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Trepidation High as County Enters Managed Care Era

■ **Health:** Critics worry that poor will be overwhelmed by complicated system. But others see hope for better service.

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Sparking both fear and hope, Los Angeles County this week launches the nation's largest and most complex effort to enroll poor people into managed health care programs.

The hope is to cure a sick system beset by climbing costs and a bewildering bureaucracy and to broaden health care options for people long forced to take whatever they can get.

The fear, harbored by many doctors, consumer advocates and Medi-Cal patients, is of a rushed social experiment destined to cause mass confusion and medical disaster.

Critics got some support—and a reprieve—last week with the announcement by federal regulators that a feature of the massive Los Angeles program must be placed on hold because the regulators are "gravely concerned" over start-up problems in the assignment of patients to doctors. But that is surely a temporary measure, touching only on logistic questions and affecting only those patients who do not sign up voluntarily.

The larger philosophical debate—over whether California's approach to managed care is best for an often-transient, sometimes disenfranchised population—remains unsettled. Some say it will be settled, for better or ill, here in L.A. County, by far the biggest

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testing ground of an approach planned in 11 other counties.

"This [program] is conceptually flawed," argues Dr. Brian Johnston, president of the L.A. County Medical Assn. "We think this is not a good way to take care of health care. The underlying agenda is to limit costs, to control costs, by withholding services" to people ill-equipped to fight back.

Managed-care advocates counter that many physicians spurn the traditional Medi-Cal program as an unprofitable hassle, forcing patients to scout the landscape for providers or seek costly care in emergency rooms. Under managed care, a patient must first choose or be assigned to a doctor or clinic that will handle all the patient's health care and referrals; under more customary coverage, eligible people could go to any doctor or clinic accepting Medi-Cal.

"In managed care, you don't have to go walking through the Yellow Pages," said Joseph Kelly, who is heading the state's managed care effort. "It will increase and assure access."

How the Plans Differ

	Medi-Cal Health Plan	Regular Medi-Cal
Choosing a Doctor	Members choose from a list of doctors and clinics, and must go to the doctor for health care.	Members may go to any doctor or clinic that takes Medi-Cal.
Specialty Care and Other Providers	Members' doctor sends patients to specialists or other providers who are part of the health plan.	Members may go to any doctor or clinic that takes Medi-Cal.
Pharmacy, Medical Supplies	Each plan has pharmacies and other providers as part of the plan.	Members may take prescriptions to any pharmacy that takes Medi-Cal.
Exams for Well Adults	Plans cover physician checkups for healthy adults as well as for adults who are sick.	Only covers physician checkups for adults who are sick.
Medical Advice	All providers must have a 24-hour medical advice number.	Some doctors or clinics have medical advice numbers.
Health Education	All offer health education classes.	Some offer health education classes.
Changing Doctors	Members call a central office to choose a different primary care doctor.	Members unhappy with their doctor or clinic may simply go to a different one.
Changing Your Mind	Members may choose to leave the plan altogether, called "disenrollment."	Members unhappy with regular Medi-Cal can try out the Medi-Cal Health Plan.

A Choice of Two Programs

Critics are not of one mind on how to fix the old Medi-Cal system. But many agree that it is broken, and that managed care is coming, like it or not.

Other doctors and health experts are more optimistic, seeing this unprecedented transition as an opportunity to give poor patients the kind of stability, early attention and oversight they have never had before.

"We think it offers a sense of standardization, coordination and direction that fee-for-service Medi-Cal has not provided," said Dr. James Drinkard, medical director of Adventist Health Southern California Medical Assn. in East Los Angeles, which has served Medi-Cal patients for more than a decade. "I'm sure we won't know until we try."

Under the county's new "two-plan model," patients will choose between L.A. Care—actually a partnership of one public and six private plans—and Foundation Health, a private HMO, with two subcontracting plans. The managed care program involves paying the plans fixed monthly rates per patient as opposed to fees for each service, as in the traditional Medi-Cal program. The state's goal is to attract more providers with the guaranteed rates, while containing costs.

Beneficiaries may opt to stay in the traditional Medi-Cal program until both L.A. Care and Foundation are in full gear. After that, managed care will be the rule for most Medi-Cal recipients on welfare (not including many disabled and chronically ill beneficiaries).

California's most daunting challenge is in this county, which has a medley of cultures and languages, a public health system just yanked from the brink of collapse by a massive federal bailout, and a huge roster of a million eligible patients.

The county's venture, with contracts worth up to $10 billion over nearly six years, will have 10 times as many patients as the largest comparable endeavor in Northern California. Success would bring national acclaim. But failure, or even a shaky start that jolts the still-recovering public health sector, could create financial and medical chaos.

"A failure in the state's Medi-Cal program in Los Angeles, particularly one that causes collateral damage to the rest of the health care system, will cause sickness, suffering and death," the county medical association warned in February.

With L.A. Care set to open for business Tuesday, the local medical association and a cluster of consumer groups have desperately tried to slow, even stop, the switch to managed care.

They point to rocky start-ups in other counties. When Alameda County, for example, began its program last year, as many as 8 in 10 patients did not choose a plan and had to be placed in one, perhaps reflecting poor understanding of the program. The rate of such automatic assignments—also known as defaults—is now far lower.

Another possible preview comes from L.A. County itself, where since last fall a limited number of beneficiaries have been "defaulted" to managed care as their cases came up for review or as they entered the system for the first time.

Critics complain that patients were mis-assigned to plans they never heard of and that information sometimes wasn't sent or was wrong, confusing or late. Some examples, cited by patients, doctors and advocates:

- In Alameda County, two premature babies, born no bigger than kittens, were assigned by default to two different plans, a hospital official told the Assembly Health Committee in testimony last month. One child's assigned doctor had no experience with medically fragile infants. The other child, who desperately needs eye care to forestall possible blindness, could not be assigned a doctor because none was yet available in the area.

- A 64-year-old San Pedro grandmother with custody of six grandchildren said she learned late last year that the youngsters had been assigned by default to health care providers in Pasadena (35 miles away), Laguna Niguel (45 miles in the opposite direction) and El Monte (35 miles). The children were assigned to a mail-order pharmacy in Rancho Cordova, near Sacramento, more than 400 miles away.

She panicked at the apparent mistake and beseeched her doctor to sort it out. After a trip to Sacramento, he got her family back on traditional Medi-Cal.

- A premature baby who had been in intensive care for a month at a Los Angeles hospital had to be readmitted for vomiting and dehydration. The child's parents discovered they had been defaulted to an HMO that would not allow treatment at that hospital; they were directed by their plan to another hospital without expertise in fragile children. Medical association president Johnston, who is also an emergency room physician, refused to transfer the baby, and when the HMO still declined to authorize treatment, Johnston treated the child anyway.

"We asked the parents, 'Do you belong to an HMO?' They said, 'No, we didn't sign up.' " They probably had been notified, he said, but didn't understand what it meant.

The state has insisted that these enrollment glitches are a thing of the past, blaming most of them on a former contractor it has since sued. The old contractor, Benova Inc., contends that the state is looking for a scapegoat after poorly planning and funding the effort from the beginning.

Now, in a letter to the state, federal regulators say that the new enrollment contractor, Maximus, has not "demonstrated an ability to send timely or accurate mailings to beneficiaries" or provide "accurate and informative presentations. . . ."

Inch-Thick Information Packets

Whoever is to blame, critics worry that the woes bode ill for the incoming beneficiaries, not just in Los Angeles County, but everywhere managed care is being tried in California.

"This is the most complicated,

convoluted system," said Lynn Kersey, director of Maternal and Child Health Access, a community-based organization in downtown Los Angeles that serves poor mothers and children. "How do they select a plan? Whom do they ask? They get a packet chock full of information, but it's [sometimes] in the wrong language."

The inch-thick information packets sent to beneficiaries contain a variety of instructions and brochures. Until the last month or so, the cover letter was in English only, consumer groups complain. Now it is available in Spanish as well, although eight major languages are spoken in the county.

In Alameda County, community organizers and others offer this hard-earned advice to Los Angeles: Get the word out. The earlier the better.

"We had enrollments on site," said Ana O'Connor, associate director of East Oakland's La Clinica de la Raza. "Still, patients did not [sign up]. So we put a table right outside the medical department and told people, 'Hey, this is what the [enrollment] envelope looks like. . . . This is what you do."

Community organizations in Los Angeles County say they are struggling to educate people, but some lament that they don't have the resources, or the time, to do it right.

Meanwhile, L.A. Care and Foundation have been trying to inform patients and providers in community presentations. L.A. Care had planned a broader effort, but scaled back as start-up funds dwindled. The state launched its first communitywide publicity effort here this month with bus ads and a simplified explanatory brochure.

Some doctors and consumer groups have additional concerns—about the low payment rates, for example. The doctors worry they will be driven out of business. Though monthly rates to the health care plans will be about $75 per patient, primary-care physicians expect to receive between $5 and $9 per patient each month—not enough, they say, to cover their costs.

The state's Kelly and other managed care proponents explain that the doctors are being paid not just for patients they see, but for those they don't. Welfare families are relatively healthy, and most won't come in very often, but doctors will still receive monthly payments for them.

By federal law, managed care programs can use no more dollars than a traditional Medicaid program. The trouble, say critics, is that California's program has been sparsely funded for years.

"It's hard to imagine that without some rate adjustment that this thing will work for any period of time," said Mark Finucane, the county's Director of Health Services, who holds a seat on the governing board of L.A. Care.

The county's public health system was rescued from collapse in 1995 by a huge federal bailout. Now, county hospitals and health clinics, busy trying to build public-private partnerships in the community, face the added challenge of vying with private competitors for poor patients. Initially, the county's Community Health Plan will be guaranteed a certain level of patients to keep its funding intact. The trick will be to keep those patients after the guarantees are gone.

"Then it's really based on performance, and we will have to compete with the best of them," said Margaret Bermen of the county health department's managed care office.

The bulk of the medical care for the county's 2.7 million uninsured is paid for by federal and county funds. Medi-Cal dollars also indirectly benefit the uninsured by supporting the public health care system.

Johnston and others have unsuccessfully sought a unified plan incorporating both groups—the uninsured, and those publicly insured under Medi-Cal—as is being tried in Orange County, so that the entire poor population of the Los Angeles County—about half its residents—has better access.

The county medical association fears the once-teetering public health system could be brought down by a significant loss of Medi-Cal dollars—but Finucane is adamant that his department, and the federal government, won't let that happen.

"People know managed care will be a failure if this [public] safety net is done irreparable harm," he said.