

**Adults with Disabilities in  
Medi-Cal Managed Care:  
Conference Summary**

*Prepared by  
Health Systems Research, Inc.*

June 2003

Report

**The Medi-Cal Policy Institute, established in 1997 by the California HealthCare Foundation, is an independent source of information on the Medi-Cal and Healthy Families programs. The Institute seeks to facilitate and enhance the development of effective policy solutions guided by the interests of the programs' consumers. The Institute conducts and commissions research, distributes information about the programs and the people they serve, highlights the programs' successes, and identifies the challenges ahead. It collaborates with a broad spectrum of policymakers, researchers, providers, consumer representatives, and other stakeholders who are working to create higher-quality, more efficient Medi-Cal and Healthy Families programs.**

# **Adults with Disabilities in Medi-Cal Managed Care: Conference Summary**

June 2003

Prepared for the Medi-Cal Policy Institute  
by Health Systems Research, Inc.  
Based on Discussions at a February 2003 Conference

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Medi-Cal Policy Institute  
476 Ninth Street  
Oakland, CA 94607  
tel: (510) 286-8976  
fax: (510) 238-1382  
[www.medi-cal.org](http://www.medi-cal.org)

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# Adults with Disabilities in Medi-Cal Managed Care: Conference Summary

## **Background and Purpose of the Meeting**

In January 2002, the California Legislative Analyst's Office (LAO) proposed that the state consider expanding Medi-Cal managed care for beneficiaries with disabilities as part of the solution to cover the state's (then) \$20 billion budget deficit. Although the California Legislature did not adopt this change, the proposal raised questions about the state of the current Medi-Cal delivery system for people with disabilities and the implications of moving more of this population into managed care.

On February 27, 2003, the Medi-Cal Policy Institute sponsored a meeting titled "Medi-Cal Managed Care for Working-Aged Persons with Disabilities: Current Status and Future Directions." The purpose of this meeting was to provide a forum in which policymakers, program administrators, representatives from health plans and provider organizations, consumer advocates, and researchers could participate in a productive discussion of the implications of expanding Medi-Cal managed care for people with disabilities.

To this end, findings from a number of recent studies commissioned by the Medi-Cal Policy Institute were released and discussed at the meeting. These publications are listed in Appendix A. The agenda for the meeting appears in Appendix B. The list of conference attendees and presenters appears in Appendix C.

In opening the meeting, Chris Perrone, director of the Medi-Cal Policy Institute, outlined four specific goals:

1. To improve the collective understanding of the characteristics, needs, and service use patterns of working-aged people with disabilities covered by the Medi-Cal program;
2. To improve understanding of the current Medi-Cal delivery system and its strengths and weaknesses in meeting the needs of beneficiaries with disabilities;
3. To identify promising approaches and potential pitfalls in expanding managed care for the this population by reviewing the experiences of other states that have pursued such initiatives; and
4. To identify opportunities and strategies for improving the Medi-Cal program's ability to meet the needs of beneficiaries with disabilities.

This report summarizes the presentations and discussions that took place at the meeting. It is organized around the following four topic areas: (1) the current policy context with respect to Medi-Cal managed care for people with disabilities; (2) the opportunities and challenges associated with a transition to mandatory managed care for Medi-Cal beneficiaries with disabilities, as perceived by consumers, providers, and health plans; (3) an examination of the lessons learned from other states that have enrolled working-aged Medicaid recipients with disabilities in managed care; and (4) the outstanding issues and information needs identified by participants.

## **The Policy Context: Medi-Cal Managed Care for People with Disabilities**

As of January 2003, roughly 6.3 million people in the state of California were enrolled in the Medi-Cal program. Of those, about 13 percent (approximately 767,000 individuals) were nonelderly individuals who qualified for the program because of a disability. On average, people with disabilities have higher health care costs than nondisabled individuals. As a result, beneficiaries with disabilities account for 44 percent of Medi-Cal program expenditures. (See *Medi-Cal for Non-Elderly People with Disabilities*, Medi-Cal Policy Institute, February 2003.)

These higher costs can be attributed to the fact that people with disabilities have health care needs that are greater than those of the nondisabled population: they often require more services, more specialty care and supplies, and they have more frequent episodes of acute illness requiring hospital stays. For example, a presentation by Todd Gilmer from the University of California, San Diego, indicated that pharmacy expenditures for adults with disabilities under Medi-Cal fee-for-service averaged \$2,500 annually, or roughly ten times the total of pharmacy costs for nondisabled adults. Likewise, the number of days that people with disabilities spent in hospitals was on average nearly four times what it was for the nondisabled.

Medi-Cal services are delivered either through traditional fee-for-service or through managed care. Roughly half of all Medi-Cal beneficiaries are enrolled in some form of managed care. As

described by Stan Rosenstein, deputy director of Medical Care Services at the California Department of Health Services (the state's Medi-Cal director), Medi-Cal has three main managed care models: County Organized Health Systems, Geographic Managed Care, and the Two-Plan Model. In addition, there are a number of small, specialized managed care programs for individuals with certain health problems, such as HIV/AIDS.

Enrollment in managed care is mandatory for nondisabled children and families living in the 22 counties in which Medi-Cal managed care programs operate. For beneficiaries with disabilities, enrollment in managed care is required in the 8 counties with County Organized Health Systems, but it is voluntary in the other 14 counties with managed care programs. Statewide, 64 percent of nondisabled beneficiaries are enrolled in managed care, compared to 21 percent of beneficiaries with disabilities.

Mr. Rosenstein emphasized that, from the state's perspective, one of the important goals of enrolling Medi-Cal beneficiaries in managed care is to improve their access to services and the quality of care they receive. However, he noted that although the state collects standardized quality data on the Medi-Cal program, only one of the measures focuses specifically on service use by people with a disability (eye exams for people with diabetes). Further, consumer satisfaction surveys conducted of managed care enrollees have not been geared to collect or analyze separately information about the performance of health plans in meeting the particular needs of individuals with disabilities.

In addition to access and quality considerations, managed care has also been seen by states, including California, as a way to control the growth of Medicaid spending. Farra Bracht of the Legislative Analyst's Office indicated that an expansion of mandatory managed care for working-aged Medi-Cal beneficiaries with disabilities could result in estimated annual savings of \$214 to \$360 million, of which half—\$107 to \$180 million—would be state General Fund dollars.

Ms. Bracht explained the key assumptions upon which this estimate was based, including: the exclusion of dual Medicare/Medi-Cal eligibles, individuals in long-term care facilities, and certain other populations; full (rather than phased-in) implementation in all counties in which Medi-Cal managed care programs currently operate; and the establishment of managed care health plan capitation rates at levels equivalent to 95 to 98 percent of fee-for-service expenditures. This savings estimate does not include any potential loss of federal funds for California's disproportionate share hospital programs that would occur for beneficiaries who enroll in a health plan.

In discussing the analyses being conducted by LAO, Ms. Bracht noted that her office is also examining the impact of another Medi-Cal program change with implications for people with disabilities. Namely, LAO is exploring the establishment of disease management pilot programs for coordinating the care of individuals with certain chronic conditions.

## Opportunities and Challenges Associated with the Implementation of Mandatory Managed Care

As noted by many of the participants at the meeting, Medi-Cal managed care for beneficiaries with disabilities can offer many advantages as compared to fee-for-service Medi-Cal, at least in concept. A presentation by the Center for Health Care Strategies outlined the potential benefits of managed care for a range of stakeholders. For consumers, it can provide access to prevention-focused primary care, coordination of care, and access to services not traditionally covered under fee-for-service Medi-Cal. States can use managed care to purchase a system of care based on value, to ensure greater accountability, and to guarantee budget predictability and cost containment over time. Any savings from expanding managed care can be used to support other priorities, such as maintaining current Medi-Cal eligibility levels, or possibly expanding these eligibility levels when the state's economy recovers. Health plans also benefit from higher enrollment and the opportunity to spread fixed costs across a larger enrollee population. For physicians and other providers, the benefits of managed care include assistance with care coordination for complex populations, better disease management, and in some cases, higher reimbursement rates than fee-for-service Medi-Cal.

Nevertheless, meeting participants raised a number of serious issues and challenges related to meeting the health care needs of people with disabilities—challenges that need to be addressed if care is to be improved for this population. Most of the challenges identified apply to both fee-for-service and managed care and are discussed below.

### Ensuring Access to Needed Services

Given the often complex health care needs of individuals with disabilities, it is important that these individuals have access to a wide range of services delivered by providers who are knowledgeable about the many health problems this population faces. Problems of adequate access to care under both managed care and fee-for-service arrangements were cited by many participants as a major issue and one of the core criteria to be used in assessing the impact of managed care expansions on the quality of care received by Medi-Cal beneficiaries with disabilities.

A key message arising from the meeting's discussions was the importance of addressing the concept of "access" broadly and at several different levels, particularly with respect to people with disabilities.

"Under the right circumstances, a managed care system could work, but I don't want someone else telling me they know what's best for me."

—Consumer with a Disability

The access issue was explored by Brenda Premo, director of the Center for Disability Issues and the Health Professions at Western University of Health Sciences, who presented preliminary findings from a series of focus groups with people with disabilities commissioned by the Medi-Cal Policy Institute. Certainly, whether a

Medi-Cal beneficiary is able to find a primary care physician or specialist who is willing to take Medi-Cal is a critical indicator of access. However, as Ms. Premo pointed out, this is a necessary but not sufficient condition for ensuring appropriate access.

Ms. Premo emphasized that other more qualitative attributes of the providers in the network are important. These providers must not only be willing to care for people with disabilities, but should also be knowledgeable about the many complex and often multiple conditions that people with disabilities have. Providers should also exhibit the appropriate awareness and sensitivity in caring for individuals with disabilities.

Further, while access to physicians, including subspecialists, was a central issue, the complex needs of individuals with disabilities make access to a broad range of medical and support services vitally important. Indeed, focus group participants and conference attendees emphasized the need to address the gaps that exist in the availability of such services as interpreter services; the maintenance, repair, and replacement of durable medical equipment; preventive services; dental care; mental health; and nonemergency transportation.

An equally important access-related issue is the need to ensure that health care providers' facilities and equipment are physically accessible to people with disabilities. Focus group participants cited such difficulties as nonaccessible exam tables and scales as barriers that negatively affect the quality of care they receive.

### **Coordination of Services**

Given the significant health care needs of many people with disabilities and their need for a broad array of health care services, there was general agreement among meeting participants that effective and appropriate care coordination is a key component of any system designed to meet the needs of this population.

Consumer representatives emphasized that the care coordination efforts they supported were not heavy-handed "gatekeeper" approaches that sought to keep costs down by limiting access to needed specialty care or other referrals. Rather, they advocated for care coordination approaches that sought to achieve quality and cost objectives by helping patients access needed services in an efficient, cost-effective manner. Consumer representatives also stressed the importance of these systems recognizing the value of and seeking input from individual patients (and their families, as appropriate) in decision making with respect to their care needs and options.

A survey of California health plans currently providing care to Medi-Cal beneficiaries with disabilities, conducted by independent consultant Jackie Nolen, revealed interest in providing care to this population and demonstrated a number of promising practices in care coordination and other areas. However, Ms. Nolen noted that the study also documents a number of significant barriers, including the challenge of carrying out effective care coordination when services (such as mental health services) are "carved out" of the care for which the plans are responsible. Those surveyed noted that it often is not clear what the role of the health plan

should be with respect to carved-out services and observed that the confidentiality concerns may preclude effective information sharing between the plan and the providers of those carved out services.

### **Identification of Beneficiaries with Disabilities**

The aforementioned survey of managed care plans also found that, while health plans expressed a willingness to provide care coordination and other support services to members with disabilities, it often is difficult for the plans to actually identify who these individuals are. Ms. Nolen explained that the Medi-Cal aid codes used to classify beneficiaries do not provide sufficient information to allow plans to develop targeted outreach efforts and to ensure that appropriate care coordination plans are developed for their members with disabilities.

### **Adequacy of Payment**

Several issues with respect to payment under managed care arrangements for care provided to Medi-Cal beneficiaries with disabilities were raised during the meeting. The first issue is the importance of ensuring that capitated payments made to health plans reflect the higher health care costs associated with people with disabilities. An analysis of Medi-Cal fee-for-service expenditures for different groups of program beneficiaries presented at the meeting by Dr. Gilmer showed that average annual Medi-Cal expenditures for beneficiaries with disabilities are significantly higher than for nondisabled beneficiaries (for example, in 2001 expenditures were nearly \$8,000 per adult with a disability versus slightly less than \$2,000 per nondisabled adult). His analysis also showed considerable variation in average expenditures among beneficiaries with disabilities based upon differences in the nature of their health conditions.

A second important payment-related issue associated with managed care is the level of payments that health plans receiving capitated payments from the state in turn pay to the providers with which they contract. Consumer advocates noted that many providers refused to participate in Medi-Cal under its fee-for-service system or through a managed care plan because of low reimbursement rates. For managed care plans to provide beneficiaries with disabilities with needed access to care, the plans will need to ensure that reimbursement rates are sufficient to generate an adequate supply of quality providers within their networks.

### **Enrollment and Outreach**

Many meeting participants felt that if managed care was to be successful in meeting the needs of people with disabilities, a comprehensive education effort targeted to consumers would be needed. Focus groups with consumers with disabilities revealed a significant lack of understanding about managed care options. Specifically, focus group participants residing in counties where managed care enrollment is currently voluntary were often unaware that they had a choice about whether to enroll in managed care or that they had a choice of health plan. Ms. Premo emphasized that if mandatory managed care is implemented, beneficiaries must be made aware of their health plan choices and they must be educated about their benefits,

grievances and appeals processes, and how to navigate managed care in general. As indicated in Ms. Premo's focus group findings, these were areas in which consumers experienced a significant lack of knowledge.

## **Lessons Learned from Other States**

Other states across the country have sought to improve quality and control costs by enrolling adult Medicaid beneficiaries with disabilities in managed care. Approximately 1.6 million nonelderly SSI recipients in 36 states are enrolled in Medicaid managed care; the majority are in mandatory, capitated plans.

To help California policymakers and stakeholders learn from these other states, the Medi-Cal Policy Institute commissioned a study to examine the experiences of states that have implemented a variety of managed care programs for their adult populations with disabilities. The study, conducted by the Center for Health Care Strategies (CHCS), highlights the lessons learned from four of these states—Massachusetts, New Jersey, Oregon, and Pennsylvania—as well as a number of other specialty managed care arrangements designed for specific populations with disabilities.

The CHCS report focuses on six key aspects of the Medicaid managed care initiatives that were examined: managed care model and design, beneficiary enrollment and consumer engagement, financing, network adequacy, care coordination, and quality monitoring and improvement. The report offers a series of lessons learned from the experiences of these states.

In summarizing their findings for conference participants, study authors Stephen Somers and Nikki Highsmith of CHCS highlighted the following overarching lessons learned from the study states that can help guide the development of future managed care initiatives:

- Envision a comprehensive program that is implemented at a reasonable pace.
- Quick fiscal relief is not a realistic expectation.
- Enrollees can benefit from more prevention-oriented, coordinated care.
- Capitalize on the managed care infrastructure to continuously improve quality.

An afternoon session at the conference complemented the CHCS study presentation by providing an opportunity for a panel of individuals knowledgeable about the managed care efforts in the study states to share their perspectives.

Peg Dierkers, an associate with Malady & Wooten Public Affairs and formerly the Pennsylvania Medicaid director, emphasized that increasing the value received for each program dollar spent is the biggest benefit to result from implementing comprehensive managed care for people with disabilities. The state's purchasing power is increased through such an arrangement because, in contracting with health plans, the state is purchasing an entire system of care,

“Remember: If you have a lot of carve-outs or many models of managed care, you’ll end up with service gaps. The more complex the model, the more overwhelming it becomes.”

—Peg Dierkers, former director  
of Pennsylvania Medicaid

including care coordination, rather than paying for individual services on a piecemeal basis. Similarly, she emphasized that the size of the state’s overall managed care program matters: With a larger program, states can spread the overhead, influence service delivery, and maintain stability and competition. Dr. Dierkers observed that Pennsylvania found that high numbers of carve-outs or differing models of managed care work

against these economies, and she emphasized that the more complex the model of managed care, the more overwhelming it becomes administratively. She also noted that Pennsylvania learned that it is important to carefully construct rates to motivate and protect providers, and that the sophistication of risk adjustment needs to increase over time.

Donna Checkett of Schaller Anderson, Inc.—a firm that has consulted with numerous health plans and Medicaid programs nationwide—offered a health plan perspective and identified what she considered to be the four essential building blocks for developing a successful managed care program for people with disabilities:

1. **Identification mechanisms** that use a broad range of tools to identify members with disabilities, such as screening tools, outreach, client surveys, claims data, and referrals.
2. **A network** that is wide and deep, with a range of facilities and levels of care, providers, coordination with schools, transportation, and other social services.
3. **Well-structured care coordination** that focuses on individuals with identified medical or social needs, provides coordination for a full continuum of care services, offers more intensive assistance for special needs cases (“high touch for high needs”), and supports data-driven decision making.
4. **Quality systems** that allow the tracking of utilization trends (for example, anticipated increases in primary care physician and outpatient visits and transportation services, and decreases in emergency room use and unscheduled hospitalizations) and member perceptions of health status. Systems and measures should also be put in place to promote a shift from crisis management to case management and eventually to self-management of chronic conditions.

Lowell Arye of the Alliance for the Betterment of Citizens with Disabilities in New Jersey noted that all stakeholders must play a role in the planning and implementation of any system, both to discuss issues and concerns and to ensure protections around people with disabilities. He stated that the involvement of consumer advocates is critically important because they can provide knowledge to government and health officials about the unique needs of people with

disabilities, assist in the development of provider networks, and serve as an extended arm of independent enrollment brokers in outreach to the community.

Mr. Arye suggested that advocates be involved in every stage of the process, through implementation. There are many roles for advocates to play, including:

- Participating in drafting the contracts and requests for proposals (RFPs) with managed care organizations to ensure protections are included for the most vulnerable populations;
- Creating a broad cross-disability coalition to work with the state and other stakeholders;
- Cultivating separate relationships with other stakeholders, including managed care and Medicaid officials;
- Ensuring that quality outcome measures specific to people with disabilities are included; and
- Promoting a commitment to evaluating the program in its early stages.

“Managed care, with the right protections, allows people with disabilities to get good services, but everyone must be on equal footing—from the CEOs of the health maintenance organizations to the advocates at the consumer level.”

—Lowell Arye, *Alliance for the Betterment of Citizens with Disabilities*

## **Suggestions Emerging from the Discussion**

While the objective of the conference was not to reach a consensus on whether current efforts to enroll Medi-Cal beneficiaries with disabilities should be expanded and enrollment made mandatory, there did emerge from the day’s discussions a number of overarching points about which most participants agreed.

### **1. A clear articulation of the goals and attributes of a desired system of care for people with disabilities is needed to ground debates about whether to expand managed care for this population.**

While a number of participants cautioned that the discussion of possible policy changes needed to be viewed in the context of the state’s very severe fiscal crisis, many participants suggested that the overarching goal of any system of care for people with disabilities should be to provide these individuals with access to the full range of high-quality services that they need.

Consistent with this goal, a set of desirable system attributes also emerged from the discussions, including:

- **Access** (broadly defined to include the scope of plan coverage, network adequacy, and physical accessibility of facilities) to a comprehensive array of health and enabling services (for example, transportation and interpreter services) delivered by knowledgeable and sensitive providers;
- **Effective care coordination** that facilitates, rather than impedes, access to needed services;
- An **emphasis on quality** and accountability;
- **Consumer involvement** and patient input in all aspects of the system's policies and processes; and
- Although budget predictability can be achieved in the short-term, long-term cost savings can be achieved only through a **cost-effective use of health care**; cost savings should not be the only driver in moving toward managed care.

**2. The public debate concerning the expansion of managed care enrollment requirements for Medi-Cal beneficiaries with disabilities is occurring in the absence of important information.**

A considerable amount of valuable information was shared during the meeting by state officials, the authors of studies commissioned by the Medi-Cal Policy Institute, and other presenters and participants. Nonetheless, it became clear during the discussions that much was not known about important topics, such as utilization patterns, the extent of access problems faced by disabled Medi-Cal beneficiaries under both fee-for-service and managed care, the quality of care these individuals receive and their levels of satisfaction under the two systems, and the cost of implementing some of the best practices highlighted by the health plan survey.

For California policymakers to make informed decisions that affect the systems through which Medi-Cal beneficiaries with disabilities receive critically important health care services, it is important that these information gaps be closed.

**3. In the absence of data on the performance of the Medi-Cal managed care and Medi-Cal fee-for-service programs, there can be no clear winner between the two options.**

Participants at the meeting spoke about problems involving the lack of access to providers, a lack of care coordination, and confusion about policies and processes under both the fee-for-service and managed care systems.

As was noted several times throughout the conference, managed care systems theoretically should be stronger in several areas (such as care coordination and quality/accountability). However, many participants expressed the fear that managed care's reimbursement rates, utilization review practices, and red tape would exacerbate, rather than alleviate, the problems that they confront in the fee-for-service sector.

What did come through in the day's discussions is that, while the above views reflect individual experiences, hopes, or concerns, the overall reality is less clear given the paucity of data to measure quality of care provided to beneficiaries with disabilities in either fee-for-service Medi-Cal or Medi-Cal managed care.

## **Looking Ahead**

To address these information gaps and the shortcomings that currently exist under both Medi-Cal managed care and fee-for-service Medi-Cal, meeting participants suggested that the following activities be pursued:

- Continue efforts to develop and articulate a clear statement of the goals, objectives, and attributes of the desired system of care for people with disabilities. The full range of stakeholders should be involved in these discussions.
- Begin to develop, collect, and report on quality measures that reflect performance in addressing the needs of people with disabilities. To the extent possible, comparable measures should be developed for both fee-for-service Medi-Cal and Medi-Cal managed care.
- Establish a consistent set of disability accessibility standards and guidelines for all Medi-Cal health care delivery models (fee-for-service and managed care).
- Facilitate a better understanding among consumers about Medi-Cal fee-for-service and managed care, including the scope of covered services, grievance procedures, and so on. Also, incorporate cross-disability awareness and sensitivity in provider education, training, and recruitment activities.
- Revisit and refine current estimates of savings associated with moving to mandatory managed care enrollment of adult Medi-Cal beneficiaries with disabilities to reflect the important issues raised during the meeting (for example, the need for a phased-in implementation).
- Examine other delivery systems models—such as disease management programs—in the context of the goals, objectives, and attributes of a desired system for people with disabilities.

In conclusion, a common theme among many conference participants was the importance of involving consumers—as well as other stakeholders—in future deliberations concerning systems of care for Medi-Cal beneficiaries with disabilities. It will only be with the active involvement of those who best understand the needs of the working-aged disabled population that California will be able to shape a health care delivery system that meets these needs in the most cost-effective, high-quality manner.



## Appendix A: Related Publications

Findings from a number of recent studies commissioned by the Medi-Cal Policy Institute were released and discussed at the conference. These studies will be published by the Medi-Cal Policy Institute and will be available on the Institute's Web site ([www.medi-cal.org](http://www.medi-cal.org)).

(Note: Titles in quotation marks are draft titles and the final publication might be published under a different title.)

- *Adults with Disabilities in Medi-Cal Managed Care: Utilization and Expenditure Trends, 1995-2001* – Todd Gilmer, University of California, San Diego
- “Focus Groups of Medi-Cal Beneficiaries with Disabilities” – Center for Disability Issues and the Health Professions, Western University of Health Sciences
- *Adults with Disabilities in Medi-Cal Managed Care: Health Plan Practices and Perspectives* – Jackie Nolen, Independent Consultant
- “Enrolling People with Disabilities in Medi-Cal Managed Care for the Right Reasons: Lessons from Other States” – Center for Health Care Strategies
- *Medi-Cal for Non-Elderly People with Disabilities*, Medi-Cal Policy Institute, February 2003

# Appendix B: Conference Agenda

February 27, 2003  
Holiday Inn Capitol Plaza  
Sacramento, California

**9:00 Welcome, Overview, and Purpose of the Conference**

- Chris Perrone, Medi-Cal Policy Institute
- Larry Bartlett, Health Systems Research, Inc.

**9:15 Program Highlights and Legislative Proposals**

- Stan Rosenstein, California Department of Health Services
- Farra Bracht, California Legislative Analyst's Office

**10:00 Insights from Recent Research**

- "Characteristics, Service Use, and Expenditures of Medi-Cal Beneficiaries with Disabilities" – Todd Gilmer, University of California, San Diego
- "Focus Groups of Medi-Cal Beneficiaries with Disabilities" – Brenda Premo, Center for Disability Issues and the Health Professions, Western University of Health Sciences
- "Medi-Cal Health Plans Serving People with Disabilities: Promising Practices and Perspectives" – Jackie Nolen, Independent Consultant

**11:15 Break**

**11:30 Lessons from Other States: Overview**

- Stephen Somers and Nikki Highsmith, Center for Health Care Strategies

**12:15 Lunch**

**1:00 Stakeholder Perspectives from Other States**

- Peg Dierkers, Malady & Wooten (former Pennsylvania Medicaid director)
- Donna Checkett, Schaller Anderson, Inc.
- Lowell Arye, Alliance for the Betterment of Citizens with Disabilities

**1:50 California Perspectives and Priorities**

- Jason Farrar, Medi-Cal Consumer Perspective
- Nic Forde, Sacramento Family Medical Clinic
- Robert Sillen, Santa Clara Valley Health & Hospital System
- Dave Meadows, Health Net

**2:30 Working Group Discussion**

Facilitator: Larry Bartlett, Health Systems Research, Inc.

**3:50 Closing Remarks**

**4:00 Adjourn**

# Appendix C: Conference Attendees and Presenters

February 27, 2003  
Holiday Inn Capitol Plaza  
Sacramento, California

## Attendees

**Michael Ashcraft, M.D.**  
Principal Consultant  
California Senate Insurance Committee  
Sacramento, CA

**Margaret Belton**  
Board Chair  
Personal Assistance Services Council of  
Los Angeles  
Sherman Oaks, CA

**Sharon Bishop**  
Principal Consultant  
Senate Republican Fiscal Office  
California State Legislature  
Sacramento, CA

**Randy T. Boyle, J.D.**  
Staff Attorney  
National Health Law Program  
Los Angeles, CA

**Jacquelyn Brand**  
President  
Independent Living Network  
San Rafael, CA

**Gretchen Brosius**  
Consultant  
Alameda Alliance for Health  
Alameda, CA

**Richard Bruno**  
Chief Executive Officer  
Inland Empire Health Plan  
San Bernardino, CA

**Rhys Burchill**  
Executive Director  
Area Board XI on Developmental Disabilities  
Santa Ana, CA

**Milton S. Camhi, M.P.H.**  
Chief Executive Officer  
Health Services Department  
Contra Costa Health Plan  
Martinez, CA

**Heather Campbell**  
Associate Director, Government Relations  
California Medical Association  
Sacramento, CA

**Catherine Campisi**  
Director  
California Department of Rehabilitation  
Sacramento, CA

**Edmund Carolan**  
Assistant Director, Government Programs  
California Primary Care Association  
Sacramento, CA

**Daniel Carson**  
Coordinator  
Legislative Analyst's Office  
Sacramento, CA

**Michael C. Collins**  
Executive Director  
State Independent Living Council  
Sacramento, CA

**Alec Cunningham, M.B.A.**  
Staff Vice President  
WellPoint Health Networks  
Camarillo, CA

**Caroline Davis**  
Special Projects Coordinator  
Medi-Cal Managed Care Division  
California Department of Health Services  
Sacramento, CA

**Jeffrey V. Davis**

Chief Operations Officer  
Universal Care  
Signal Hill, CA

**Mary K. Dewane**

Chief Executive Officer  
CalOptima  
Orange, CA

**Hellan Dowden**

Owner  
HR Dowden and Associates  
Sacramento, CA

**Cherie Fields, M.P.A.**

Executive Director, Policy and Analysis  
Local Health Plans of California  
Sacramento, CA

**Richard W. Figueroa**

Deputy Legislative Secretary  
Office of Governor Gray Davis  
Sacramento, CA

**Barbara J. Flynn**

Health Services Director  
Central Cost Alliance for Health  
Santa Cruz, CA

**Jean Fraser, J.D.**

Chief Executive Officer  
San Francisco Health Plan  
San Francisco, CA

**David J. Friedman**

Chief Operations Officer  
Public Programs  
Health Net of California  
Rancho Cordova, CA

**Maeve Gannon**

Coordinator, Benefits Department  
Center for Independent Living  
Berkeley, CA

**Bradley Gilbert, M.D.**

Medical Director  
Inland Empire Health Plan  
San Bernardino, CA

**Erin Aaberg Givans**

Executive Director  
Children's Specialty Care Coalition  
Sacramento, CA

**Dolly Chandra Goel, M.D.**

Medical Director  
Santa Clara Family Health Plan  
Campbell, CA

**Monica A. Goracke, J.D.**

DRA Fellow  
Disability Rights Advocates  
Oakland, CA

**Maridee Gregory, M.D.**

Chief  
Children's Medical Services  
California Department of Health Services  
Sacramento, CA

**Kathy T. Hajopoulos, M.P.H.**

Senior Program Officer  
California HealthCare Foundation  
Oakland, CA

**Peter Harbage**

Assistant Secretary  
California Health and Human Services Agency  
Sacramento, CA

**Richard Helmer, M.D.**

Chief Medical Officer  
Medical Affairs  
Molina Health Care, Inc.  
Long Beach, CA

**Howard Kahn**

Chief Executive Officer  
L.A. Care Health Plan  
Los Angeles, CA

**June I. Kailes**

Associate Director  
Center for Disability Issues and  
the Health Professions  
Playa Del Rey, CA

**Ellen Kaiser**

Director, Planning and Evaluation Services  
San Francisco Health Plan  
San Francisco, CA

**Deborah Kaplan, J.D.**  
Executive Director  
World Institute on Disability  
Oakland, CA

**Mary Lamar-Wiley**  
Acting Branch Chief  
California Department of Health Services  
Sacramento, CA

**Terry Mack, M.A.**  
Chief Executive Officer  
Health Plan of San Joaquin  
Stockton, CA

**Julie G. Madorsky, M.D.**  
Professor and Chairperson  
Center for Disability Issues and  
the Health Professions  
Western University of Health Sciences  
Encino, CA

**Denise K. Martin**  
President and Chief Executive Director  
California Association of Public Hospitals and  
Health Systems  
Oakland, CA

**Shawn Martin**  
Fiscal and Policy Analyst  
Legislative Analyst's Office  
Sacramento, CA

**John P. Monahan, M.P.H.**  
Senior Vice President  
State-Sponsored Programs  
Blue Cross of California  
Camarillo, CA

**Peter T. Nakahata**  
Director, Strategic Development  
CalOptima  
Orange, CA

**Gilbert Ojeda**  
Program Director—Academic Affairs  
California Program on Access to Care  
Berkeley, CA

**Barbara Palla, M.D.**  
Medical Director  
Central Coast Alliance for Health  
Santa Cruz, CA

**Elsa Quezada**  
Executive Director  
Central Coast Center for Independent Living  
Salinas, CA

**Steven B. Raffin, M.D.**  
Chief Medical Officer  
Public Programs  
Health Net  
Rancho Cordova, CA

**Curtis L. Richards**  
Director  
The Advocat Group  
Washington, DC

**Luis Rico**  
Acting Chief/Chief of Policy  
and Development Branch  
Medi-Cal Managed Care  
Sacramento, CA

**Silvia Rodriguez-Sanchez**  
Associate Mental Health Specialist  
Systems of Care  
California Department of Mental Health  
Sacramento, CA

**Linda Rudolph, M.D., M.P.H.**  
Chief Medical Consultant  
California Department of Health Services  
Sacramento, CA

**Bud Sayles**  
San Diego In Home Supportive Services  
Public Authority  
Chula Vista, CA

**Erin Schwier, M.A.O.T.R.**  
Policy Fellow  
Center for Disability Issues and the  
Health Professions  
Los Angeles, CA

**Gilbert Simon, M.D.**  
Medical Director  
Sacramento Family Medical Services  
Sacramento, CA

**R. Dean Smith**

Coordinator, Government Affairs  
Personal Assistance Services Council  
of Los Angeles County  
Sherman Oaks, CA

**Laurie A. Soman, M.S.W.**

Senior Policy Analyst  
Center for the Vulnerable Child  
Children's Hospital Oakland  
Oakland, CA

**Lucy Streett, M.P.H.**

Program Officer  
Medi-Cal Policy Institute  
Oakland, CA

**Marjorie C. Swartz, J.D.**

Attorney at Law  
Western Center on Law and Poverty  
Sacramento, CA

**Seren Taylor, M.P.H.**

Fiscal Consultant  
Assembly Republican Fiscal Office  
Sacramento, CA

**Janie Tyre**

Vice President of Marketing, Member Services  
Santa Clara Family Health Plan  
Campbell, CA

**James Verdier, J.D.**

Senior Fellow  
Mathematica Policy Research, Inc.  
Washington, DC

**F. Burns Vick, J.D.**

Public Policy Consultant  
Vick & Associates  
Sacramento, CA

**Jackie Walus-Wigle, R.N., J.D.**

Compliance Manager  
UCSD Health Plan  
San Diego, CA

**Dawn Wood, M.D.**

Vice President and Medical Director  
State-Sponsored Programs  
Blue Cross of California, Medi-Cal Programs  
Camarillo, CA

**Jacqueline Wright**

Director of Provider Services  
Santa Barbara Regional Health Authority  
Goleta, CA

**Patricia A. Yeager, M.S.**

Executive Director  
California Foundation for Independent  
Living Centers  
Sacramento, CA

**Beverly Yokoi**

Research Analyst II  
Fiscal Forecasting and Data Management Branch  
California Department of Health Services  
Sacramento, CA

## **Presenters**

**Lowell Arye, M.S.S.A.**  
Executive Director  
Alliance for the Betterment of Citizens  
with Disabilities  
Hamilton, NJ

**Lawrence Bartlett, Ph.D.**  
Director  
Health Systems Research, Inc.  
Washington, DC

**Farra Bracht, M.P.A.**  
Senior Fiscal and Policy Analyst  
California Legislative Analyst's Office  
Sacramento, CA

**Donna Checkett**  
Senior Vice President  
Schaller Anderson, Inc.  
Columbia, MO

**Peg J. Dierkers, Ph.D.**  
Associate  
Malady & Wooten Public Affairs  
Harrisburg, PA

**Jason Farrar**  
Grover Beach, CA

**Nic Forde, M.D.**  
Sacramento Family Medical Clinic  
Sacramento, CA

**Todd Gilmer, Ph.D.**  
Assistant Professor  
University of California, San Diego  
La Jolla, CA

**Nikki Highsmith, M.P.A.**  
Vice President for Programs  
Center for Health Care Strategies  
Lawrenceville, NJ

**David M. Meadows**  
Vice President  
Health Net  
Rancho Cordova, CA

**Jackie R. Nolen**  
Consultant  
Sacramento, CA

**Christopher Perrone, M.P.P.**  
Director  
Medi-Cal Policy Institute  
Oakland, CA

**Brenda Premo, M.B.A.**  
Director  
Center for Disability Issues and  
the Health Professions  
Western University of Health Sciences  
Pomona, CA

**Stan Rosenstein, M.P.A.**  
Deputy Director  
Medical Care Services  
California Department of Health Services  
Sacramento, CA

**Robert Sillen, M.P.H.**  
Executive Director  
Santa Clara Valley Health & Hospital System  
San Jose, CA

**Stephen A. Somers, Ph.D.**  
President  
Center for Health Care Strategies  
Lawrenceville, NJ



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HEALTHCARE  
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**Medi-Cal** *Policy Institute*

476 Ninth Street  
Oakland, CA 94607  
tel: 510/286-8976  
fax: 510/238-1382  
[www.medi-cal.org](http://www.medi-cal.org)

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