FAMILY VOICES

Preliminary Summary of MCO Interviews in California

California Health Care Summit
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Purpose of the Interviews

There are three key purposes to having family leaders conduct interviews with managed care organizations (MCO). These are:

- to collect information from plans about practices and policies in areas of importance to CSHCN and their families;
- to share information on best practice examples from plans; and,
- to establish constructive relationships between MCO and Family Voices.

Funding Source

Funding provided by the David and Lucille Packard Foundation.

Interview Process

Family leaders contacted managed care plans and conducted interviews in teams of two with a member of the senior staff at the health plan. Interviewees were sent the information about the project and interview questions prior to the meeting in preparation for the interview.

Status Report

In California, 5 interviews have been completed to date. (Nationally, 18 interviews have been completed.) Interviews in CA have been conducted with plan directors and quality management staff. The plans that have been interviewed include plans that serve private consumers and MediCal managed care participants.

Summary Points

Based on the 5 interviews in CA, the following key points have been identified from review of the interview reports.

✓ *Identification of CSHCN*

Most of the plans said that they have systematic ways to identify CSHCN. Plans use CCS or regional center information to identify these children. The plans that said they did not have a formal way to identify these children did in fact informally use CCS or regional center eligibility. Additionally, one plan identifies children by diagnosis and use of certain medications.

✓ *Training for Staff about CSHCN*

Plans indicated that they use a variety of resources to train staff, including educational conferences, in-service training and staff newsletters. These include

information on specific programs for CSHCN and how to access and utilize these programs. One plan mentioned that they contract with Planned Parenthood to provide gynecological care for developmentally disabled enrollees. Another plan mentioned a disability conference that included a panel to present to staff.

✓ *Family Involvement in the Health Plans*

Plans mentioned consumer committees, many of which did not have "slots" for families of CSHCN specifically but consumers and families are invited to attend and participate. One plan has an outstanding service provider award for community involvement and consumers vote for this award.

✓ *Primary and Specialty Care for CSHCN (Ensuring Capacity)*

Most plans indicated that they had a large network of providers. Families are able to select their child's primary care provider, and several of the plans indicated that they allow or are considering allowing a specialist to be a child's primary care provider. Several plans indicated that they allow open-ended authorization for specialist visits. There was little attention in plans to the issues of transition from pediatric to adolescent and adult care. All of the plans had a pediatric hospital in their network.

✓ *Coordination of care*

The plans all have some form of case management. Referral to case management ranges from case by case referral to an open benefit for all plan members. For children in CCS, there is often case management as part of eligibility for this program. Most plans indicate that the coordinate with many other providers and agencies serving CSHCN. One plan indicated that they would provide a case manager even if the child has a case manager under another system.

✓ *Medical necessity*

Most plans had written definitions of medical necessity. One plan did not have a written statement but indicated that if a physician feels something will lead to significant improvement in health or quality of life then it is considered medically necessary. Several of the plans distinguished between habilitative and rehabilitative services; one plan relied on CCS policy to make this distinction.

✓ *Procedures for families when they disagree about care decisions*

Most plans have a formal appeal or grievance process. Information on this process is available to families, and in several plans is made available in a number of different languages. Dental care and speech therapy were mentioned by one plan as frequent areas of disagreement.

✓ *Innovative practices*

One plan participates in a state workgroup on how health plans and agencies serve CSHCN. Another plan indicated that they have discretionary funds that case managers can use to help families in many different ways, including helping parents spend the night when a child is in the hospital and for transportation needs. Newsletters for families were also mentioned as a way to provide information on services and other programs for

children. When families disagree about care decisions, one plan has an ombudsperson available. Another plan offered special training for families of children with diabetes and asthma, two high incidence conditions in their county. In addition, this plan sends birthday card to patients when they turn 18 years old to provide them with information on MediCal.

What Families Think

In contrast to the information obtained from the MCO interviews, families surveyed in the Your Voice Counts!!! national survey carried out in 1998 by Family Voices and Abt Associates indicated a number of problem areas. Families of CSHCN had problems: accessing specialty services, finding providers who were informed about the needs of their children, obtaining information that they needed, and having their child's care coordinated. Most parents, however, were satisfied with their child's primary care physician.

Preliminary Conclusions

More opportunity for discussion between family leaders and managed care plans will provide important information on the issues that CSHCN face in obtaining their health care. Both family leaders and MCO can learn from these discussions as each provide an essential perspective on these issues.