**Testimony of Dr. Gilbert Simon**

December 7, 2011

CA State Capitol, Rm 4202

*Joint Health Committee Hearing on the 2010 Medi-Cal Waiver and the Future of Seniors and People with Disabilities in the Medi-Cal Program.*

Good Afternoon. My name is Dr. Gilbert Simon and I am a MCal provider and Medical Director of the Sacramento Family Medical Clinics, a network of 10 clinics ,which have been providing primary care services to MCal enrollees for 23 years and will do 100,000 visits this year. We provide care for about 45,000 MCal enrollees which are far greater than all the FQHCs in Sacramento combined. We are an independent traditional MCal provider group, a group which provides the overwhelming amount of care to the MCal population in Sacramento, but which does not get the support given to FQHCs. It is important to understand that most of the care to the indigent population comes from the private sector.

I am also a medical director for Employees Health Systems, an affiliate of SynerMed, a management service organization in Sacramento with an active case management staff and a robust IT system that supports coordinated care. EHS is also focused on the MCal population statewide, with 62,000 patients in Sacramento—7,000 of those patients are seniors and persons with disabilities (SPDs) and 1500 duels.

Since June, when the SPD transition from fee-for-service to managed care began, EHS has added 1,100 SPD patients. During this transition, SacFamily has continued to care for our former FFS SPDs while trying to assess and respond to the needs of the SPDs who are brand new to us.

Many of our new SPD patients are former UC Davis patients. Most arrive in our offices angry, upset, in crisis and without records. Not the best way to start a relationship, but we do the best we can for them. Often times, we cannot find services in the community that are available at UCD. The University Medical Center has always been the provider of last resort for the extremely high acuity Medi-Cal FFS patient.

I understand that patients being transitioned can keep their FFS specialists if the specialist agrees to accept the same payment rate that was agreed upon prior to the transition to managed care. Making that request to UCD seems to be appropriate since they are a publically funded institution with a stated mission of community service. Where do we turn to when our community specialists tell us that the patient’s only hope is UCD?

The enrollment and default processes are confusing to educated English speaking people. Can you imagine what it is like for our patients? We do our best at counseling our patients when we have the opportunity but once they leave our offices, they are on their own. The following example tells all.

A Romanian couple has been FFS patients of our Romanian provider for the last 14 years. They came to us when they received their letter advising them to select a provider under the new system. We did our best to help them but we cannot do the actual enrollment. The husband made it through but his wife, despite making the same choice as her husband, found herself defaulted to the Iranian doctor across the street. They completed their forms exactly the same way. Go figure! When she came back to us for her ongoing care, we discovered her problem and notified the Plan. We were told that they would do their best to get her back to her Romanian provider of 14 years by the first of the following month since they will not make the change retroactively.  What do we do in the meanwhile?

**We are expected to perform a comprehensive examination and health risk assessment during the first 60 days for every new SPD. I am told that data are being provided in advance but if so, not to us.**  I believe that the goal is to get this information to us ahead of time so we can develop care plans.

Since this doesn’t happen, we call each new patient to schedule his or her assessment. About half of the phone numbers we receive from the State are wrong. The remaining 50%,fall into three equally sized categories: 1) call and no answer or get an unkept promise of a return call; 2) reach someone and make an appointment which isn’t kept and the remaining 1/6th come in for an appointment .The other 5/6ths are technically in our system but they’re don’t appear until there’s a crisis.

**Conclusion**

This managed care transition is much smaller than the first one but because the patients are sicker, it carries far more risk. Everyone involved must make changes in the way they have been functioning.

Former FFS patients will have to accept the role of the primary care physician as orchestrator of their care and to trust them to determine when specialty care is needed.

Plans will have to understand that more leeway is needed in authorizing drugs, DME and the likes when they have been previously approved by the State’s TAR process. Having longer locked-in periods may make them more comfortable with this.

MCal providers will have to accept their role as managers of complex medical problems and may have to learn a few new skills, especially in the area of behavioral health. Almost half of our new SPDs have a major mental health disorder.

Tertiary care facilities such as UCD might consider contracting with all Plans at reasonable rates since they are providers of the last resort.

The State needs to align their expectations with the realities of caring for this population. Allowing more face-face processing will facilitate enrollments and choices and thereby achieve a higher percent of choice selections since many recipients become virtually inaccessible once they leave their provider’s office and get lost in a world of confusion.

We all have to make accommodations but at the end of the day, coordinated care is still better for patients and budgets than uncoordinated care. Thank you for your attention.