Rural California:
Examining the Transition to Managed Care

An informational briefing of the California Commission on Aging and the California Collaborative for Long-Term Services and Supports

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Executive Summary

How will California accomplish the shift to Medi-Cal Managed Care in 28 rural counties?

By 2013 the State of California plans to transition all Medi-Cal/Medicare-eligible beneficiaries (dual eligibles) to managed care in order to provide more integrated care at a cost savings. The implementation will transition approximately 70,000 dual eligibles in 28 counties where service is currently provided on a fee for-service basis. The budget pressures justified proposing a rapid transition, yet resources and the on-the-ground reality do not support that approach. The sparse rural population, a shortage of providers, the lack of a uniform service infrastructure, and a managed care system that has previously abandoned efforts to serve these areas all attest to the challenge ahead.

Helping the State to identify these challenges and their solutions early was the goal of the California Commission on Aging (CCoA) in partnership with the California Collaborative for Long-Term Services and Supports. An informational briefing titled *Rural California; Examining the Transition to Managed Care* was held at the State Capitol in early June, 2012. The briefing included expert testimony from public officials, rural providers, and stakeholders sharing their experiences, their concerns and their visions for a successful transition. A public comment period was held after the prepared testimony. The CCoA followed the briefing with a respondent panel of advocates, consumers and health providers.

Consumers and local providers alike share concerns about the magnitude of the shift to Managed Care in counties where no managed care plans exist. How will the plans assure equitable service levels across the entire coverage area? Will plans be able to build the infrastructure in remote areas that will guarantee services? How will providers be retained, and what will the new managed care affiliations mean to those with private insurance?

Primary among the issues voiced is access to providers and service equity across all areas. Presenters pointed to the geographic challenges of delivering services to California's sparsely populated rural counties, where tiny communities are tucked into high mountain valleys or dot the vast southern deserts and where many individual residents live in isolation, scattered throughout the surrounding areas.

The cohesion in rural communities is found in personal relationships, making first-hand knowledge of a provider or her clients an important factor in building trust. Stakeholders believe managed care plans would benefit from working with the existing service network to identify service integration needs. Pre-existent patient/provider relationships and treatment plans must be allowed to continue. Direct communication, in-person gathering of local stakeholder input will do much to advance local acceptance of changes in the service network. Plans must consider what role existing community-based program providers will play in the new system.

Broad infrastructure-related factors that must be addressed by managed care plans moving into rural areas include significant provider shortages, a dearth of home and community-based services and supports, few care facilities, limited access to technology, and transportation

challenges. Given the magnitude of these challenges, a universal theme of the briefing was for a slower and more deliberate expansion of the State's Coordinated Care Initiative.

The challenges the State faces in making this transition are daunting at best. They are, however, not insurmountable. The recommendations that follow lay the groundwork for the State to implement Medi-Cal Managed Care in rural California in a way that both provides quality care and engages and honors local beneficiaries, providers and stakeholders.

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Introduction

In January 2012 Governor Brown proposed the Coordinated Care Initiative (CCI), to consolidate services to Medi-Cal/Medicare recipients (dual eligibles) into an integrated managed care delivery system. As proposed, the initiative sought to implement the transition in three phases: 1) integrate CBAS participants by July 2012; 2) in January 2013, implement a four-county pilot project in counties where integrated managed care exists; and 3) by January 2015, incorporate 28 rural counties where Medi-Cal is currently available only on a fee-for-service basis. Over the following months the State's timeline for implementation has shifted and stakeholder concerns have mounted. One such change is language in the enacted 2012-2013 State Budget that accelerates the expansion of Medi-Cal Managed Care into the fee-for-service counties no earlier than June 1, 2013.

The California Commission on Aging (CCoA) holds the statutory role of principal advocate on behalf of California's older adult population. As such, the CCoA researches policy and program issues affecting seniors, holding public hearings throughout the state to gather input on issues of importance to older adults, service providers and stakeholders.

Following a series of public hearings on older adults' access to health services in rural areas, in 2009 the CCoA published a summary of recommendations pointing to the need for an expanded service infrastructure in rural counties. Given the Commission's interest in this topic, the proposed CCI Medi-Cal Managed Care expansion to rural counties was of special concern. On June 7, 2012 the CCoA joined with the California Collaborative for Long-Term Services and Supports to sponsor a briefing (See Appendix 1) on the proposal to establish integrated Medi-Cal Managed Care services in the 28 rural counties (Appendix 2). The briefing and the subsequent respondent panel brought together rural service providers, consumers, and other stakeholders to shed light on the hurdles managed care plans must overcome to provide equitable quality care to rural consumers.

This document was prepared for the purpose of sharing the information with the California Department of Health Care Services as part of the Department's effort to gather stakeholder input on the Medi-Cal Managed Care expansion in rural counties.

Stakeholder Perspectives and Recommendations Regarding Expansion of Medi-Cal Managed Care Into Rural Counties

Many concerns have been voiced regarding the transition of dual eligibles (DE) to managed care plans. The State's expectation that the change will be seamless and efficient comes into question when you consider the fragile health of the population under consideration. Because DE consumers represent those individuals with serious chronic disabilities and the elderly,

shifting them away from providers and systems that have worked for them poses many risks. This has been borne out by the State's experience in transitioning the Medi-Cal SPD (seniors and persons with disabilities) population to managed care in 2011, providing valuable lessons that translate to this DE phase of the Medi-Cal shift.

What follows is a compilation of comments derived from the Informational Briefing and the subsequent Respondent Panel. The comments are divided into four broad categories and are reflective of consumer, advocate, provider and stakeholder testimony.

Quality and Access

Access to providers and assurance that high quality services will be equitably distributed are primary concerns associated with Medi-Cal Managed Care service in rural counties. For regions where physicians, health care facilities and home and community based services are already scarce, Plans must be prepared to be flexible in setting reimbursement rates to attract and retain a provider base. Stakeholders believe the distance between many rural communities and specialty care means that Plans must coordinate appointments with specialists and facilitate preliminary testing in order to make visits to specialists effective and efficient for frail patients.

True service integration in rural counties will require a new paradigm of managed care delivery, in which care planning and care coordination assure all appropriate services that elders and persons with disabilities need. Respite and linkages can improve patient outcomes, and Plans must work to obtain or develop these services by building on the capacity of the local community-based service network.

Consumer Concerns, Participation and Protection

Consumer concerns regarding access to services in rural areas are not new. Geography, weather and poverty combine with a shortage of transportation options to make access to services difficult in many rural parts of the state. Presenters at the briefing urged Managed Care Plans to consider that access to providers, support systems and transportation substantially impacts quality of care. Hospital to home transitional care must be included in order to assure these high-needs, high-cost patients can recover at home.

The concept of expanding managed care into communities that are not currently served by health plans is frightening and confusing to a range of stakeholders. Some rural representatives shared experiences of having had a Managed Care Plan serve their area for a short time, but then the Plan pulled out – leaving these communities to question "What will be different this time?"

Consumers fear that the expansion will preclude the arrangements they have in place, interfere with the doctor-patient relationships and deny them medications they require. Delivery of effective care will require access to support services and transportation services. Plans serving these areas must look for ways to provide flexibility that addresses the unique circumstances of the dual eligible population in a rural setting.

Many stakeholders see the need for thoughtful and comprehensive outreach to beneficiaries. In addition to the call for language-specific materials, there were recommendations to obtain

stakeholder input through local, in-person sessions and to utilize informal neighborhood networks. The rural safety net is built on personalized contacts.

Officials must keep in mind the independent nature of rural residents and the likelihood that there will be resistance to being "case managed." Many consumers have relied on their own self-advocacy and are satisfied with the service structure they have arranged.

Local Infrastructure

Rural communities are often described as "service poor." They face may infrastructure issues, such as an insufficient pool of medical providers, lack of transportation services, long distances between home and needed services, geography, weather, inadequate funding from governmental sources, service fragmentation, limited service availability and, as a result of the out-migration of youth, family support may be restricted. Before the Medi-Cal Managed Care transition takes place in rural California, officials must be clear on the current state of the health and social service infrastructure in these areas. Comprehensive inventories must be conducted to identify where services exist, where there are gaps and ways to link services together. For those in "border counties," the nearest services may be across county or state lines. Will the Plans be able to purchase services across borders?

The availability of community-based programs in California is not uniform, leaving many rural counties without a necessary framework of long-term services and supports. Testimony from an Area Agency on Aging Director representing five counties reported that two of those counties do not have a case management program. In another Area Agency on Aging covering two counties, only one of those counties has a Community Based Adult Service Program and a Multipurpose Senior Service Program. While most speakers supported the notion that coordination with community-based services will improve care, they also felt that Plans must be asked to address inequity in their service area.

Several respondents spoke in support of the current fee-for-service model and the capacity and caring of providers who have chosen to practice in rural communities. These providers are an integral part of a delicate balance of services created throughout rural California. Some wondered if the expansion of Medi-Cal Managed Care would erode this balance and destroy the fee-for-service system. Another respondent suggested that the Plans need to utilize and value the service infrastructure already in place in the fee-for-service counties.

Many presenters commented that healthcare technology can increase access to many services in remote communities, recommending that Plans consider the use of technology where it can be most beneficial. In regions with less-than-state-of-the art telecommunications (some remote communities in the state still have only dial-up Internet access), alternative arrangements may be required. Even where technology is available, presenters noted that some in the DE population may feel that face-to-face interaction is the only acceptable approach.

System Development

As the State moves forward to implement the Coordinated Care Initiative (CCI) in rural counties, several stakeholders requested that the Department of Health Care Services (DHCS)

clearly identify the terms of care coordination, expectations for service delivery and payment options. One respondent suggested that DHCS research rural areas where HMOs and PPOs have been unable to survive and use the "lessons learned" from these experiences to avoid the same problems with the rural roll-out of Medi-Cal Managed Care.

Many witnesses spoke to the importance of plan oversight and monitoring. While acknowledging the good work being done by DHCS, it was clear to some respondents that the Department may require additional staffing support to ensure the CCI is implemented appropriately and fairly.

The expansion of managed care services to the DE population in general raises the question of how long-term service and supports (such as IHSS, CBAS, MSSP and facility-based care) will be integrated. The question becomes more critical in rural counties, which many not have these long-term service and support programs. Stakeholders reminded Health Plans competing for the opportunity to provide service in rural communities that they should be cognizant of the shortage of direct care workers and assisted living facilities. Plans with experience in the provision of managed care must draw upon their experience to derive solutions for the challenges they face in rural areas. The solutions can only be strengthened with the inclusion of, and input from, the local medical, social service and community-based networks.

Rural advocates noted that costs for service provision is higher in rural areas than in urban areas due to distances between services, locations of specialists, limited care providers and higher gas prices. The development of reimbursement rates for rural providers should be weighted to support higher operational costs. One provider spoke in support of local determination in selecting managed care models.

Conclusion

The size and scope of the CCI coupled with an aggressive timeline means at this writing that there are still many unknowns about how the initiative will be designed, implemented and evaluated overall. The trailer bills linked to the 2012-2013 Budget, the State's proposal to the federal government and numerous stakeholder meetings are just the beginning of the implementation process.

In the Commission's role as advocate and advisor, co-hosting this briefing was intended to generate a collective "first look" at the specific concerns around the expansion of managed care into the 28 rural fee-for-service counties. Views were compiled from consumers, advocates, providers, health plans and other stakeholders. Through 2012 and 2013 the CCoA will continue to focus on the rural expansion of Medi-Cal Managed Care.

This report is intended to provide the Administration and other interested parties with information about the unique constraints and opportunities in the rural counties and recommendations to guide the development of a coordinated care model that is responsive to those constraints and beneficial to consumers who make up the DE population.

The challenges the State faces in making this transition to managed care are daunting at best. The goal of providing quality care is, however, not insurmountable. The recommendations offered by those who will be most affected – the rural stakeholders – demonstrate openness along with their concerns. Their hope is for an approach to the rural Medi-Cal Managed Care implementation that acknowledges the rural way of life as it honors local beneficiaries, providers and stakeholders.

Appendix 1

Expert testimony for the briefing was provided by:

Bruce A. Chernof, M.D., President and Chief Executive Officer, The SCAN Foundation
Lee Kemper, Executive Director of the County Medical Services Program (CMSP) Governing Board
Margaret Tatar, Chief, Medi-Cal Managed Care Division, California Department of Health Care Services
Ana Clark, Manager, Medi-Cal and Public Health Administration, HealthNet, Inc.
Marshall K. Kubota, M.D., Regional Medical Director, Partnership HealthPlan of California
Joe Cobery, Executive Director, PASSAGES, Area 3 Agency on Aging
Forest Harlan, System Change Coordinator, Independent Living Services of Northern California
Mary Sawicki, Director, Calaveras Works and Human Services Department and Chair, Twenty Small Counties Committee, CWDA
Al Hernandez-Santana, Director of Policy, California State Rural Health Association
Judith Shaplin, CEO and President, Mountain Health and Community Services

The briefing was facilitated by CCoA Chair Bert Bettis and Jack Hailey of the CCLTSS.

Respondent Panel Members:

Steve Barrow, California Rural Health Association
Vanessa Cajina, Western Center on Law and Poverty
Cindy Calderon, California IHSS Consumer Alliance
Jack Hailey, California Collaborative for Long-Term Services and Supports

Also included:

Comments from the State Independent Living Council
Comments from California Welfare Director's Association's Twenty Small Counties Committee

Appendix 2

Current Medi-Cal Fee-For-Service Counties

County	# Medi-Cal Eligibles	County	# Medi-Cal Eligibles	County	# Medi-Cal Eligibles
Alpine	204	Inyo	3,213	Shasta	38,039
Amador	4,095	Lassen	4,544	Sierra	458
Butte	47,834	Lake	16,566	Siskiyou	9,759
Calaveras	6,106	Mariposa	2,599	Sutter	21,724
Colusa	4,271	Modoc	1,866	Tehama	16,049
Del Norte	7,706	Mono	1,143	Trinity	2,628
El Dorado	17,216	Nevada	10,452	Tuolumne	18,857
Glenn	6,610	Placer	28,269	Yuba	18,857
Humboldt	25,208	Plumas	2,971	TOTAL	369,785
Imperial	54,563	San Benito	9,334		