Medi-Cal Redesign: Impact on Older Californians

Geriatric Leaders Identify Essential Education and Training Needs

Executive Summary

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Pressures to reduce Medicaid spending have led many states, including California, to put many recipients into managed care plans. Elderly and disabled Medi-Cal recipients have not yet been included in the mandatory managed care programs in most California counties. As part of an agreement between California and the federal agency that administers Medicaid, in 2005 the state proposed a "Medi-Cal Redesign" policy that included a number of changes to the way that Medi-Cal would be administered to the aged and disabled.

In response to this proposal, the California Geriatric Education Center (CGEC) brought together key stakeholders from around the state on May 18, 2006 in Manhattan Beach, CA. The assembled leaders pooled their expertise and experience to identify the educational demands related to the initiation and maintenance of the redesign plan. The meeting focused on understanding the proposed changes to the Medi-Cal program and identifying what impact the redesign would have on older Californians. Topics addressed the education and training needs of the current and future workforce, consumer advocacy in the state legislative process and future opportunities for collaboration among organizations and agencies. While the redesign proposal was subsequently withdrawn, the issues raised by the stakeholder meeting remain relevant for any future modifications of the program.

The Context

California's Medicaid program, called Medi-Cal, has provided medical assistance for qualified individuals with low incomes and assets since 1965. Just under one in five Californians, 6.7 million beneficiaries, currently receive services under the plan.[1] **Medi-Cal recipients include 1.6 million seniors and persons with disabilities who account for 25 percent of recipients and 53 percent of the program's expenditures.**[1, 5]

Medi-Cal is the second largest expenditure in the state budget, ranking only behind K-12 education. The California Department of Health Services (CA DHS) notes that since 1998-99, General Fund expenditures for Medi-Cal have grown by 60 percent. These increases have been attributed to a range of factors that include a 35% beneficiary enrollment increase, higher health care costs and an escalation in treatment costs due to improvements in medical advances and outcomes. **As the population continues to age, the enrollment of seniors and persons with disabilities has shown a 13 percent increase between 2002 and 2005, representing approximately 193,000 new individuals to the program.** Though the DHS acknowledges that Medi-Cal is one of the most cost-effective Medicaid programs in the nation, growing demands on the program raise concern over the program's long-term financial viability.[2]

Medi-Cal recipients include a range of beneficiaries—families, children, seniors and people with disabilities—and it is the current proposal's expectation that modifications will see better coverage provided to its eligible individuals and reduce annual general fund expenditures by about $145 million/year.[1] The state of California proposed a Medi-Cal Redesign policy to help maintain health care coverage for beneficiaries, while also containing costs and maximizing operating efficiencies.

The Proposal

The Medi-Cal redesign proposal that the stakeholder meeting addressed included measures to move all aged and disabled beneficiaries into mandatory managed care plans in counties where Medi-Cal manage care existed, reduced dental benefits, and the introduction of a new $10/month premium for adults with incomes over the poverty line. The managed care aspect of the proposal drew the most discussion among participants because it involves the most substantial change in the way that providers and patients would relate to the system of care.

Recommendations

The stakeholders recommend that the following issues be addressed within program design and implementation, education and legislative areas when considering Medi-Cal Redesign policies:

I. Program Design:

1. **Network adequacy: the ability to meet medical needs and enhance linkages**.
    a. Centralization of patient medical information
    b. Plan for evaluation of program changes
        i. Continuous evaluation and documentation
        ii. Create and utilize measured objectives to meet set standards
        iii. Examine cost-savings
    c. Educational preparation for current service providers.
        i. Geriatrics training required for all health care professionals
        ii. Cultural sensitivity training (identify needs and approach)
        iii. Care Management training (communication and procedures)
    d. Access to care
        i. Address rural vs. urban differences

2. **Address readiness standards and quality of care.** Ensure compliance with state and federal guidelines and measure participant satisfaction.

3. **Carve Outs.** Assess coordination and utilization of specific services related to population need and overall costs; address issues such as carve out of mental health services in particular.

4. **Pilot Study information and dissemination.** Acute and Long-Term Care Integration Projects were piloted in the Contra Costa, Orange and San Diego counties (including Integration Projects in the redesign proposal was subsequently tabled due to the issue being addressed under separate legislation[5, 3]). Meeting attendees were particularly

interested in the success of the pilot projects and how their geographic areas and programs serving Medi-Cal beneficiaries could learn from their experiences. Post study dissemination will be critical for all to use throughout the state of California.

II. Implementation:

5. **Ensure community, provider and consumer input into the implementation process**. Feedback from community members on issues surrounding access to information on transition, options, and requirements under the redesign policy is essential.
    a. Outreach by service provider teams to ensure beneficiaries are informed of changes (target population: community members, Medi-Cal enrollees, family members, caregivers)

III. Education:

6. **Educational preparation of future Medi-Cal service providers and administrators.**
    a. Faculty Preparedness
        i. Incorporate field experience(s) into classroom
        ii. Infuse core gerontology and geriatric competencies into curriculum
        iii. Increase awareness of heterogeneous Medi-Cal population
        iv. Encourage relationships between institutions and service provider agencies
        v. Address community and consumer needs
    b. Enhance curriculum and teaching tools
    c. Student needs/requirements/standards
        i. Utilize multidisciplinary case-based models

IV. Legislative:

7. **Community and Agency Advocacy**
    a. Local Level: Encourage networking of senior organizations and service agencies with shared missions. Encourage advocacy training to utilize the inter-connectedness to advocate for aging related needs.
    b. State Level: Encourage community participation during legislative hearings to put a real face to issues.
    c. Utilize consumer friendly materials for public.
    d. Create community-university partnerships to link curriculum in higher education to community issues and service needs.

The need for education, training and available resources for the current direct care workforce (i.e. practitioners and administrators), educators (i.e. faculty and administrators), community members (i.e. Medi-Cal beneficiaries, family members, caregivers) and the future workforce (i.e. students) is critical to ensuring a smooth transition with any implementation of the Medi-Cal Redesign Policy. Attendees have outlined their necessary ideas/topics to consider in assisting with the implementation process.

Next Steps

Subsequent to the CGEC Key Stakeholders Meeting, the state proposal for Medi-Cal Redesign was tabled. Conference recommendations should be considered when renewed efforts for policy redesign are undertaken by the state. The cross-discipline and agency discussions and deliberations call attention to key issues in Medi-Cal policy development and implementation in the future.

References

1. California Department of Health Services, Medi-Cal Redesign: January 2005 available at: http://www.dhs.ca.gov/medi-cal%20reform/PDFs/MC%20Redesign%201-12-05%20final%20updated.pdf.
2. California Department of Health Services, Medi-Cal Redesign Fact Sheet: January 12, 2005 available at: http://www.dhs.ca.gov/medi-cal%20reform/PDFs/MC%20Redesign%20Fact%20Sheet%201-12-05%20Final.pdf.
3. California Department of Health Services, Updated Medi-Cal Redesign Fact Sheet: August 2, 2005 available at: http://www.dhs.ca.gov/medi-cal%20reform/PDFs/MC%20Redesign%20Fact%20Sheet%20Updated%208-05.pdf
4. Joint Informational Hearing of the Senate Committee on Health and the Senate Committee on Budget and Fiscal Review, Subcommittee No. 3 Health and Human Services, Governor's Proposed Medic-Cal Redesign: Staff Briefing Paper, Wed. March 2, 2005, 1:30-5:00pm: John L. Burton Hearing Room.
5. California Department of Health Services, Access Plus and Access Plus Community Choices: Briefing Paper, Budget Change Proposal MC-26, 2/17/2006.

For further sources on the Medi-Cal Redesign Proposal please visit the DHS website at: http://www.dhs.ca.gov/medi-cal%20reform/html/ActivitiesProgramInit.htm#Program_Initiatives

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