California HealthCare Foundation

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Summary Brief

Medi-Cal Win-Win: Surging Enrollment Fosters Investment in the Safety Net

This summary brief looks at the post-ACA landscape through mid-2015 in terms of enrollment and health plan investments in the safety net. It highlights the main findings in *Medi-Cal Managed Care Plans and Safety-Net Clinics Under the ACA*, (www.chcf.org).

Buoyed by the expansion of Medi-Cal eligibility and benefits under the Affordable Care Act (ACA), the rolls of beneficiaries swelled from 7.5 million in 2010 to 12.4 million by early 2015.[1] Complementary policy initiatives, through the Bridge to Reform 1115 Medicaid Waiver in California, have expanded mandatory Medi-Cal managed care enrollment to additional populations and geographies.

The multiple policy and enrollment changes in 2013-2015 have resulted in new relationships, opportunities, and pressures for Medi-Cal managed care plans and safety-net clinics (see box), as Medi-Cal has increased its reliance on managed care.

This research examines the following questions:

- How has enrollment in Medi-Cal managed care plans changed over this tumultuous period?
- How are commercial and public Medi-Cal managed care health plans investing in safety-net clinics?
- What are the issues facing Medi-Cal managed care and its relationship to the safety net?

Definitions

Safety-net clinics. Include county primary and specialty services and community clinics and health centers (CCHCs).

Community clinics and health centers (CCHCs). Include licensed community clinics, Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes, Rural Health Centers (RHC), and Indian clinics.

Public plans. Local Initiative and County Organized Health Systems (COHS) are referred to as public plans.[2]

Medi-Cal Enrollment

Medi-Cal enrollment in public plans and safety-net clinics has grown sharply, and there have been significant financial investments by these plans in their safety-net clinic allies.

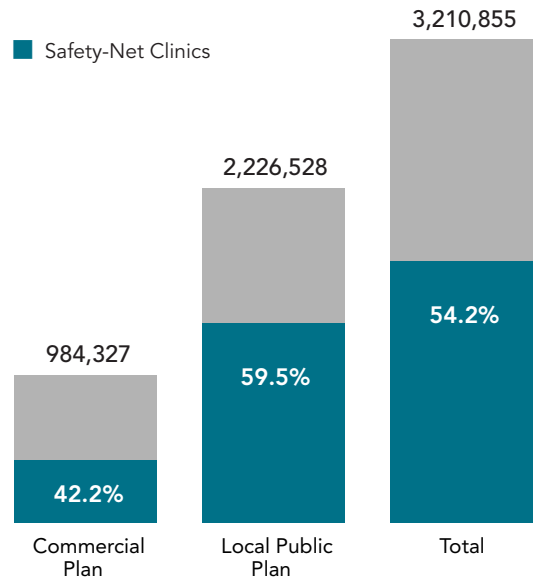
Major findings include:

- Public plans and safety-net clinics are major players in Medi-Cal managed care. Almost 70% of beneficiaries were enrolled with public plans in 2015. Safety-net clinics now have 41% of beneficiaries enrolled in Medi-Cal plans, including 30.3% in CCHCs and another 10.3% in county clinics.
- The safety-net clinics became even more important with the ACA expansion, after which they accounted for 54% of new managed care members. Safety-net clinics' share of overall enrollment rose from 33% in 2013 to 41% in 2015. Although the commercial plans also moved new members into these clinics, the public plans depended on them much more heavily, assigning almost 1.3 million new members to safety-net clinics in response to the expansion.
- There is wide variation in safety-net clinics' market share across type of clinic (county vs. CCHCs), type of health plan (commercial, Local Initiative, and COHS), geographic location (north vs. south), and Medi-Cal aid category (Adult Expansion, SPD, and other aid categories).[3] The COHSs have the highest safety-net clinic enrollment, followed by the Local Initiatives, and then the commercial plans. The CCHCs have a larger share of enrollment than do the county clinics in general, including all aid categories, while county enrollment is heavily concentrated in the Adult Expansion aid category. The safety net has a higher percentage of enrollment in Northern California than in Southern California.
- The high levels of Medi-Cal enrollment in public plans heightens the importance of quality data comparisons between commercial plans and public health plans. HEDIS[4] data from the Department of Health Care Services (DHCS) 2015 Aggregated Quality Factor Score ranks Medi-Cal managed care plans. The 11 highest scoring Medi-Cal plans (excluding Kaiser) are all public plans.[5]

Enrollment data from the 22 Medi-Cal managed care plans indicate that safety-net clinics provided the majority of access required to meet the explosive growth in Medi-Cal during the implementation of the ACA. About 3.2 million members were added to Medi-Cal managed care enrollment during this three-year period, and nearly 2.2 million (69%) were added through the Adult Expansion. Fully 54% of new managed care members entering public and commercial plans enrolled with safety-net primary care providers. The safety net had 60% of enrollment growth with public plans and 42% of enrollment growth with commercial plans.

The COHS plans had 73% of their growth enrolled in safety-net clinics. The safety-net enrollment is higher in the north (67% safety-net market share) than in the south (25% safety-net market share).[6] The most dramatic change in enrollment across the safety net and plans was the enrollment in county clinics through commercial plans.

Figure 1. Total Medi-Cal Enrollment Growth and Portion Attributed to Safety-Net Clinics, by Plan Type, September 2013 to April 2015



Note: *N* = total enrollment growth.

Source: Data self-reported by plans; special data run provided by DHCS & Research Analytics Division; DHCS Year 9 & 10 Default Algorithm Reports.

Health Plan Investments in Safety-Net Clinics

Interviews and self-reported data from both commercial and public plans documented a record of financial support and targeted payments for safety-net clinics designed to support access and quality improvements during the reporting period (2013-2015). Public plans were far more likely than commercial plans to make investments in safety-net

clinics and were more likely to pair payments with technical assistance. Commercial plans have lower enrollment, and their investments are spread over the state, while public plan investments are focused on a single county or region.

There are a variety of reasons for the higher level of investment: the public plan's mission to support safety-net viability; pressures to drive delivery system change to meet access and quality standards; and higher membership in safety-net clinics resulting in a greater need to invest. Public plan governing boards include safety-net leaders, bolstering support for redesigned delivery systems.

Interviewees from plans emphasized that new expectations for safety-net clinics — including timely access, quality benchmarks, comprehensive assessments, and care management — could not be met without designing new ways to incentivize and drive change. Clinics often did not have the expertise or resources needed to transform how they delivered care, and plans needed flexible ways to drive improvements. The investments were cited as an innovative approach to help plans meet contractual requirements related to access, quality, and care coordination.

Data from public plans demonstrated a consistent history of support; significantly high levels of investment; and a wide variety of incentives and technical assistance to support change. Approaches included incentive bonuses for improved access, on-site consultants to support practice redesign and improved efficiency, and learning collaboratives focused on team care, panel management, and advanced access. Interviewees noted that these investments resulted in reduced appointment delays, increased capacity for new patients, and improved quality scores.

Views from the Field

A number of insights and questions emerged from interviews with commercial and public Medi-Cal managed care plans and statewide stakeholder organizations.

Public Medi-Cal managed care plans absorbed the largest percentage of new ACA members. There is significantly more money flowing through Medi-Cal managed care plans to safety-net clinics as coverage expands and the state shifts populations into managed care.

Safety-net clinics are at the center of ensuring access for both public and commercial Medi-Cal managed care plans. State policy now explicitly encourages health plans to contract with safety-net clinics. Health plans noted there is inconsistent and insufficient capacity across safety-net clinics to meet new capacity and practice transformation expectations.

Value-based purchasing requires rapid reboot. Government and health plan payments to providers are moving to value-based purchasing to align quality and care coordination, and increase prevention. New payment models that acknowledge the needs and strengths of safety-net clinics and identify unique safety-net value are nascent.

DHCS role as an active purchaser to uphold performance standards becomes more formal. The state's oversight role is increasing as a consequence of expanded reliance on organized systems of care and the significant size of the Medi-Cal program. These efforts bring new reporting burdens and potential business consequences for health plans and providers.

Increasing scrutiny follows from expanded reliance on managed care. The expansion of managed care is increasing scrutiny on performance standards such as timely access to care for new members.[7] There is some question as to whether safety-net clinics can meet or even adequately report on compliance measures, and failure to meet standards is tied to financial penalties.

Federal and state regulators have significantly increased oversight and monitoring of system performance. There is significant question as to whether safety-net clinics can meet or even adequately report on compliance measures. How will plans, public and commercial, respond if safety-net clinics do not perform as required? Will financial penalties fall disproportionately to the safety net? How will state and federal regulators handle deficiencies that remain?

Concerns about competition for Medi-Cal enrollment remain top of mind. Although public plan enrollment remains strong, there are longstanding concerns that public plan enrollment may decrease, over time, which will, in turn, reduce plan stability and result in reductions in resources available for safety-net investment. Commercial plans have less history with safety-net clinics and are less likely to favor specific policies to support enrollment.

Plans perceive shifting attitudes from DHCS and CMS. Notwithstanding state policy initiatives in support of the safety net, plans perceive, at best, an indifferent attitude from DHCS toward the safety net. CMS proposed rule changes for Medicaid managed care that eliminate specialized payment arrangements supporting the safety net (Intergovernmental Transfer Process and Disproportionate Share Hospital) signal a possible shift.[8] The combination of financing restrictions and potential reporting sanctions could result in lower rates or return of funds from health plans. A caution emerged from plan leaders about whether the relative stability that public plans currently enjoy is sustainable.

Rate reductions are at the heart of uncertainty. As the state and health plans have more experience with Medi-Cal expansion, the state is beginning to reduce rates to the plans. This reduction may impact plans' ability to incentivize new providers and erode investments in the safety net if they view rates as unpredictable and trending in the wrong direction.

Different challenges face rural Medi-Cal managed care. Competition and consolidation trends are less prominent in rural areas where the lack of providers and difficult economies of scale make meeting timely access requirements a daily challenge. Public plans, with local knowledge and mission, play a leadership role in rural areas to broker cooperation, spur more rapid diffusion of technology, and even recruit primary care providers.

Waiver renewal agreement signals greater financial uncertainty. On October 31, 2015, DHCS and CMS announced conceptual agreement on an 1115 Medicaid Waiver renewal with at least $6.2 billion in federal funds over five years.[9] While ongoing funding may reduce pressure to increase payments to county safety-net providers in the short term, the agreement requires moving more public hospitals to risk-based payment models with health plans over the life of the waiver. Funding for public hospitals will decline in the final years of the waiver, and this raises the likelihood of new pressure to develop risk-based payment methodologies that offset the loss of waiver funding in the out years.

Implications for the Future

The alignment of public plans and safety-net providers, coupled with policies to protect and strengthen the safety net, led to health plan investments to respond to the boom in insurance coverage among low-income Californians.

Looking ahead, policymaker consideration of this analysis and findings will be critical to sustaining the safety-net system while driving new focus on quality, performance, and system integration.

- The Medi-Cal program's reliance on public and nonprofit safety-net clinics has grown significantly, and these critical access points require continuing and increasing levels of investment to expand capacity and improve care.
- Historically, there has been tremendous variation between public and commercial plans' investments in safety-net clinics. At the same time, the public plans' quality scores are consistently higher than those of the commercial plans. The interdependence between public plans and safety-net clinics could be a mechanism to strengthen systems of care for Medi-Cal beneficiaries.
- Compared to commercial plans, public plans have made more consistent investments over time, and their investments have been larger in size and more varied in type. This investment by public plans in capacity and care improvements has resulted in stronger systems of care for Medi-Cal beneficiaries.
- Regulatory oversight, practice reform imperatives, and rate reductions may reduce local investment in the safety net, which is the backbone of the Medi-Cal program. With few other sources of investment and capital, such changes would threaten safety-net viability at a time of significant need for the expanded Medi-Cal population.

About the Authors

Bobbie Wunsch and Tim Reilly are founders and partners with Pacific Health Consulting Group. Laura Hogan is a consultant with the Group.

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About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit www.chcf.org.

Endnotes

1. A special data run provided by DHCS, Research & Analytics Studies Division in October 2015 reports 12.4 million total enrollees in March 2015.
2. A *Local Initiative* is governed by a commission, a public entity that holds the Medi-Cal contract with DHCS and is at full risk. All local initiative health plans are Knox-Keene licensed and compete with a commercial plan under the Two Plan Model. They were specifically created to protect and promote safety-net providers. A *COHS* is governed by a commission, a public entity that holds the Medi-Cal contract with DHCS and is at full risk. The COHS operates a single, countywide health plan to serve the Medi-Cal population. There are no other competing health plans. For its Medi-Cal operations, a COHS must meet selective Knox-Keene requirements, like proof of financial solvency, but is not required to be licensed.
3. Adult Expansion refers to Medi-Cal's expansion under the ACA to include most low-income adults age 19-64 without children. SPD refers to Seniors and Persons with Disabilities.
4. The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of US health plans to measure performance on important dimensions of care and service. HEDIS consists of 71 measures across eight domains of care.
5. *Medi-Cal Managed Care Performance Dashboard,* California Department of Health Care Services, September 17, 2015, www.dhcs.ca.gov (PDF).
6. Not all commercial plans provided county-by-county data. Data from health plans with over 60% of total enrollment document clear geographic variation in safety-net market share. Southern California is represented by Inland Empire Health Plan, Molina Healthcare, CalOptima, and L.A. Care. Northern California is represented by Central California Alliance for Health, Contra Costa Health Plan, Santa Clara Family Health Plan, Health Plan of San Mateo, San Francisco Health Plan, Alameda Alliance, and Partnership Health Plan.
7. A health plan must have at least one primary care physician in a health plan's network (provider network) for every 2,000 Medi-Cal enrollees within 10 miles or 30 minutes of travel time.
8. The CMS proposed rule on Medicaid managed care contains new financing policy that prohibits the state from directing plan expenditures and restricts the use of rate ranges. The proposal restricts the ability of the state to direct plan expenditures to specific provider types like public hospitals. While this regulation may give plans more autonomy, the state and public safety-net providers are very concerned that this will prevent current practices that extend reimbursement to safety-net providers in Medi-Cal managed care. It could also prevent the hospital provider fee in managed care. In addition, these regulations prevent the state from adjusting rates to support safety-net providers. CMS is also proposing to withhold federal financing participation for incomplete encounter data. And, given the problems that DHCS and the plans have with getting complete encounter data, it could have large impacts on the state and could likely mean the state would pass the loss of FFP onto the health plans in the form of sanctions.
9. Elements include: (1) Global Payment Program (GPP) for services to the uninsured in designated public hospital (DPH) systems; (2) delivery system transformation incentive program for DPHs and district/municipal hospitals (DMPH), known as PRIME (Public hospital Redesign and Incentives in Medi-Cal); (3) dental transformation incentive program; (4) Whole Person Care Pilot; and (5) independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries.