Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

# Analyzing Access Barriers: Issues Reported on CAHPS by Patients With Disabilities in a Large Urban Medicaid Health Plan, 2006-2011

**Session:** **5039.0 Health Status and Health Service Access for Persons with Disabilities**

**Section:** **Disability**

**Topic:** **Access to Healthcare Among People With Disabilities**

**November 2, 2011**

S. Rae Starr, M.Phil., M.OrgBehav.
Earl Leonard III, M.S.
Lisa Kodmur, MPH
Lynnette Hutcherson, RN
Rus Billimoria, MBBS, MPH, CPHQ

L.A. Care HEALTH PLAN

# Presenter Disclosures

## S. Rae Starr

**(1) The following personal financial relationships with commercial interests relevant to this presentation existed during the past 12 months:**

I am employed as a Senior Biostatistician at L.A. Care Health Plan – the Local Initiative Health Authority of Los Angeles County, California.

L.A. Care is a public entity competing with commercial insurers in the Medicaid and S-CHIP markets in L.A. County.

Notes:
CAHPS® is a registered trade name of the Agency for Healthcare Research and Quality (AHRQ).
HEDIS® is a registered trade name of the National Committee for Quality Assurance (NCQA).

# Outline

I. Recap of Learning Objectives.

II. Background on L.A. Care Health Plan.

III. 2006 SPD Survey Findings.

IV. Accommodating Members with Disabilities in a Health Plan. Designed for TANF and a Largely Pediatric Population.

V. Comparing Ratings of Quality of Services by Disabled Members. vs. TANF Members.

VI. Recap of Learning Objectives.

VII. Actionability: Opportunities Going Forward.

VIII. Ways to Improve Information on Members Living with Disabilities by Augmenting Surveys with Administrative Data.

IX. Changes in Operations to Accommodate SPD Transition.

Appendix. Sharing knowledge on quality improvement.

# I. Learning Objectives

1. Identify methods to improve the actionability of CAHPS data for measuring disparities in access to care for Medicaid patients living with disabilities compared to the general Medicaid population.
2. Contrast issues reported by adult and pediatric patients living with disabilities.
3. Analyze patients' assessment of providers' competence in working with patients with disabilities.
4. Identify which access barriers are most frequently reported by patients with disabilities.
5. Discuss how Medicaid health plans that evolved to serve disproportionately pediatric populations, can adapt to accommodate adult patients with disabilities.

# II. Background – L.A. Care Health Plan

Large, diverse membership in Los Angeles, California:

- Mostly Medicaid, urban, 2/3rd pediatric, often Spanish-speaking.
- Roughly 21% of Medicaid managed care population in California.
- Roughly 2.1% of Medicaid managed care population in the U.S.
- Roughly 1-in-14 L.A. County residents is an L.A. Care member.
- Mostly Medicaid, some S-CHIP, SNP, and special programs.
- Serves 10 distinct language concentrations ("threshold languages"): Spanish, English, Armenian, Korean, Cambodian, Chinese, Russian, Vietnamese, Farsi, Tagalog.
- Mostly urban and suburban; 1 semi-rural region in the high desert.

# III. L.A. Care 2006 SPD Survey Findings

- Members with disabilities rated services at levels surprisingly similar to the ratings provided by TANF members.
- There were areas of concern, such as Coordination of Care.
- And there were areas where SPD members reported getting quicker service than TANF members.
- It is possible that SPD members – given a persistent condition, may learn to navigate managed care as well or better than their counterparts in TANF, who may enroll episodically for a pregnancy or illness.

# IV. Accommodating Members with Disabilities in a Health Plan Designed for TANF+Seniors and a Largely Pediatric Population


California, 06/2011: Under an 1115 waiver, Medicaid Fee-For-Service (FFS) members are being transitioned into Managed Care (MC).

Challenges:

- Keeping new members informed about the changes.
- Preparing and training staff about likely challenges (Member Services).
- Distributing informational materials.
- Initial health risk assessments (Utilization Management).
- Stabilizing care and giving treatments missed under FFS.
- Adapting the provider network (particularly in specialist network).
- Ensuring continuity of care during the transition.
- Ensuring continuity of medications during the transition.
- Adult day care.
- Staff outreach to affected clinics and skilled nursing facilities for on-site assistance.

# The 1115 waiver:

"Improved care for vulnerable populations"

- Would require most SPD Medicaid beneficiaries to join Medi-Cal Managed Care.
- ~172,000 FFS enrollees in L.A. County will have to join a Medi-Cal HMO.
- Mandatory enrollment begins June 1, 2011 and is tied to birthdays – moving approximately 10,000 people per month (120,000).

Accommodating the transition in FFS membership impacts nearly every functional department in the health plan.

| JUNE 2011 | | | | | | |
|---|---|---|---|---|---|---|
| SUN | MON | TUES | WED | THURS | FRI | SAT |
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

# V. Comparing Ratings of Quality of Services by Disabled Members vs. TANF Members

- **Disabled and TANF groups each include adults and pediatric members.**
- **Disabled patients rated Health Plan and Health Care less favorably than TANF patients, but reported an easier time getting specialist appointments.**
- **Low sample size impaired comparisons for most customer service measures.**

| (2007 - 2011) | | $X^2$ | | |
|---|---|---|---|---|
| Disabled | TANF | G.A. | P-value | Measure |
| 348 | 6,684 | -- | -- | n: Sample size. |
| 73.9% | 80.7% | 9.79 | 0.0018 | Rating: Health Plan Overall (most signif. in 2010). |
| 66.9% | 73.7% | 5.77 | 0.0163 | Rating: All Health Care (most signif. in 2010). |
| 78.4% | 79.9% | 0.31 | 0.5802 | Rating: Personal Doctor (most signif. in 2010). |
| 77.4% | 77.6% | <0.01 | 0.9944 | Rating: Specialist. |
| 77.1% | 77.1% | <0.01 | 0.9611 | Rating: Pharmacy Services (not an NCQA rating). |
| 84.2% | 72.8% | 4.73 | 0.0297 (n=688) | Customer Srvc.: Easy getting appts. w/specialist. |
| 85.7% | 80.4% | 0.28 | 0.5959 (n=53) | Customer Service: Got info. and help needed. |
| 71.4% | 88.9% | 3.00 | 0.0833 (n=52) | Customer Service: Staff courteous / respectful. |
| 100.0% | 92.3% | 0.08 | 0.7815 (n=14) | Customer Service: Forms were easy to fill out. |

Tests w/i rows: Signif. lower . Signif. higher. Data pooled 2007-2011. Percents: Diff. of prop. test; averages: t-test; (α=0.05). G.A.=Chi-square test of general association. For pediatric members (ages 0-17.9), the parent is the survey respondent.
Low sample sizes occurred because the members included proportionately few disabled members during the time period; and because members are not included in the denominator for a measure unless they sought the information or services being assessed therein.

# V. Comparing Ratings of Quality of Services by Disabled Members vs. TANF Members (Cont.)

- **Disabled and TANF groups each include adults and pediatric members.**
- **Disabled and TANF groups had no statistically discernable differences in communicating with their doctors and involvement in decisions.**
- **Low sample size impaired other tests on this page, which we view as inconclusive.**

| (2007 - 2011) Disabled | TANF | $X^2$ G.A. | P-value | Measure |
|---|---|---|---|---|
| | | | | **Communication:** |
| 90.0% | 79.1% | 1.93 | 0.1652 | Doctor explained things well. |
| 83.3% | 79.1% | 0.36 | 0.5458 | Doctor listened. |
| 90.0% | 82.9% | 1.13 | 0.2875 | Doctor showed respect for what patient had to say. |
| 73.3% | 72.6% | 0.07 | 0.7949 | Doctor spent enough time w/patient. |
| 78.6% | 72.6% | 0.20 | 0.6581 | Doctor seemed informed re. care patient received. |
| | | | | **Shared Decision-Making:** |
| 0.0% | 10.2% | 2.37 | 0.1235 | Doctor discussed treatment choices. |
| 10.5% | 3.1% | 0.96 | 0.3270 | Doctor discussed pros & cons of treatment choices. |
| 57.9% | 78.1% | 3.01 | 0.0827 | **Health Ed.: Caregiver discussed how to prevent illness.** |

Tests w/i rows: Signif. lower . Signif. higher. Data pooled 2007-2011. Percents: Diff. of prop. test; averages: t-test; (α=0.05). G.A.=CMH Chi-square test of general association. For pediatric members (ages 0-17.9), the parent is the survey respondent.

# V. Comparing Ratings of Quality of Services by Disabled Members vs. TANF Members (Cont.)

- **Disabled and TANF groups each include adults and pediatric members.**
- **In most facets of timely access, there was no statistically significant difference in assessments reported by Disabled and TANF patients.**
- **However, disabled patients reported Getting Needed Care (covering authorizations and other facets of getting specialist appointments) more favorably than TANF patients.**
- **As in prior slides, low sample size impaired the comparisons -- but wherever statistically-significant differences were found, those are reportable.**

| (2007 - 2011) | | $X^2$ | | |
|---|---|---|---|---|
| Disabled | TANF | G.A. | P-value | Measure |
| 86.2% | 72.8% | 4.73 | 0.0297 | Getting Needed Care: Specialist Appointments. |
| 85.1% | 75.5% | 2.82 | 0.0929 | Getting Needed Care: Care, Tests, Treatment (signif. 2007). |
| 83.3% | 79.2% | 0.27 | 0.6010 | Got Urgent Care Quickly. |
| 75.7% | 80.4% | 0.43 | 0.5110 | Got Routine Care Quickly. |

Tests w/i rows: Signif. lower . Signif. higher. Data pooled 2007-2011. Percents: Diff. of prop. test; averages: t-test; (α=0.05). G.A.=CMH Chi-square test of general association. For pediatric members (ages 0-17.9), the parent is the survey respondent.

# VI. Recap of Learning Objectives

1. Identify methods to improve the actionability of CAHPS data for measuring disparities in access to care for Medicaid patients living with disabilities compared to the general Medicaid population.

   **Contract CAHPS to include appending of Aid Code and other status indicators, so that analyses can identify populations, like those with disabilities, to target appropriate interventions.**

   **Members with disabilities are typically a small subset of CAHPS. Contract for oversampling patients with disabilities to get usable samples.**

2. Contrast issues reported by adult and pediatric patients living with disabilities.

- **We do not have sufficient sample size among persons with disabilities to detect differences with adequate sensitivity.**
- **The 2006 study had sufficient sample size and no large differences were detected. However we know that certain rare pediatric specialties are difficult to recruit in LA County. We suspect that access differs by disease.**

3. Analyze patients' assessment of providers' competence in working with patients with disabilities.

- **Roughly 22% of Adults and children reported that their doctors needed training on how to work with people with disabilities.**

# VI. Recap of Learning Objectives (Cont.)

4. Identify which access barriers are most frequently reported by patients with disabilities.

   **Create a 3 to 5 item questionnaire through which patients can provide feedback of how they feel about services. Have case management navigators field the survey to identify patients at-risk of hospitalization due to fall history and other risk factors. Use the results of this short survey to keep staff aware of problems, patients concerns, and learn what medical groups are doing to solve problems.**

5. Discuss how Medicaid health plans that evolved to serve pediatric populations, can adapt to accommodate adult patients with disabilities.

   **Adapting to accommodate patients with disabilities required awareness, changes in procedures, staff training, and other changes in most functional departments throughout the health plan.**

   - **Tapping into outside expertise is worthwhile.**
   - **The provider network for addressing disabilities is different from that for a healthy pediatric population.**
   - **Considerable outreach is required to assure that providers and contracted facilities are suitable for the higher levels of care required.**
   - **Anticipate policy shifts in related programs (Adult Day Care, etc.).**

# VII. Actionability

A key challenge in 2011 is California's effort to control costs and improve quality of care by moving many patients with disabilities from Fee-For-Service (FFS) care into Managed Care:

- Accommodating large numbers of members in transition.
- Maintaining and coordinating care during the transition.
- Augmenting provider networks to handle complex cases.
- Educating new members on how to navigate managed care and get familiar services.
- Stabilizing members whose conditions weren't well-managed under FFS.

# VIII. Ways to Improve Information on Members Living with Disabilities by Augmenting Surveys with Administrative Data

Administrative variables are available for drilldown to identify barriers for various demographic groups:

- Aid Code is added to the CAHPS sampling frame files, but is too detailed for release back to L.A. Care without breaching anonymity.
- Non-NCQA samples need make no promise of anonymity, so can have full Aid Code.
- Add flag variables reflecting members or doctors who received training or assistance to prepare for the incoming SPD FFS population.
- Tracking the displaced SPD FFS population using Aid Code, birth date, and lack of prior member history as indicators that they are in the new cohort.

# IX. Changes in Operations to Accommodate SPD Transition

## Provider Network Operations:

- Matched FFS providers to current network (% overlap).
- Informed IPAs of FFS providers and encouraged them to reach out.
- Focused network on more-capable IPAs.
- Educated IPA staff on transition and new regulatory requirements.
- Contract new providers such as nursing agencies, home health, SNF, etc.
- Contracted directly with hard-to-find specialists.
- Executed a contract with County DHS.

## Member Services:

- Added Call Center representatives.
- Hired new Health Navigators.
- Trained staff on how to handle complex calls.
- Created new technical bulletins and policies.
- Launched an outbound call program to no-choice or partial-choice members to get PCP and Plan Partner selection.
- Created a new Member Assignment Algorithm to support County DHS.

# Health Services

## SPD Department:

- Attended DHCS 1115 waiver stakeholder meetings.
- Coordinated response to DHCS policy letters and data requests.

## Medical Management:

- Hired new nurses and care coordinators.
- Hired a licensed clinical social worker.
- Launched a risk stratification and health risk assessment process.
- Created a ranking system to identify more-capable IPAs.
- Created a workgroup with County Department of Mental Health to improve access to mental health services.
- Created automated authorization process for IPAs to increase timely referrals.

## Pharmacy:

- Hired a clinical pharmacist and pharmacy technicians.
- Implemented 90-day transition plan to ensure new SPD members can continue with non-formulary or non-authorized medications.
- Sent a fax blast to pharmacies to educate about the SPD transition.

# Training

**Culture and Linguistics:**

- Trained L.A. Care staff on disability awareness.
- Webinars for providers.
- Video in ASL for deaf members on how to get interpreter services at clinics.

**Health Education:**

- Conducted needs assessment to guide health ed. program development.
- Launched "Living Well with A Disability" workshops in partnership with community-based organizations (CBOs), also held at FRCs.

**Family Resource Centers (FRCs):**

- Parenting classes for parents of children with intellectual/developmental disabilities (partnership with South Central L.A. Regional Center).
- Exercise class for adults with intellectual and developmental disabilities.
- Support group for adults with disabilities (partnership with Westside Center for Independent Living – an Independent Living Center (ILC)).

**Sales and Outreach:** Provided onsite trainings at FRCs, CBOs, ILCs.

- Attended SPD health fairs and community events to educate consumers and distribute L.A. Care collateral pertaining to the transition.

# Support Services

**Claims.**

**Legal:**

- Reviewed DHS contract amendments.
- Fast-tracked contracts and MOUs to ensure readiness for June 1st.

**Government Affairs.**

**Health Information Technology (HIT):**

- Expanding e-Consult.
- CTN.
- Launched HITEC-LA and EHR adoption to support capacity of providers to manage SPDs.

**Special Projects:**

- Patient-Centered Medical Homes.
- Contract with county Department of Health Services.

**Information Services:**

- Core system replacement.

# Contact Information

S. Rae Starr, M.Phil, M.OrgBehav
Senior Biostatistician
L.A. Care Health Plan
RStarr@LACare.org, rae_starr@hotmail.com
213-694-1250 x-4190

Earl Leonard, M.S.
Senior Biostatistician
L.A. Care Health Plan
ELeonard@LACare.org, ballers4christ@yahoo.com
213-694-1250 x-4714

## Online discussion on using CAHPS to improve quality of service:

http://groups.yahoo.com/group/member_satisfaction
member_satisfaction-subscribe@yahoogroups.com