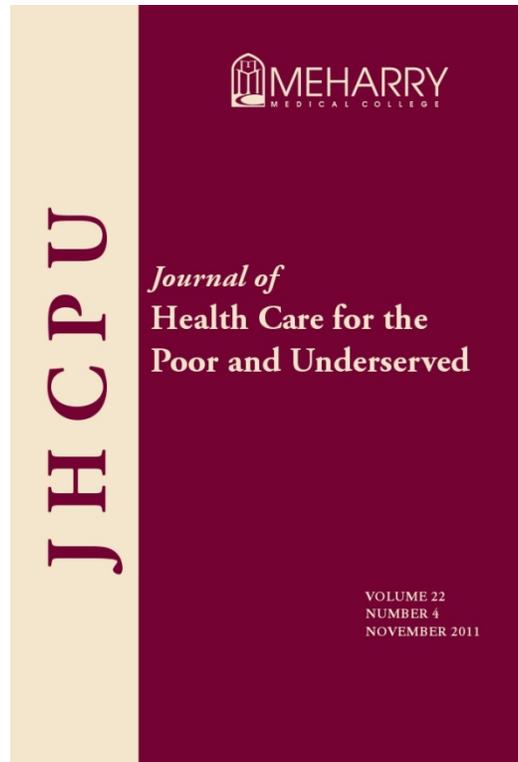




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Fee-for-Service and Managed Care for Seniors and People with Disabilities on Medicaid: Implications for the Managed Care Mandate in California

Fee for service and managed care Medicaid for SPD beneficiaries

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Abstract: **Objective.** To assess differences in perceived quality of care between fee-for-service (FFS) and managed care Medicaid (MMC) by seniors and persons with disabilities (SPD) and to generate hypotheses for future evaluations of the new managed care mandate for SPD in California. **Methods.** A cross-sectional telephone survey of 403 SPD Medicaid beneficiaries comparing perceived access to, satisfaction with, and quality of care between beneficiaries who had voluntarily enrolled in MMC with those who had remained in FFS. **Results.** Beneficiaries in MMC were more likely to be “very satisfied” with their benefits than those in FFS. There was no significant difference on any measure of access to care. Most beneficiaries in MMC reported their access to and quality of health care was either the same or better than it had been in FFS. **Conclusion.** On most measures, MMC was rated either the same or better than FFS by SPD beneficiaries who voluntarily enrolled in MMC.

Key words: Medicaid managed care, quality of care, access to care, seniors and people with disabilities.

Of the 60 million Medicaid beneficiaries in the U.S., seniors and people with disabilities (SPD) represent just one-fourth of program enrollees. However, because of their higher utilization of acute and long-term care services, they account for 70% of program spending.¹ While SPD in California have been the only beneficiaries who were offered a choice between fee-for-service (FFS) and Medicaid managed care (MMC) in the past, this is changing. As part of Federal Medicaid Waiver 1115, the state of California will, for the first time, mandate SPD beneficiaries into MMC—effectively moving approximately 380,000 Medicaid-only SPD from FFS to MMC in 16 California counties beginning in June 2011. It is estimated that this new policy could reduce California's Medicaid spending for each SPD beneficiary by approximately \$90 per month, saving the state \$365 million annually.² Although they are routinely grouped together by the state for policy purposes, the SPD Medicaid-only population in California is made up of approximately 90% people with disabilities and only 10% seniors (personal written communication from the California Department of Health Care Services, September 2009). Beneficiaries are exempted from the new managed care mandate if they are dually eligible for Medicare, foster children, in long-term care, pay a share of cost, or receive California Children's Services.³ This research compared the experiences of SPD beneficiaries who voluntarily switched to managed care with those who remained in FFS in order to generate hypotheses and set the stage for future evaluations of the managed care mandate.

In 1994, the California Department of Health Care Services (DHCS) began moving a large segment of its Medicaid (called Medi-Cal in California) population from a FFS delivery system to a managed care delivery system. Medi-Cal beneficiaries in 16 managed care counties typically have at least two managed care plans to choose from, including at least one

commercial plan and one local initiative (county organized) health plan.* The goals of the managed care system in California are to increase access to care, improve the quality of care, and control costs. Medi-Cal managed care health plans are required to have the infrastructure to provide both the primary and specialty care that beneficiaries require. Once beneficiaries are enrolled in MMC, they choose (or are assigned) a primary care provider who focuses on primary and preventive care and acts as a gatekeeper and referral agent for specialty care. The state requires MMC plans to ensure that beneficiaries get the appointments they need within a defined amount of time. Although the MMC program covers the same benefits as FFS Medicaid, the program makes costs more predictable by paying a capitated rate for each beneficiary rather than paying providers per visit as in a FFS system. Medicaid managed care has also been associated with large reductions in hospitalizations for ambulatory sensitive conditions compared with fee-for-service Medicaid, which likely reflects both cost reductions and improvements in access to care.⁴

Currently, 48 of the 50 states have some portion of their Medicaid population enrolled in managed care, and it is the dominant delivery system in most states.⁵ In California most non-SPD Medi-Cal beneficiaries are required to enroll in managed care in counties where it is available. The SPD population was originally exempted from this mandate and was instead defaulted to FFS. However, they were given the option—and in fact encouraged—to enroll voluntarily in MMC. While providing beneficiaries with a choice of delivery systems is typically associated in the literature with more beneficiary satisfaction and access to care,⁶ studies of the SPD population show that, despite efforts to inform beneficiaries of their choices, the majority had 1) low levels of awareness of their choice; and 2) a poor understanding of the differences between the two delivery systems.⁷⁻¹¹ According to DHCS few Medi-Cal only SPD in California

*Eight California counties have a county organized health system (COHS) where one managed care health plan covers all Medicaid beneficiaries including SPD.

make an informed choice between delivery systems and over three quarters of these beneficiaries default to FFS (written personal communication with DHCS, January 2010).

Seniors and people with disabilities were originally exempted from the managed care mandate because of concerns from consumer advocacy groups that managed care might limit access, decrease the quality of care, or interrupt care for this high-needs population.¹² There is little definitive evidence supporting this assertion, however. Research focused specifically on Medicaid beneficiaries with disabilities show that health care access and use of services for beneficiaries enrolled in mandatory managed care programs were not significantly different on most measures from those in FFS.¹³ In studies of the general Medicaid population (not focused specifically on SPD), those in HMOs scored better on access to care measures and reported higher satisfaction than those in FFS Medicaid.^{14,15} In qualitative studies of access to care specifically for seniors and persons with disabilities, access to primary care appears to be slightly worse in FFS, and poor access to specialty care is reported as a major problem in both delivery systems.^{9,16,17} There is also evidence that access to specialty physicians might be particularly limited in MMC in California;¹⁸ however, these studies do not single out the SPD population.

Study results are mixed on the effect of MMC on racial disparities in access to health care. One study showed that MMC (for a general Medicaid population, not just SPD) did not reduce racial disparities in access to and use of preventive services,¹⁹ while another found that racial minorities had better access to primary care in managed care than in fee-for-service Medicaid.²⁰

With the passing of Federal Medicaid Waiver 1115 and the resulting transition of SPD into mandatory managed care Medi-Cal, it is more important than ever to predict how MMC will affect access to, quality of, and satisfaction with care for Medi-Cal SPD beneficiaries. To explore

these questions in depth, we conducted a cross-sectional telephone survey of SPD on Medi-Cal, including one group in FFS and one group who had voluntarily switched to MMC. The research objectives were to assess differences in perceived access to care, perceived quality of care, and satisfaction with care and to identify important domains for future evaluations of the SPD managed care transition in California.

Methods

We conducted a cross-sectional study in which we interviewed the following groups of SPD Medi-Cal beneficiaries:

- Managed care (MMC) beneficiaries (N=200): This group included beneficiaries who had switched from FFS to MMC within 22 months of the telephone survey.
- Fee-for-service (FFS) beneficiaries (N=203): This group included beneficiaries who were on FFS both 22 months before and at the time of the telephone survey.

Beneficiaries from these two groups were randomly sampled from lists provided by DHCS of beneficiaries meeting the inclusion criteria: English-speaking, seniors or people with disabilities aged 18 years or older on Medi-Cal, and living in one of three California counties (Riverside, Sacramento, or Alameda). We chose to include beneficiaries in the MMC group who had switched to MMC within 22 months of the survey in order to get relevant comparisons between FFS and MMC. Beneficiaries were excluded from the study if they had made more than one change in delivery systems between May 2008 and October 2009 (e.g., those who started out on FFS, switched to MMC, and then switched back again before the telephone survey) or were dually eligible for Medicare and Medi-Cal.* A total of 31,074 potential participants remained. We cleaned the list to eliminate potential participants with missing/invalid phone numbers;

* Beneficiaries who are dually eligible for Medi-Cal and Medicare were excluded because Medicare is the primary payer and they are eligible for Medicare managed care plans.

addresses that appeared to be non-residential institutions (e.g., regional centers); prisons; and participants in a previous survey we conducted.¹⁵ We retained only one beneficiary at each address or phone number. After cleaning the list, the remaining 1,482 MMC beneficiaries and a random sample of 3,000 from the list of 29,592 FFS beneficiaries were used as the stratified sampling frame. Survey respondents included 200 MMC beneficiaries and 203 FFS beneficiaries. Table 1 compares the population of potential respondents with the survey respondents on age, type of beneficiary, and county of residence.

	Potential respondents n=31,074	Survey respondents n=403
Mean age (SD)	47.0 (14.7)	48.1 (12.7)
County [n (%)]		
Alameda	9894 (31.8)	115 (28.5)
Sacramento	9875 (31.8)	136 (33.8)
Riverside	11305 (36.4)	152 (37.7)
Type of beneficiary [n (%)]		
Senior	2228 (7.2)	18 (4.5)
Disabled	28846 (92.8)	385 (95.5)

Table 1. Comparison of potential respondents vs. survey respondents

Beneficiaries who could not participate in the survey because of a disability were offered the option of having a health care proxy respond to the survey in their stead.* We conducted telephone interviews between January 12, 2010, and March 16, 2010. Following the guidelines of the American Association for Public Opinion Research (rate 3), we calculated a response rate of 64% for MMC beneficiaries and 65% for FFS beneficiaries.

Domains were selected for examination based on the themes that emerged from previous qualitative focus groups with MMC and FFS SPD Medi-Cal beneficiaries⁹ and included: satisfaction with care, perceived quality of care, and perceived access to prescription drugs, primary care, specialty care, disability access, and overall quality of care. The questions

* A health care proxy was defined as a person who made health care choices for the beneficiary.

regarding satisfaction with current care, attitude toward MMC, and likelihood of switching back to FFS (asked only of respondents who were enrolled in an MMC plan) were developed by the researchers for a previous survey with the same population.⁷ The items assessing perceived access to care with their current benefits were adapted from items in the Consumer Assessment of Healthcare Providers and Systems (CHAPS) Health Plan Survey 4.0.²¹ Questions asking respondents who are enrolled in an MMC plan to rate their current quality of care and access to care compared with when they had FFS Medi-Cal were developed by the researchers. In addition to questions about demographic characteristics, we also included a measure of health literacy (the ability to understand and act on health information) developed by Chew *et al.*²²: “How confident are you filling out medical forms by yourself?” The survey instrument was piloted and revised accordingly prior to beginning the telephone interviews. We used Lorig’s self-efficacy questions²³ as a model to create two new self-efficacy questions (referred to as *confidence*) related to making Medi-Cal choices.

The Office for the Protection of Human Subjects at the University of California, Berkeley approved all procedures for this research, including those for informed consent.

Results

Demographic characteristics. The majority of survey respondents were female (71.2%), under 65 years of age (95.5%), and Medi-Cal beneficiaries (78.9%), rather than proxies. The mean age was 51 years. Most respondents were never married (33.7%), divorced (26.3%), or married (19.5%) (the remainder living with a partner, widowed, or separated). Respondents reported their educational level as high school graduate/GED or less (52.6%), some college or vocational school (32.6%), or college graduate or above (14.8%). When asked to rate their general health, most respondents reported good (23%), fair (34.5%), or poor (27.5%).

Beneficiaries of MMC and of FFS differed significantly on only three demographic characteristics: race/ethnicity ($p=.0003$), county of residence ($p=.0463$), and confidence filling out medical forms ($p= .0139$). Beneficiaries of MMC were much more likely to be White (54.4%) than African American (19.2%); FFS beneficiaries were evenly distributed among Whites (37.6%) and African Americans (40.6%). Beneficiaries of FFS were evenly distributed between the three counties, while MMC beneficiaries were most likely to live in Riverside County (43.5%). Beneficiaries of FFS were more likely to report the lowest levels of confidence filling out medical forms—24.6% reported *A little bit confident* or *Not at all confident*—compared with 14.5% of MMC beneficiaries.

Attitudes and self-efficacy. We asked all respondents to rate their current attitude toward MMC (“Are your impressions of Medi-Cal Health Plans generally positive, neutral or negative?”). Those in MMC were more likely to report a positive attitude toward MMC (45.0%) than those in FFS (30.4%, $p= .0116$).

To measure beneficiaries’ self-efficacy, respondents were asked two questions regarding their confidence getting health care and their confidence understanding their Medi-Cal choices. There was no statistically significant difference between MMC beneficiaries’ and FFS beneficiaries’ feelings of confidence getting the health care they need (“How confident are you that you understand how to get the health care that you need--very confident, somewhat confident, or not at all confident?”). Overall, 42.6% were very confident and 45.1% were somewhat confident. Beneficiaries currently in FFS were less likely to feel confident that they understood their choices in types of Medi-Cal plans (“How confident are you that you understand the different types of Medi-Cal plans you have to choose from—very confident, somewhat confident, or not at all confident?”). Beneficiaries of FFS were more likely to report

being not at all confident compared with MMC beneficiaries (33.0% and 20.9% respectively, $p=.0187$).

Satisfaction with benefits. We asked about respondents' general satisfaction with their current benefits ("Are you now satisfied or dissatisfied with your current Medi-Cal benefits? Would you say you are very (dis)satisfied or somewhat (dis)satisfied?"). Most respondents were either somewhat or very satisfied (32.4% and 33.4%, respectively) with their current Medi-Cal benefits. Beneficiaries in MMC were more likely to report being very satisfied with their benefits than were beneficiaries on FFS (39.8% vs. 27.3%, $p=.0086$). African American beneficiaries in MMC were more likely to report being somewhat or very satisfied with their current benefits (62.9%) than African American beneficiaries in FFS (55.1%) ($p=.0388$).

Beneficiaries of MMC were asked to rate their overall quality of care since switching to a MMC plan ("Since switching to a Medi-Cal Health Plan, would you say the overall quality of care you receive is better, the same or worse than when you were on regular Medi-Cal?"). Most said their current quality of care in MMC was better or about the same as it was in FFS. Forty-nine percent (95% confidence interval (CI) 42.1 — 56.3) said quality of care was better in MMC than in FFS. Thirty-eight percent (95% CI 30.8 — 44.6) said quality of care was about the same as in FFS. Thirteen percent (95% CI 8.3 — 17.9) said quality of care was worse than in FFS.

To assess satisfaction with MMC further, we asked MMC beneficiaries, "Are you likely or unlikely to switch [name] back to Regular Medi-Cal in the next six months? Are you very (un)likely or somewhat (un)likely?" Most said they were unlikely to switch back, with 70% saying they were very unlikely and 14.8% saying they were somewhat unlikely to switch back to FFS. It should also be noted that most FFS beneficiaries also said they would be unlikely to switch to MMC.

Access to care and quality of care. We compared perceived access to care between SPD in FFS and MMC by asking a series of questions about access to care with their current benefits. Respondents were asked to think back to the past 12 months if they had FFS Medi-Cal or since they enrolled in a MMC plan if they had MMC Medi-Cal. In all five domains (prescription drugs, primary care, specialty care, disability access, and overall quality of care), there were no significant differences between beneficiaries in MMC and beneficiaries in FFS. We also asked MMC beneficiaries to compare their current health care in MMC with the care they received in FFS (“Compared to when you were on regular Medi-Cal, would you say your access to [prescription drugs, primary care, specialty care, etc.], is better, about the same, or worse than when you were on regular Medi-Cal?”). In all domains, most MMC beneficiaries said their current MMC benefits were either the same as or better than those in FFS.

Access to prescription drugs. There were no significant differences between MMC beneficiaries and FFS beneficiaries in their perceived access to prescription drugs (“How often was it easy to get your prescription medication from your health plan—never, sometimes, usually or always?”). Overall, 50.1% of both groups said it was always easy to fill prescriptions, and 25.6% said it was usually easy.

Beneficiaries of MMC said their current access to prescription drugs in MMC was about the same or better than it was in FFS.

- 39.1% (95% CI 32.0 — 46.3) said access was better in MMC than in FFS.
- 46.9% (95% CI 39.6 — 54.2) said access was about the same.
- 14.0% (95% CI 8.9 — 19.1) said access was worse in MMC than in FFS.

There were some differences by race. Overall, Whites were more likely to report that it was always or usually easy to get prescriptions (81.9%) compared with African Americans

(64.5%, $p=.0071$). Among FFS beneficiaries, Whites were more likely than African Americans to report it was always or usually easy to get prescriptions (83.8% vs. 58.1%, $p=.0099$).

Among African Americans in MMC, results on access to prescriptions were mixed. African American beneficiaries in MMC were more likely to report it was always or usually easy to get prescriptions (77.8%) compared with African American beneficiaries in FFS (58.1%) ($p=.023$). On the other hand, African American beneficiaries in MMC were more likely to report their access to prescription drugs is worse in MMC than it was before in FFS (25.7%) compared with White beneficiaries in MMC (9.3%) ($p=.0514$).

Access to primary care. To assess perceived access to primary care, respondents were asked "Not counting the times you needed health care right away, how long did you usually have to wait between making an appointment and actually seeing your primary care doctor--the same day or within one week, within one month, within two months, or within three or more months?" There were no significant differences between MMC and FFS beneficiaries. Overall 66.0% reported waiting one week or less.

Beneficiaries of MMC were asked to rate retrospectively their access to primary care compared with when they were in FFS. Most said their current access to primary care was the same or better than their access in FFS. Forty-three percent said access was better in MMC than in FFS (95% CI 35.5 — 49.8). A similar proportion (44.3%) said access was about the same (95% CI 37.1 — 51.5). A far smaller proportion (13.1%) said access is worse in MMC than in FFS (95% CI 8.2 — 18.0).

Access to specialists. Respondents were asked, "How often was it easy to get appointments with specialists—never, sometimes, usually or always?" There were no differences between MMC beneficiaries and FFS beneficiaries on self-reported access to specialists. Overall the range of responses varied more than the responses to the other access questions. Nearly a

third (32.2%) said it was always easy to get appointments. Nearly one quarter (23.9%) said it was usually easy to get appointments. Similar proportions said it was sometimes easy to get appointments (22.7%) and that it was never easy to get appointments (21.2%).

Beneficiaries of MMC said their current access to specialists was the same or better than it was in FFS. Forty-one percent said access was better in MMC than in FFS (95% CI 33.8 — 48.9). Forty-four percent said access in MMC was about the same as in FFS (95% CI 36.2 — 51.5). Fifteen percent said access in MMC was worse than in FFS (95% CI 9.3 — 20.3).

Disability access. Beneficiaries with disabilities were asked about their access to disability services at their doctor's office. Respondents were asked, "How often have you had trouble getting the care you needed at the doctor's office because they did not have the services or equipment to accommodate your disability--never, sometimes, usually or always?" Disability services were described for respondents as: "...special equipment such as wheelchair ramps, adjustable tables, or other equipment and services that make it easier for people with disabilities to get the care they need at the doctor's office. When offices don't have these things, it can be more difficult for people with disabilities to get the care they need." There were no significant differences in perceptions of MMC beneficiaries and FFS beneficiaries regarding disability access. Overall, 71.0% said they never had difficulty getting health care because of poor disability access.

Beneficiaries of MMC said their disability access was about the same or better than it was in FFS:

- Nearly a third (32.2%) said access was better in MMC than in FFS (95% CI 22.4 -- 42.0).
- Over half (55.2%) said access was about the same as FFS (95% CI 44.7-65.6).

- A much smaller proportion (12.6%) said access was worse in MMC than in FFS (95% CI 5.7-19.6).

Discussion

Many states face critical decisions about the use of managed care for seniors and people with disabilities (SPD) on Medicaid. Although advocacy and consumer groups have raised concerns about the appropriateness of Medicaid managed care plans for SPD, there has been little evidence to guide decisions. This study examined the experiences of SPD Medi-Cal beneficiaries in managed care and fee-for-service as a first step in predicting the experiences of SPD Medi-Cal beneficiaries when, beginning in June 2011, they are mandated to enroll in managed care plans. But because MMC has been optional for the SPD population in California, the MMC beneficiaries in this study voluntarily enrolled in managed care. Because we know that increased choice of health plan tends to have a positive effect on satisfaction,⁶ the mere fact that they were given a choice and were not mandated into MMC probably has some effect on their perceived experiences. Thus, while this study is not generalizable to populations mandated into managed care, its findings are useful for generating hypotheses for future evaluations of the managed care transition for SPD in California.

The study findings, based on the perceptions of beneficiaries themselves, generate the hypothesis that MMC could be an equivalent or better health care choice than FFS for many SPD beneficiaries. We found that beneficiaries who had voluntarily enrolled in MMC were more likely than those in FFS to be very satisfied with their current benefits and that the majority reported that they were unlikely to switch back to FFS. Furthermore, when we asked beneficiaries in MMC retrospectively to rate their access to care and satisfaction with care in FFS, most of those who had switched to MMC felt their access to care and satisfaction with care

was either the same, or better than, it had been in FFS. Finally, we found that there were no significant differences between the FFS and MMC beneficiaries' perceived access to care in any of the five domains studied (overall access, prescription drugs, primary care, specialty care, and disability access). These are all important hypotheses that future evaluations of California's Medi-Cal managed care transition can test. Additional studies should also include an examination of factors known to be particularly important for chronically ill or other high needs populations such as disruptions in care and changes in hospitalizations for ambulatory sensitive conditions.^{4,12}

Findings from this study also suggest that future evaluations should incorporate examination of effects of race on perceived experiences with managed care. In one domain (prescription drug access) findings suggested some differences by race: our findings bolster previous research²⁴ showing that managed care may ameliorate some racial disparities specifically around access to prescription drugs. In the present study, African Americans in FFS were less likely than Whites in FFS to report ease in getting prescriptions, while there was no statistically significant difference in ease of getting prescriptions between African Americans and Whites in MMC. On the other hand, African Americans who had voluntarily enrolled in MMC were more likely than Whites in MMC to report that their access to prescription drugs is worse in MMC than before. These mixed findings suggest that racial disparities for people in MMC would be an important topic for future research on the managed care transition for this population. The interviews in this study were conducted only in English, and because the experiences of non-English speaking populations may differ, we recommend that future evaluations of the managed care transition include non-English speaking Medicaid beneficiaries.

While this study shows that SPD beneficiaries who voluntarily enroll in MMC report their care is better than or the same as it was in FFS, these findings are not necessarily generalizable

to the upcoming transition during which Medi-Cal beneficiaries will be mandated into managed care. Short-term evaluation and long term monitoring of the transition to managed care will be essential to ensure that seniors and persons with disabilities continue to have positive experiences with their care. Given differences found by others between voluntary enrollees and those mandated to join managed care, future evaluations will require a stratified sample that will allow for comparisons of those who voluntarily enrolled in MMC and those who have been newly mandated into it.

This study sets the groundwork for future evaluations of the Medi-Cal managed care mandate in California. It both generates hypotheses that can be tested and is useful as a baseline to examine how SPD beneficiaries' perceived experiences might be different when they are mandated *versus* voluntarily enrolled in managed care plans.

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