State of California—Health and Human Services Agency
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Seniors and Persons with Disabilities Evaluation Design September 2016

Background

Under the authority of California's Section 1115 Medicaid Waiver, Bridge to Reform, California transitioned its Seniors and Persons with Disabilities (SPDs) population from the Medi-Cal fee-for-service (FFS) delivery system into the managed care delivery system (i.e., enrolled into Medi-Cal managed care health plans (MCPs)) between June 2011 and May 2012. Specifically, the Special Terms and Conditions (STCs) of the Bridge to Reform Waiver included requirements about information and communication strategies that address the unique needs of SPDs, approaches to assignment and opportunities for changes in MCPs, participant rights, safeguards and contractual provisions regarding care coordination and linkages to other service delivery systems, person-centered approaches to service planning and delivery, and physical and geographic accessibility of service providers. The transition occurred in Two-Plan and Geographic Managed Care (GMC) plan model counties, 16 counties in total, located across California. Mandatory enrollment of SPDs in managed care and the aforementioned requirements were continued under the State's Section 1115 Medicaid Waiver renewal, Medi-Cal 2020.

Evaluation Objectives

The Medi-Cal 2020 STCs require the State to complete an assessment, using pre-mandatory enrollment as a baseline, of the impact on mandatory managed care on the SPD population, including all significant and notable findings based on all of the data accumulated through the quarterly progress report. The evaluation must address three areas: access to care; quality of care; and cost of coverage.

The below description sets forth the State's design for the SPD transition evaluation. This design approach was selected because it considers cost of care, quality of care, and access to care, all of which provide a picture of the beneficiary's experience and impact to the State's administration of the program overall. The measures selected were chosen because they provide indicators of the beneficiary's experience and resultant health outcomes when accessing care through a delivery system. They are tied to the specific health care needs of SPDs and their specific care needs due to diagnosis and the existence of, at times, multiple complex conditions.

Evaluator Selection

The State will contract with an independent entity and ensure that the entity is free of conflict of interest to conduct an evaluation of the SPD transition to the Medi-Cal managed care delivery system. The State will contract with an entity that does not have a direct relationship to the State of California, Department of Health Care Services (DHCS). A data use agreement will be included in the contract to

allow for the sharing of data with and access to data by the independent entity for purposes of conducing the SPD transition evaluation. The State will seek application(s) from interested entities that have been identified based on prior experience and expertise in analyzing the experience of the population and working with the data that would be analyzed. Proposals will be scored; if a minimal score is not achieved, the State will seek proposals from additional entities.

Evaluation Methods

General Approach

The evaluation will meet the standards of leading academic institutions and academic journals. Data will be reported at the beneficiary, provider, health plan, and statewide levels. Significant attention will be given to ensuring use of the best available data and the cleanliness of it when utilized. When necessary, the data will be adjusted and/or controls will be put into place to maximize the use of the it. Should there be data limitations, the data will be modified as needed and only used appropriately so as not to misinterpret it. Any modifications and changes will be reported in the final evaluation report. The final evaluation report will also consider how the findings from the evaluation may or may not be generalized.

The evaluation will compare pre- and post-transition data whenever possible. Research has shown that it can take up to two years for beneficiaries to become adjusted to a change in delivery system. Therefore, for the 16 transition counties, an analysis will be conducted of the experience of SPDs in FFS 24 months prior to the transition and 24 months post-transition.

For both pre- and post- transition analyses, socioeconomic and demographic factors will be considered including race/ethnicity, gender, age, geographic area, diagnosis, language, and other factors (as identified through a public comment process). Data from the California Department of Public Health will be utilized to overlay these demographic factors with applicable health disparity considerations such as average income, tobacco utilization, and crime rates. A menu of the same metrics will be used and compared for both the pre- and post-transition populations. Because additional data are available for the post-transition population and only certain assessed requirements exist for the post-transition managed care delivery system, additional metrics and data are available for it. All measures will be benchmarked against available state and national standards and benchmarks. For example, NCQA Medicaid benchmarks for performance will be utilized when possible.

State vital statistics databases will be also used to report on the number of deaths by diagnosis. This information will be presented as a comparison across transition counties and non-transition counties.

Data Sources and Types

Qualitative and quantitative data available to DHCS both from data collected directly or collected in partnership with the State will be utilized. The evaluation will consider: process and outcomes measures (MCP encounter data, FFS claims, HEDIS) (pre- and post- transition); beneficiary satisfaction (Ombudsman, call center, grievances and appeals, beneficiary surveys) (post-transition); and administrative functions (beneficiary surveys) (post-transition).

Baseline Data and Pre-Transition Evaluation

Baseline data that will be utilized to assess the pre-transition population will include FFS claims data, qualitative interviews including with beneficiaries, and HEDIS rates. The pre-transition analysis will review the beneficiary's experience 24 months prior to the transition beginning.

The pre-transition evaluation will review access to care metrics which will provide an indication of the beneficiaries' ability to access primary care providers within a close proximity to their residence while in FFS. In addition, the pre-transition evaluation will utilize HEDIS metrics to determine access to services. They will be calculated administratively using FFS claims data for the pre-transition period. Costs associated with average annual costs and avoidable costs will be considered as well. All of the aforementioned factors will provide a baseline understanding of the SPD beneficiary's overall experience when care was received through the FFS delivery system.

The data measures and sources that will be used to measure the pre-transition experience consists of, but are not limited to:

a. Access to Care
    i. Network Access
        1. Time and distance - average number of miles to primary care provider from beneficiary residence
        2. Type of available specialists

    Data Sources: California provider enrollment data

    ii. HEDIS rates (see quality of care metrics below)

b. Quality of Care (for beneficiaries transitioned to managed care)
    i. HEDIS/EAS rates stratified measures by SPD/Non-SPD (see attached for NCQA measure specifications)
        1. All-Cause Readmissions – NCQA
            a. Ambulatory Care - NCQA
                i. Outpatient visits
                ii. Emergency department visits
        2. Annual Monitoring for Patients on Persistent Medications - NCQA
        3. Comprehensive Diabetes Care (8 indicators) – NCQA
        4. Rate of post-discharge follow-up after hospitalization or ED visit - NCQA

    Data Sources: The State will use FFS claims data to calculate performance rates for these measures.

c. Cost of Coverage (for beneficiaries enrolled in the delivery system for a minimum of ten months and transitioned to managed care)
    i. Average annual cost for Medi-Cal covered health[1] services per beneficiary
    ii. Avoidable institutionalization costs:
        1. Ratio per 10,000 beneficiaries of and average cost per beneficiary for length of stays greater than ten days in an acute care hospital

[1] California is in the process of determining whether or not county mental health and SUD costs will be included for purposes of this analysis.

2. Ratio per 10,000 beneficiaries of and average cost per beneficiary stay for length of stays less than 60 days in a Skilled Nursing Facility (SNF)
3. Ratio per 10,000 beneficiaries of and average cost per beneficiary stay for length of stays less than 90 days in an acute hospital stay plus SNF

iii. Average annual pharmacy costs per beneficiary

iv. Ratio per 10,000 beneficiaries of and average emergency room costs for non-emergency visits (as defined by NCQA)

Data Source(s): FFS claims and pharmacy data

Post-Transition Evaluation

Different types of data will be used to analyze the post-transition beneficiary experience. The data will support analysis of the same metrics utilized in FFS as described above as well as additional data sets that are accessible through the managed care delivery system and an independent External Quality Review Organization (EQRO). HEDIS rates will be calculated utilizing MCP encounter data for hybrid measures; and audited EQRO data will be utilized for admin measures. This will allow for an equal comparison of the measures across the FFS and managed care delivery systems.

Additionally, data collected by Carrie Graham, University of California at Berkeley, during a qualitative study will be utilized to gauge beneficiary satisfaction including care coordination (see attachment for additional information about the questions and findings from the study).

Lastly, MCP network data which the State collects monthly, as well as MCP network certifications for the SPD transition, will also be utilized to support analysis of provider data and access. Moreover, other data sources will be utilized, such as calls to the Ombudsman, State Fair Hearing and Independent Medical Review (IMT) information, and grievances and appeals data. The State reports these data in the quarterly progress reports to CMS and serves as indicators regarding beneficiary experience. The combination of all of the aforementioned data sources will allow the State to analyze the beneficiary's experience post-transition in a comprehensive way.

The data and measures that will be used to for post-transition include, but are not limited to, the following:

i. Access to Care
    a. Network Access
        i. Time to primary care provider from place of residence
        ii. Type of available specialists in network
        iii. Out of network referrals and access
            1. Frequency of out-of-network referrals per 10,000 beneficiaries
                a. Compared to non-SPD population
        iv. Ease of getting appointments with primary care doctor – Likert scale
        v. Ease of getting appointments with specialist – Likert scale
        vi. Disability access
            1. Provider understanding of how to care for a person with specific health condition or disability – Likert scale

2. Access to equipment or services for individuals with a specific health condition or disability – Likert scale

Data Sources: MCP network certifications; MCP network provider files; Carrie Graham - beneficiary surveys

b. Beneficiary Satisfaction
   i. Beneficiary satisfaction with managed care benefits - Likert scale
   ii. Beneficiary satisfaction with quality of care – Likert scale
   iii. Benefit differences from FFS to managed care – Likert scale
      1. Prescription medications
      2. Specialty care
      3. Medical equipment and supplies
      4. Primary care

   Data Sources: Carrie Graham - beneficiary surveys

b. Care Coordination
   i. Plan navigation
      1. Do you know how to: - Yes or No
         a. Get a prescription filled
         b. Make an apt with a PCP
         c. Get tests you need
         d. Get health advice over the phone
         e. Find a doctor
         f. Get medical equipment and supplies
         g. Make an apt with a specials
         h. Know that you can switch doctors at any time
         i. Know about the continuity of care policies
   ii. Member services
      1. Were you called by your plan to discuss your health needs? – Yes or No
      2. Experience with member services – Likert scale
      3. Help finding doctors and getting the services needed – Likert scale

Data Sources: Carrie Graham - beneficiary surveys

   iv. SPD Specific Complaints – rate per 10,000 beneficiaries
      1. Grievances and appeals
      2. State Fair Hearings
      3. Independent Medical Reviews
      4. Calls to Ombudsman

Data Sources: Quarterly MCP grievances and appeals data; State Fair Hearings; Independent Medical Reviews; Quarterly progress report data

ii. Quality of Care
   a. HEDIS/EAS rates stratified measures by SPD/Non-SPD (see attached for NCQA measure specifications)
      i. All-Cause Readmissions – NCQA
      ii. Ambulatory Care - NCQA

1. Outpatient visits
2. Emergency department visits

iii. Annual Monitoring for Patients on Persistent Medications - NCQA
iv. Comprehensive Diabetes Care (8 indicators) – NCQA
v. Rate of post-discharge follow-up after hospitalization or ED visit - NCQA

Data Sources: MCP encounter data; audited EQRO HEDIS rates

iii. Cost of Coverage (for beneficiaries enrolled in the delivery system for a minimum of ten months)

iii. Average annual cost for Medi-Cal covered health services per beneficiary (note: costs will be a combination of FFS and capitation both to MCPs and from MCPs to delegated entities)
iv. Avoidable institutionalization costs:
   1. Ratio per 10,000 beneficiaries of and average cost per beneficiary for length of stays greater than ten days in an acute care hospital
   2. Ratio per 10,000 beneficiaries of and average cost per beneficiary stay for length of stays less than 60 days in a Skilled Nursing Facility (SNF)
   3. Ratio per 10,000 beneficiaries of and average cost per beneficiary stay for length of stays less than 90 days in an acute hospital stay plus SNF
v. Average annual pharmacy costs per beneficiary
vi. Ratio per 10,000 beneficiaries of and average emergency room costs for non-emergency visits (as defined by NCQA)

Data Sources: MCP encounters; Rate Development Template (RDT/Mercer; FFS claims and encounter; audited EQRO HEDIS

Communication of Findings

The evaluation will provide a general analysis and description of the population, including a report of enrollment numbers and analysis by demographic factor. The evaluation will also contain both performance metrics and a narrative description in order to present the full experience of SPDs during the transition.

Upon submission of the draft SPD evaluation design to the Centers for Medicare and Medicaid Services (CMS) it will be shared publically. The document will be distributed via email to the State's stakeholder waiver distribution list and posted on the State's website for public comment. Specifically, the State will request comment on the evaluation approach and questions that the evaluation should address. It will also be presented and discussed at the State's Waiver Stakeholder Advisory Committee (SAC) and Managed Care Advisory Group (MCAG). Updates to the design will be made based on stakeholder comment received during these meetings or in writing. The design will be finalized in conjunction with the independent entity and submitted to CMS for final approval.

Based on the methodology used to assess the pre- and post-transition population, the evaluation will provide recommendations for programmatic changes relating to access to and quality of care as well as

overall cost implications for the SPD population. The final evaluation report is due December 31, 2021 at the completion of the Medi-Cal 2020 Waiver. The findings from the assessment will allow DHCS to evaluate the experience of SPDs in the managed care delivery system as well as inform DHCS as to best practices and lessons learned.