show that some of the groups who are most vulnerable to care disruptions — those in the worst health and those with functional and cognitive impairment — had the most negative experiences in managed care and were the least likely to know how to navigate care in their new plan. Health plans and state agencies can identify these sub-populations and provide them with increased monitoring and assistance during delivery system transitions.

About the Author

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Endnotes

1. Beneficiaries in 14 counties that administered Medi-Cal through the County Organized Health System model were already on MMC before the statewide transition discussed in this paper. For more information on the different county models, see www.dhcs.ca.gov. California's other, primarily rural, counties are slated for a transition to MMC which began June 2013. For more information on Medi-Cal rural expansion, see www.dhcs.ca.gov.
2. Seniors included in this mandate are those known as "Medi-Cal only," meaning that they are not also enrolled in Medicare. Although the vast majority of seniors are eligible for Medicare, some are not because they do not meet Medicare's specific US residency or work credit requirements.
3. The 16 counties that transitioned SPD beneficiaries to MMC were: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare, Riverside, San Diego, and Sacramento. These counties had existing two-plan or geographic managed care systems in place at the time of the transition.
4. Although over 340,000 Medi-Cal-only SPDs were originally targeted for transition to MMC, many were subsequently exempted through Medical Exemption Requests, Emergency Disenrollment Requests, and aid code changes.
5. Managed Care Implementation for Seniors and Persons with Disabilities Monitoring Dashboard, www.dhcs.ca.gov.
6. Carrie Graham et al., "Fee-for-Service and Managed Care for Seniors and People with Disabilities on Medicaid: Implications for the Managed Care Mandate in California," *Journal of Health Care for the Poor and Underserved* 22, 4 (November 2011): 1,413–23, doi: 10.1353/hpu.2011.0141.
7. Beneficiaries were excluded from the survey if administrative records showed that their primary language was other than English, Spanish, or sign language, or if they did not have a complete address and complete phone number on file with DHCS. Beneficiaries who lived in group homes or other residential care settings were also excluded.
8. Based on MMC enrollment data, this study divided beneficiaries into three groups: those who enrolled in the first months of the transition, June–August 2011; those who enrolled mid-transition, September–December 2011; and those who enrolled in the later months of the transition, January–March 2012. Beneficiaries enrolled in April–May 2012 were not included in the study due to the timing of data collection.
9. The default algorithm assigned non-choosing and non-linked beneficiaries to a plan based on the quality rating of the plans in the county. The plans with higher quality ratings were assigned more beneficiaries.
10. DHCS Medi-Cal Manage Care Division SPD Dashboard, www.dhcs.ca.gov.
11. In-Home Supportive Services is California's program for self-directed home care for Medi-Cal beneficiaries with disabilities.
12. Figures include only those beneficiaries who had tried to see a doctor in MMC since the transition.
13. The survey defined mental health care very broadly as "care you get for things like depression, anxiety, nerves, or conditions like schizophrenia. Mental health care can be provided by a primary care doctor, a psychiatrist, or other professionals like psychologists, counselors or social workers."
14. Carrie Graham and Beccah Rothschild, The Medi-Cal Access Project, *Year Two Report, Technical Report to the California Department of Health Care Services* (UC Berkeley, 2008).
15. Two subgroups, Latinos and those who called member services after transitioning to managed care, had both a high likelihood of reporting a poor transition experience on five or more indicators and a low likelihood of reporting a poor transition experience on five or more other indicators.
16. Seniors who are without Medicare usually were not employed in Medicare tax-paying jobs long enough to qualify for the program, either because they immigrated late in life or because they or their spouse worked in jobs such as housecleaning, construction, or farm labor where neither they nor their employers paid into the Social Security or Medicare funds.
17. National Research Council, *Health Literacy: A Prescription to End Confusion* (Washington DC: The National Academies Press, 2004).
18. M. Kutner, E. Greenberg, Y. Jin, C. Paulsen, *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy,* National Center for Education Statistics (Alexandria, VA: September 2006).
19. B.D. Weiss and R. Palmer, "Relationship Between Health Care Costs and Very Low Literacy Skills in Medically Needy and Indigent Medicaid Population," *Journal of American Board of Family Practice,* January–February, no. 17 (2004): 44–47.
20. Center for Health Care Strategies, Inc., *Health Literacy Implications of the Affordable Care Act* (The Institute of Medicine: November 2010).