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Medi-Cal Landscape Assessment

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Manatt Health
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Executive Summary

This document provides a landscape assessment of how the Medi-Cal program operates, is financed, and performs, as well as provides some insight into individuals who use the system. This document relies mostly on secondary research; relevant sources are noted in the footer of each slide for reference and a glossary of terms can be found at the end of the document.

This document focuses primarily on Medi-Cal managed care, the dominant care delivery system in the state. It provides a brief overview of how the program provides behavioral health, long-term services and supports (LTSS), and other services, but does not cover them in detail.

- **Enrollment**: Medi-Cal enrollment has greatly increased over the past decade, with the program now covering 1 in 3 Californians.
- **Spending**: Medi-Cal costs have grown nearly threefold over the last 10 years and today total $92 billion in total annual expenditures.
- **Managed Care**: The Medi-Cal program overwhelmingly relies on the managed care delivery system, with over 80% of all beneficiaries enrolled in managed care; certain services, such as behavioral health services for individuals with severe conditions, are carved out of managed care.
- **Beneficiary Characteristics**: Medi-Cal beneficiaries are, by definition, low-income. About 60% of Medi-Cal beneficiaries identify as Latino and close to 50% of beneficiaries report not speaking English well or at all.
- **Access, Quality, & Health Outcomes**: Managed care plan performance on quality metrics varies greatly, but in general members reported being satisfied with their personal doctor, while being dissatisfied with their health plan and ability to access care quickly. Overall, the population covered is in poorer health when compared to those not enrolled in Medi-Cal.

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Medi-Cal Today: Key Takeaways

- Medi-Cal has dramatically reduced the number of uninsured in California, most notably since the adult expansion was implemented in 2014. The program now covers one out of three Californians.

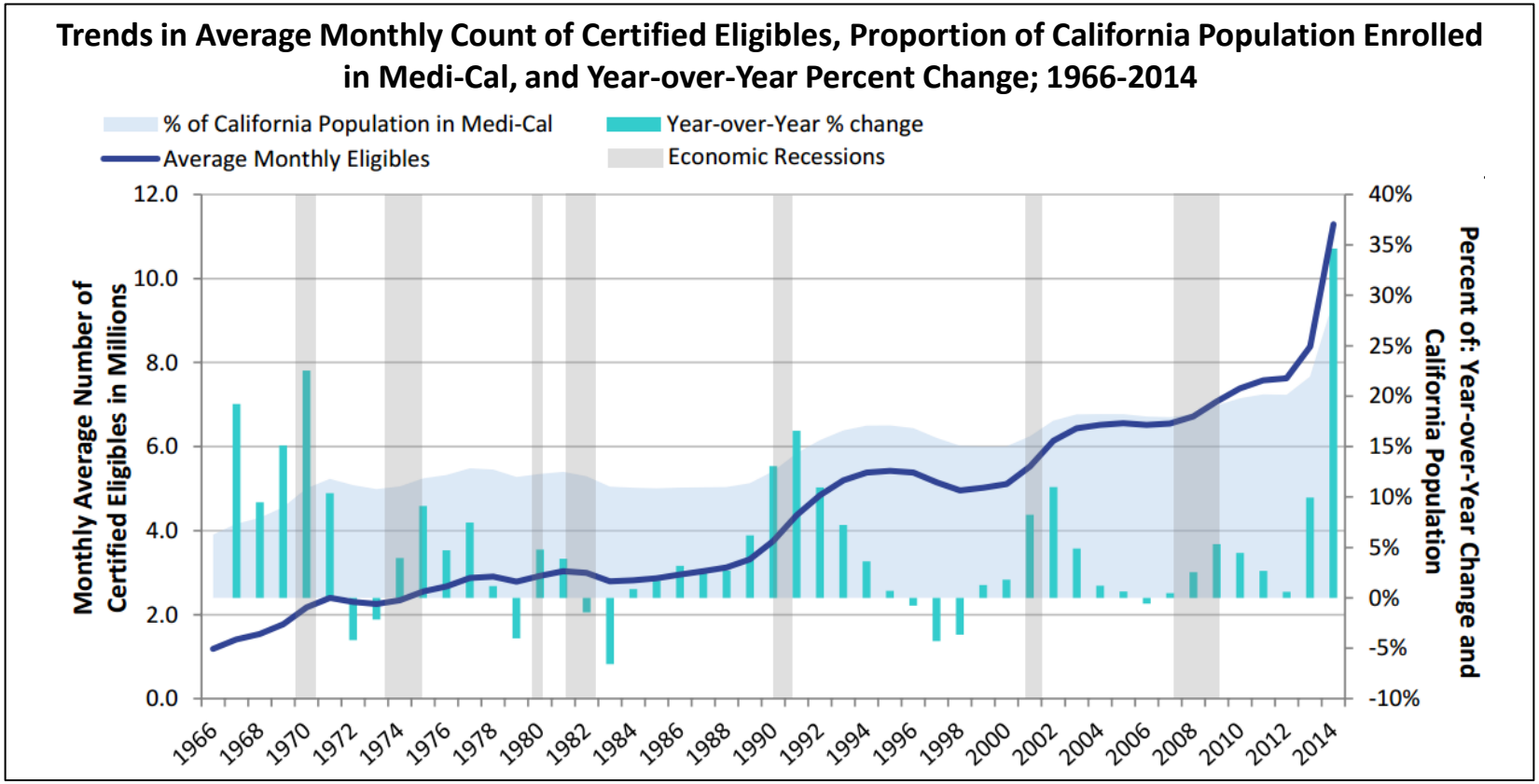
- Medi-Cal enrollees are a heterogeneous population, but overall they report lower rates of good health.

- As enrollment and the cost of health care has grown, so has the cost of the program. However, the distribution of the share of cost has changed considerably over the last decade, with the state's General Fund share declining while federal funds and other state funds, including provider tax revenues, increasing.

- Medi-Cal's fee-for-service provider rates are among the lowest in the nation. Within Medi-Cal managed care, there is little visibility into the rates paid to providers by plans. In the case of hospitals, payments by plans include retroactive supplemental payments intended to compensate for low base payments; in some cases, plans report increasing rates to providers, such as specialists, to ensure that patients have access to services and to meet network adequacy requirements.

Enrollment

California has regularly turned to Medi-Cal to cover new groups of uninsured residents; enrollment has grown during recessions, covering people whose income declined or who lost their job-based coverage. Today, more than 13 million Californians, or a third of the state population, are enrolled in Medi-Cal.



Source: *Medi-Cal's Historical Period of Growth, DHCS, August 2015*

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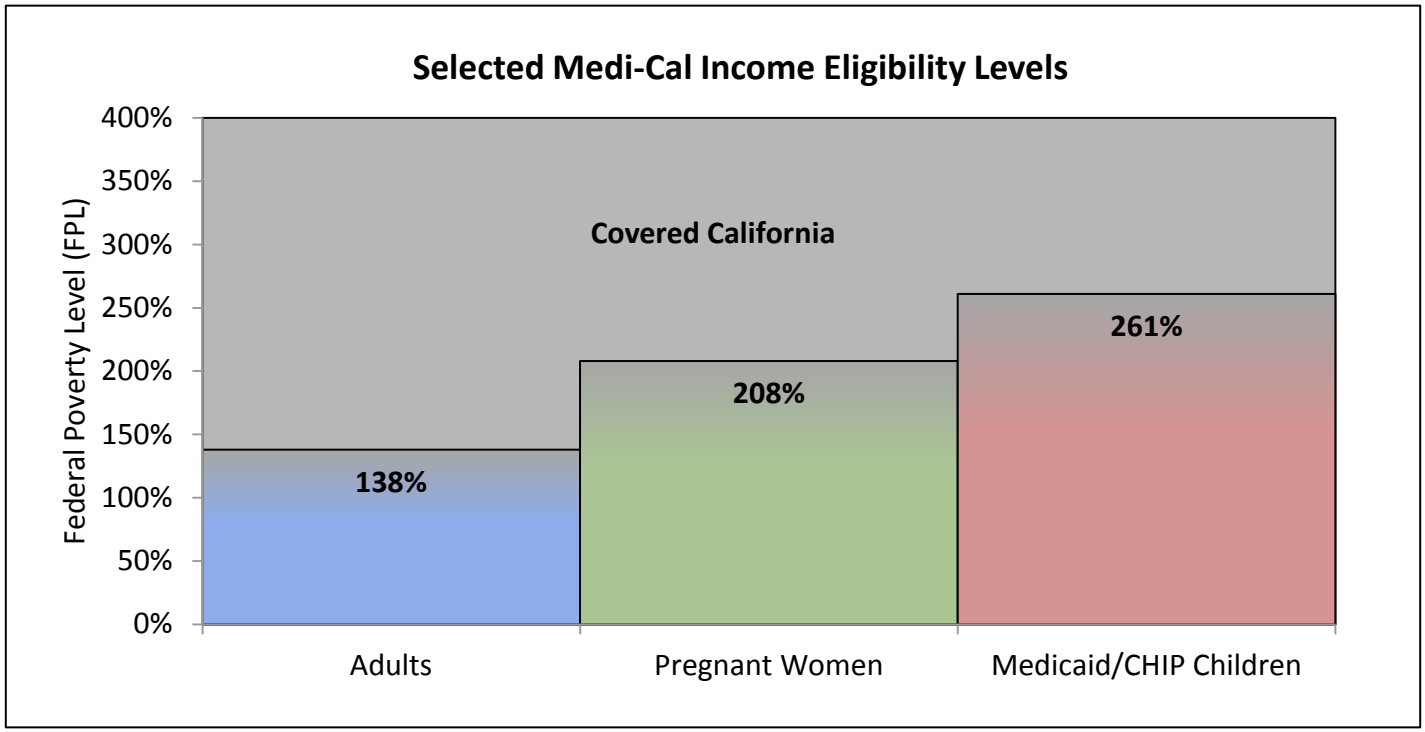
New Coverage Paradigm in California

Adults below 138% of the Federal Poverty Level (FPL), pregnant women below 208% FPL, and children below 261% FPL can access Medicaid services in California.

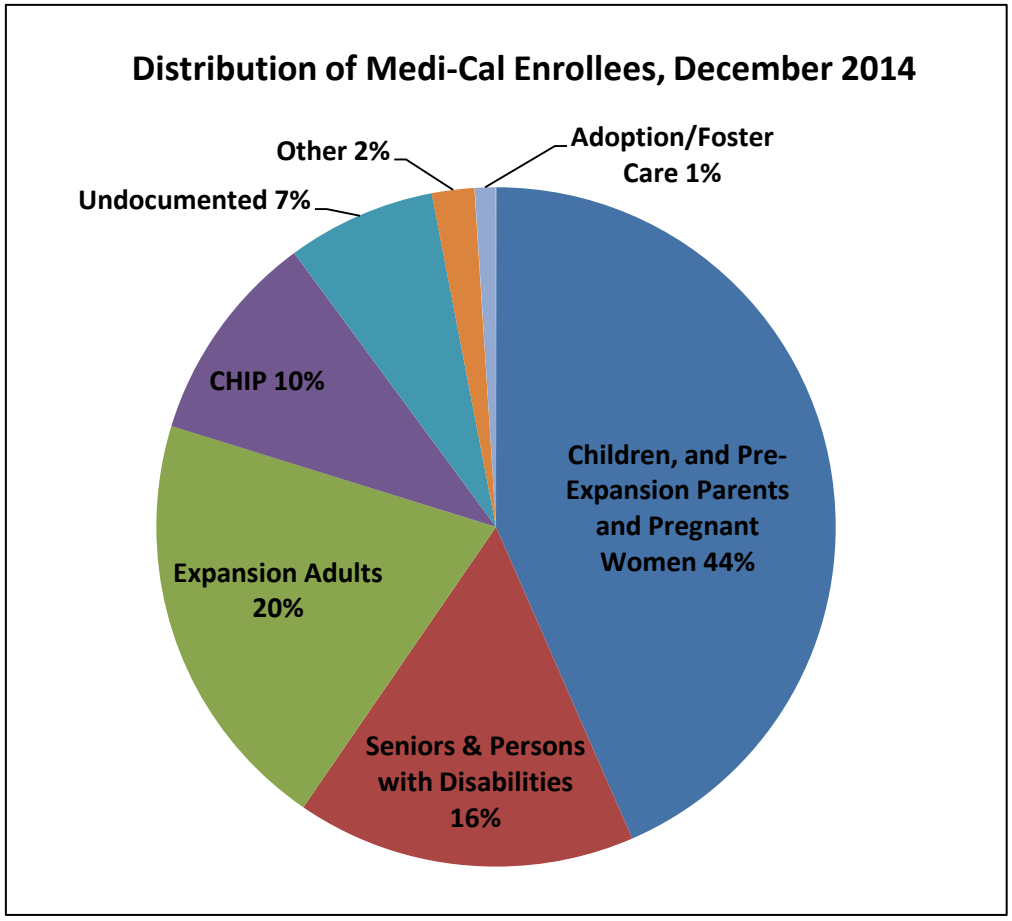


Note: Aged and disabled individuals, individuals in a skilled nursing or intermediate care facility, and individuals enrolled in other programs, including CalFresh, SSI, CalWorks, Refugee Assistance, and Foster Care or Adoption Assistance are eligible for Medicaid coverage in California. In addition, some specific groups of undocumented persons are eligible for coverage, but most are only eligible for emergency services. As of May 2016, California will expand full scope Medi-Cal coverage to all low-income children under 19 years of age regardless of immigration status.

Source: *Do You Qualify for Medi-Cal Benefits, DHCS, August 2015; State Medicaid and CHIP Income Eligibility Standards, CMS, October 2014; SB 75 – Medi-Cal for All Children, DHCS, 2016.*

Enrollment

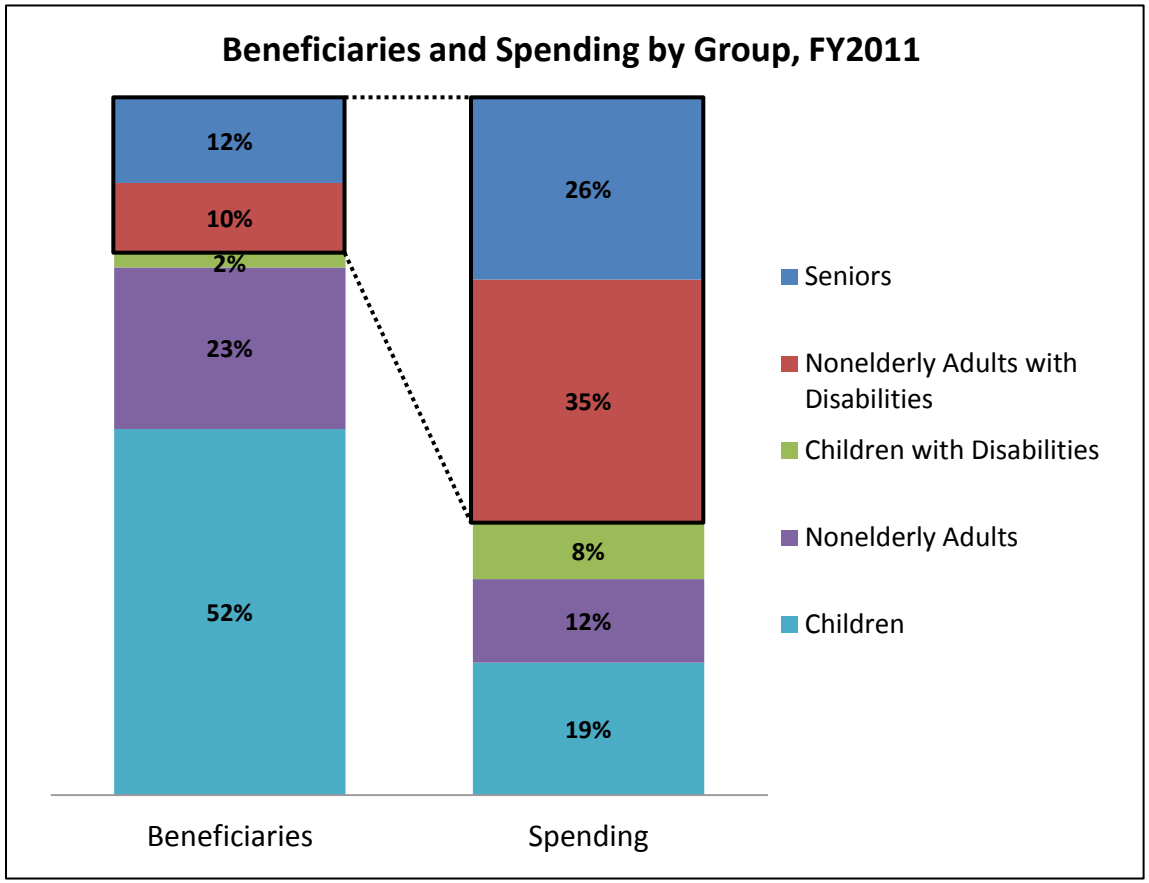
At the end of 2014, expansion adults accounted for 20% of Medi-Cal enrollees.



Source: *Medi-Cal's Historical Period of Growth, DHCS, August 2015.*

Spending by Enrollee Group

Seniors and nonelderly adults with disabilities account for less than 25% of all beneficiaries, but more than 60% of all spending in the program.

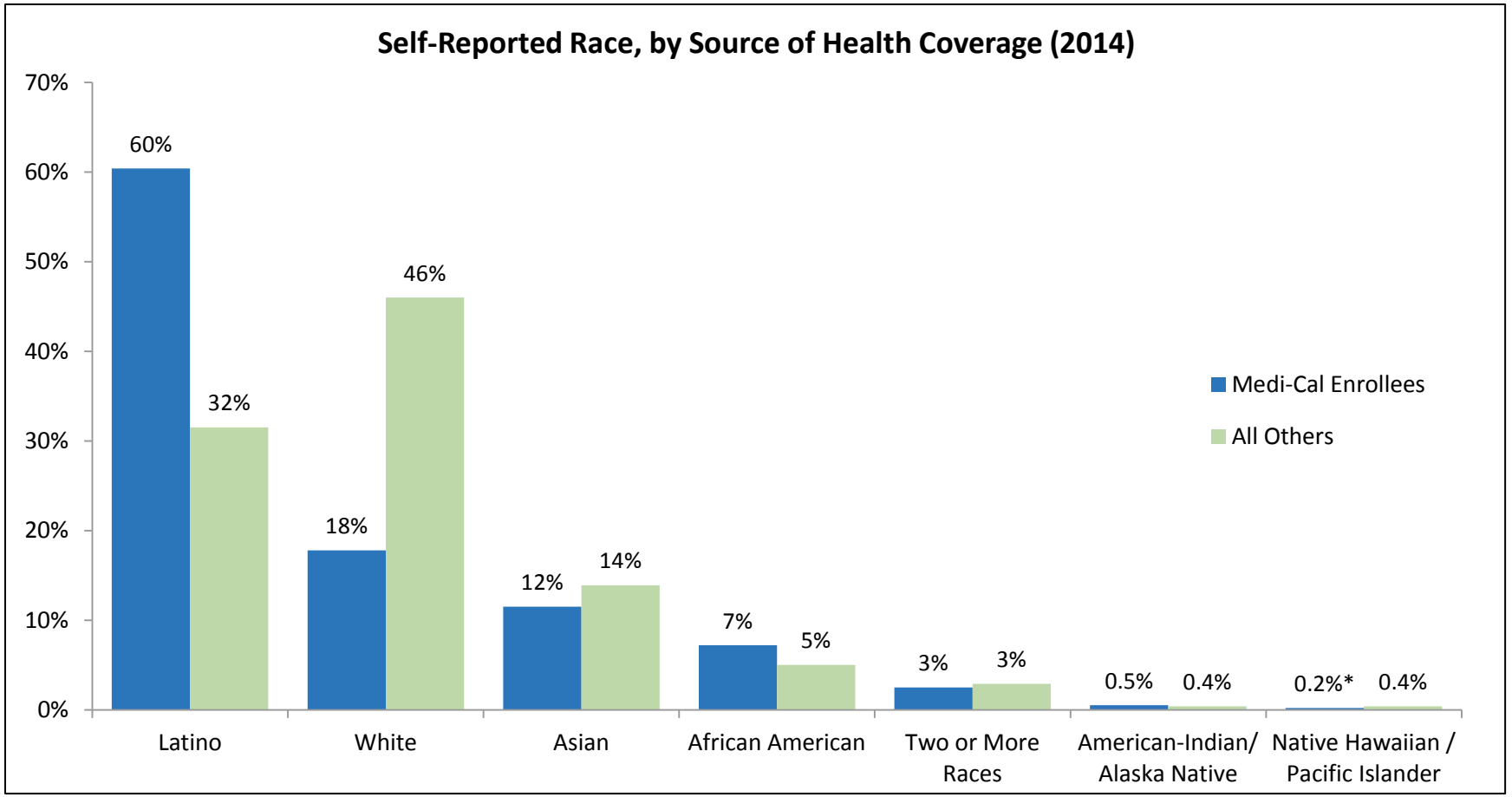


- In 2011, 1% of beneficiaries accounted for 27% of total spending.
- In 2011, 5% of beneficiaries accounted for 51% of total spending.

Source: *Medi-Cal Facts and Figures: A Program Transforms, CHCF, May 2013.*

Medi-Cal Enrollee Profile: Race/Ethnicity

Compared to other Californians, individuals who report being covered by Medi-Cal are more likely to be Latino or African American.

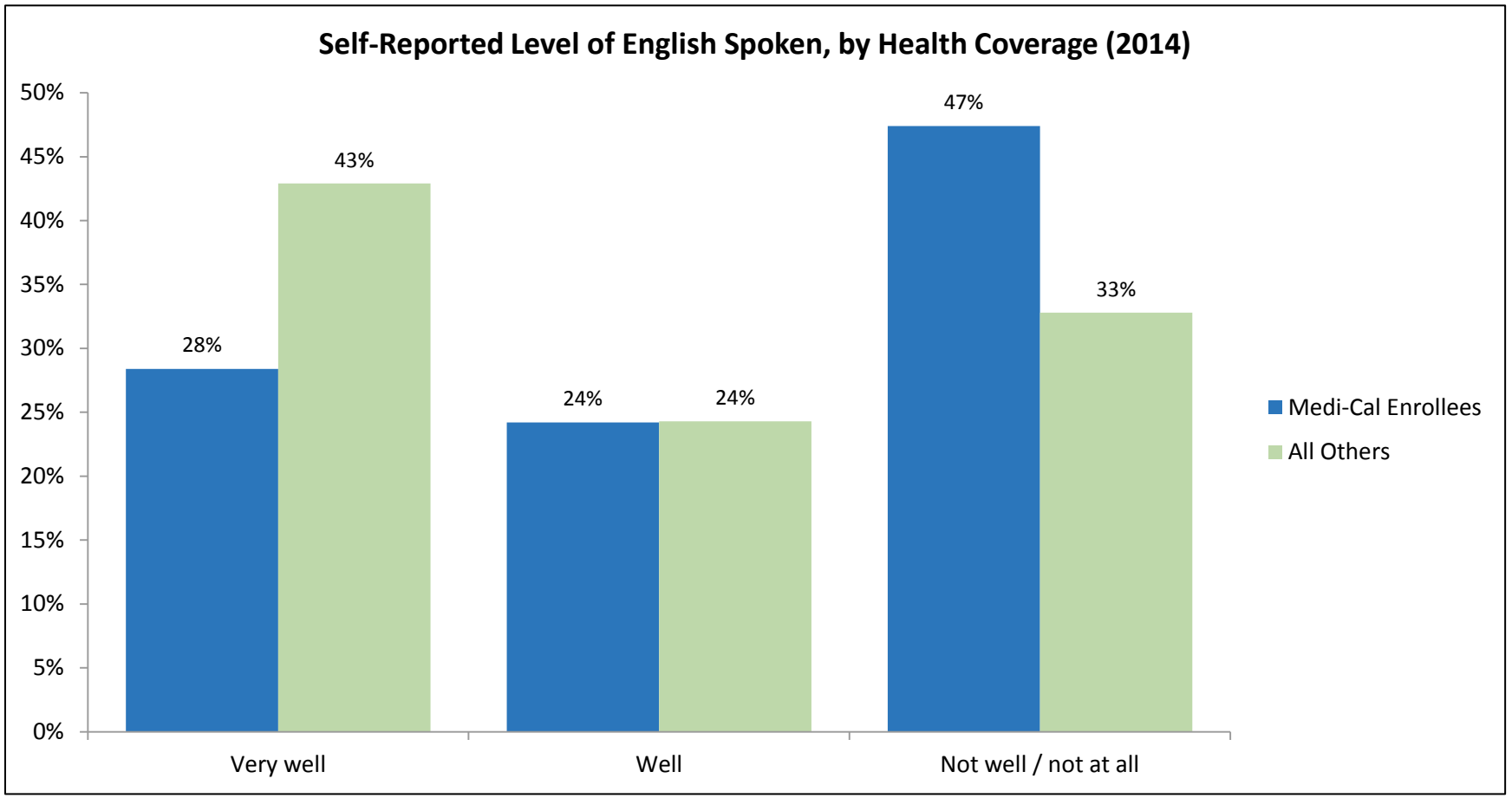


* = statistically unstable

***Source**: 2014 California Health Interview Survey, UCLA Center for Health Policy Research.*

Medi-Cal Enrollee Profile: Languages Spoken

Close to half of all Medi-Cal enrollees report that they do not speak English well or at all. The most common language reported (other than English) is Spanish, followed by Vietnamese and Chinese.



Source: *2014 California Health Interview Survey, UCLA Center for Health Policy Research.*

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Medi-Cal Enrollee Profile: Selected Health Measures

Overall Health Status	Medi-Cal enrollees are more likely to report fair or poor health (18%, 6% respectively) than those not enrolled in Medi-Cal (12%, 3% respectively).
Disability	Adults in Medi-Cal are more likely to report that they are disabled due to a physical, mental, or emotional condition (44% vs. 25% not covered by Medi-Cal).
Obesity and Diabetes	34% of adults covered by Medi-Cal report a BMI of 30+, considered obese, as compared to 25% of adults not covered by Medi-Cal. Over 12.5% of those covered by Medi-Cal report a diagnosis of diabetes compared to 7.5% of those not covered by Medi-Cal.
Mental Health	8% of those covered by Medi-Cal report a serious psychological distress during the past month as compared to 3% of those not covered by Medi-Cal.
Emergency Room Usage	Over 23% of those covered by Medi-Cal report visiting an emergency room in the past 12 months, as compared to 15% of those not covered by Medi-Cal.
Heart Disease	9% of those covered by Medi-Cal report a diagnosis of heart disease, as compared to 6% of those not covered by Medi-Cal.
Asthma	Over 16% of those covered by Medi-Cal report a diagnosis of asthma, as compared to 13% of those not covered by Medi-Cal. Nearly 18% of those covered by Medi-Cal sought care at an emergency room or urgent care center for asthma in the past twelve months, as opposed to just under 5% of those not covered by Medi-Cal.

***Source**: 2014 California Health Interview Survey, UCLA Center for Health Policy Research.*

Notable Health Inequities for Medi-Cal Enrollees

Medi-Cal beneficiaries often face difficulty accessing care and may receive lower quality of care when compared to individuals covered by private insurance.

Access to Care:

- In 2013, adult Medi-Cal enrollees were more than twice as likely as those with employer-sponsored insurance (ESI) to report lacking a usual source of care other than the Emergency Room (18% vs. 8%).
- In 2013, adult Medi-Cal enrollees were more than three times more likely as those with ESI to report trouble finding a doctor (6% vs. 2%) or specialist (5% vs. 2%).

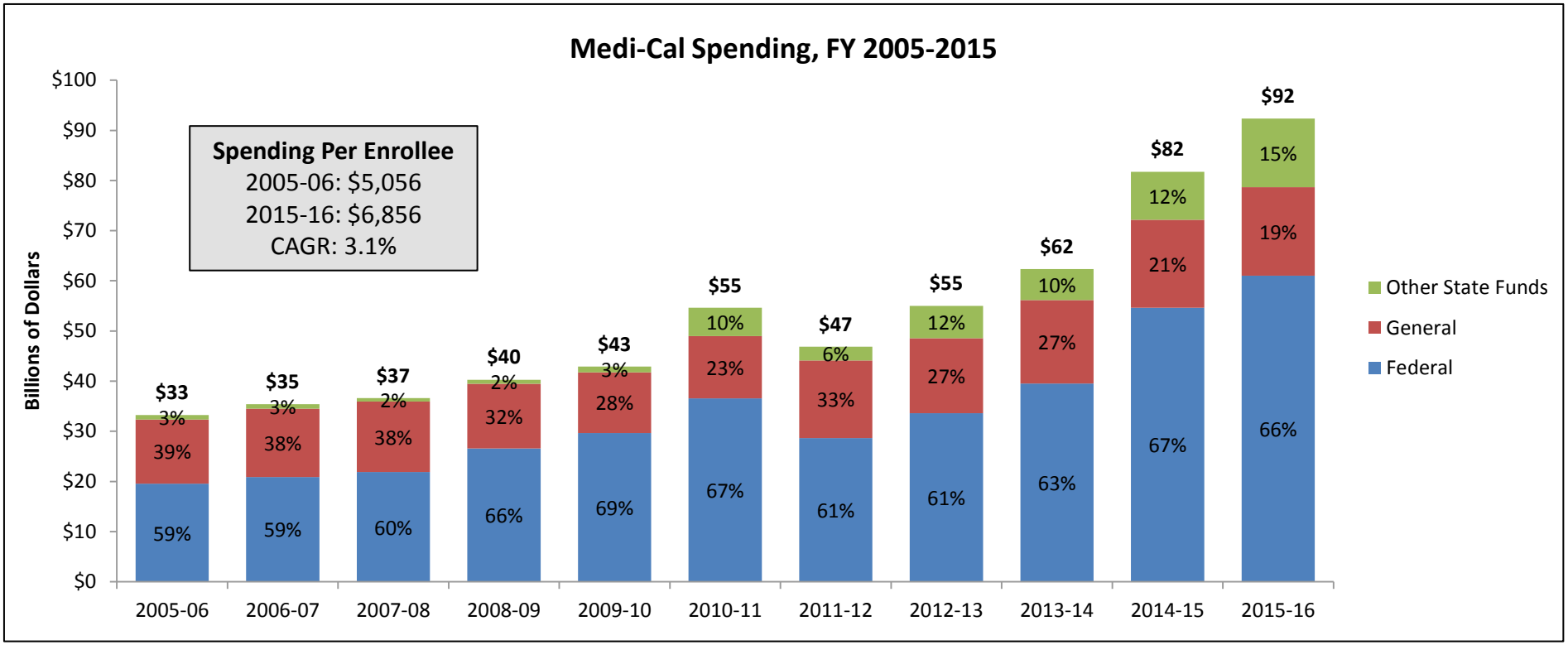
Women's Health:

- In 2012, over 30% of women covered by Medi-Cal reported having never received a mammogram and 15% reported receiving one more than 2 years ago, as compared to 21% and 12% of women not covered by Medi-Cal, respectively.
- In 2011, 78% of Medi-Cal mothers initiated prenatal care during their first trimester of pregnancy compared to 90% of mothers not covered by Medi-Cal.

Sources: *2014 California Health Interview Survey, UCLA Center for Health Policy Research; Understanding Medi-Cal's High-Cost Populations, DHCS Research and Analytics Division, March 2015; Medi-Cal Birth Statistics, DHCS Research and Analytic Studies Division, Oct. 2014; Medi-Cal Versus Employer-Based Coverage, CHCF, July 2015 (Rev. Jan 2016.*

Spending Over the Last Decade

Total Medi-Cal costs have grown nearly threefold over the last decade, although General Fund spending as a share of total spending has declined over this time period. Overall growth in spending has been driven by enrollment; spending per enrollee over the last 10 years equates to a 3.1% compound annual growth rate (CAGR).

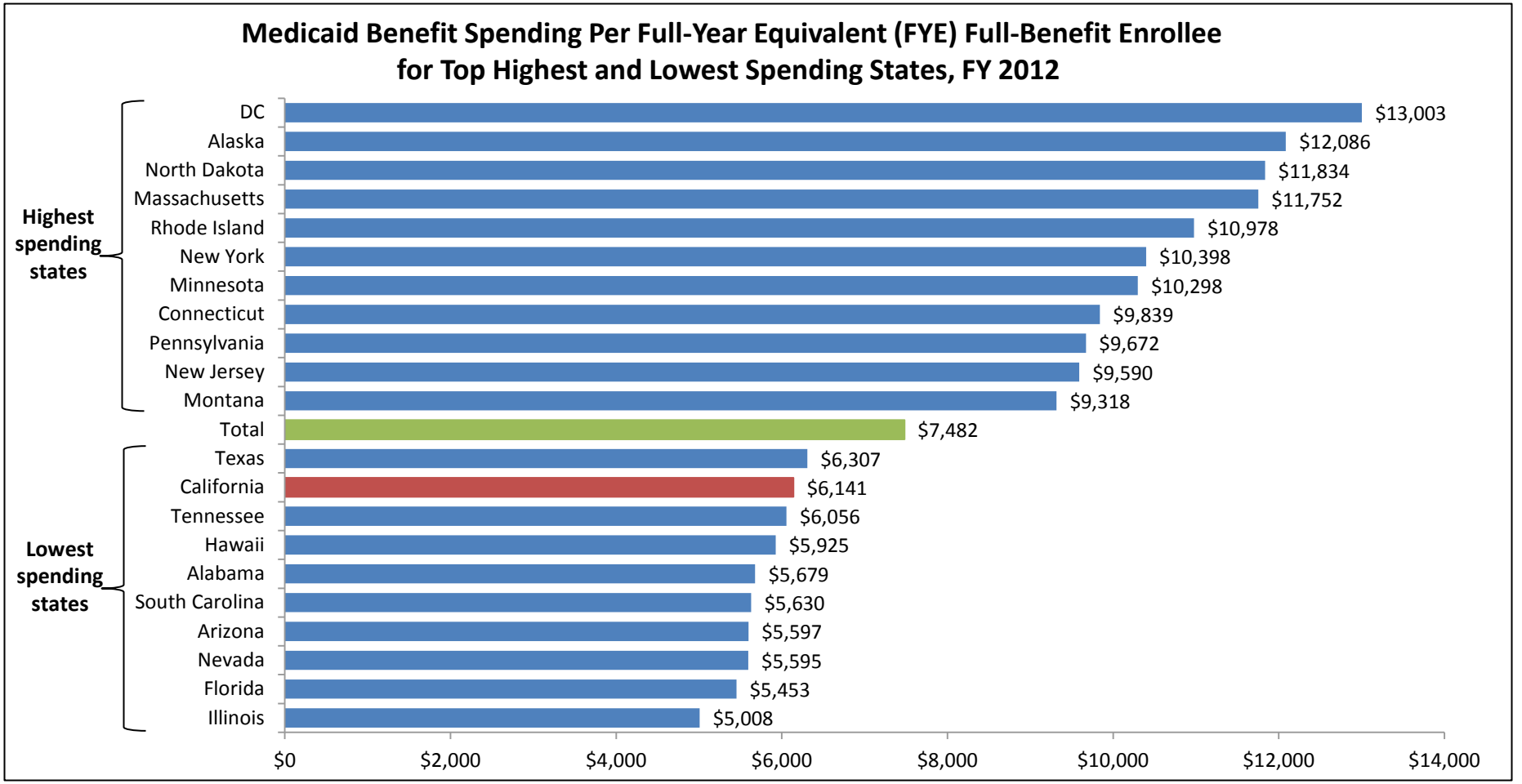


Notes: Total annual spending is taken from the DHCS May Estimate for the subsequent year (i.e., 2005-06 costs sourced from May 2006 Medi-Cal Estimate), except in the case of 2015-16, in which total spending is pulled from the November 2015 Estimate.
Other State Funds includes all funds except the General Fund, such as provider fee revenue.

Source: *Medi-Cal Local Assistance Estimates, DHCS.*

Spending Per Full-Benefit Enrollee National Comparison

In FY 2012, California spent just over $6,000 per full-benefit enrollee, ranking 9th lowest in the nation.

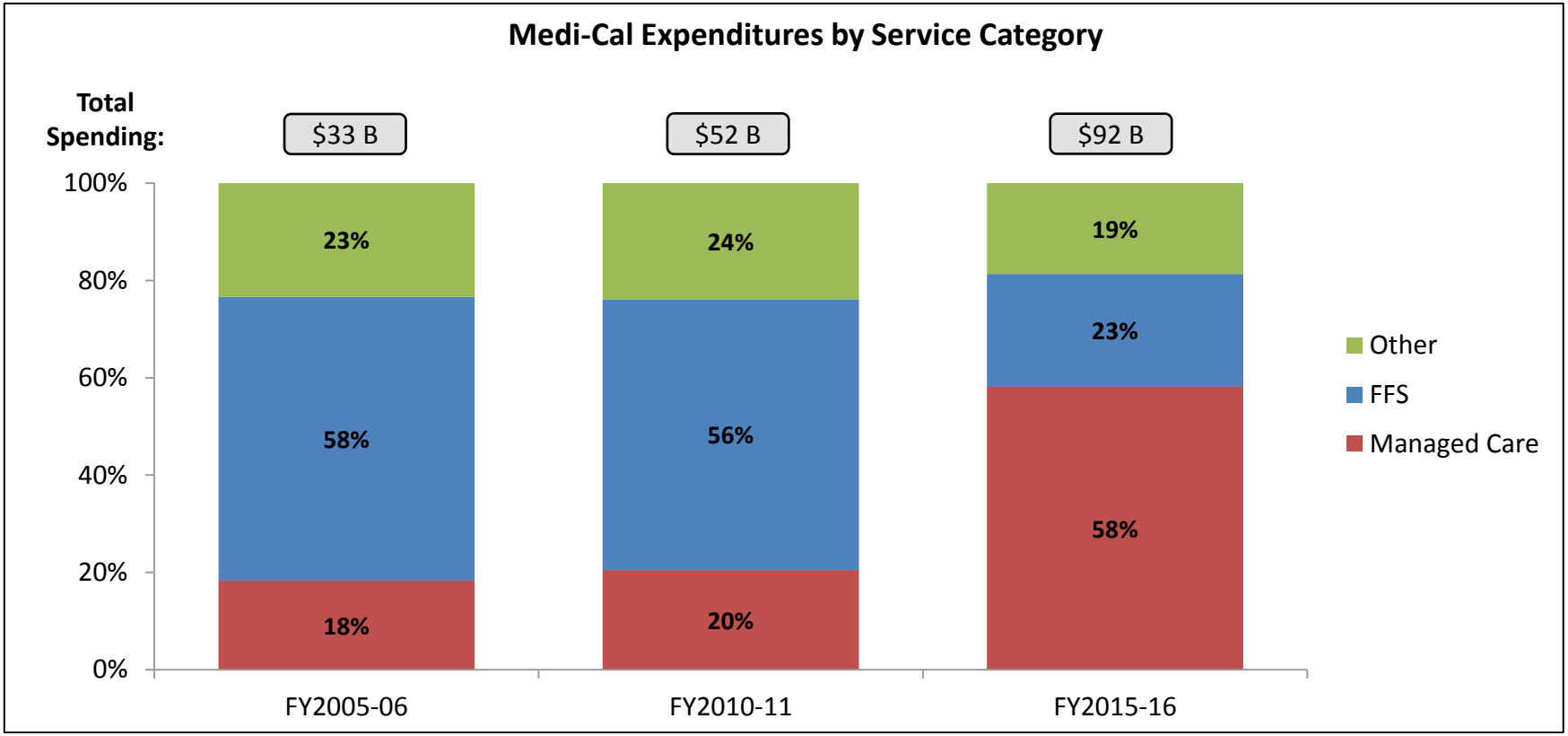


Note: Excludes enrollees reported by states in the MSIS as receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services.

Source: *Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2012, MACPAC, December 2015.*

Spending by Service Category

Over the past ten years, the majority of spending was for services provided in the fee-for-service (FFS) system. In just the past five years, however, spending has shifted dramatically, and today 58% of all spending is for managed care services.



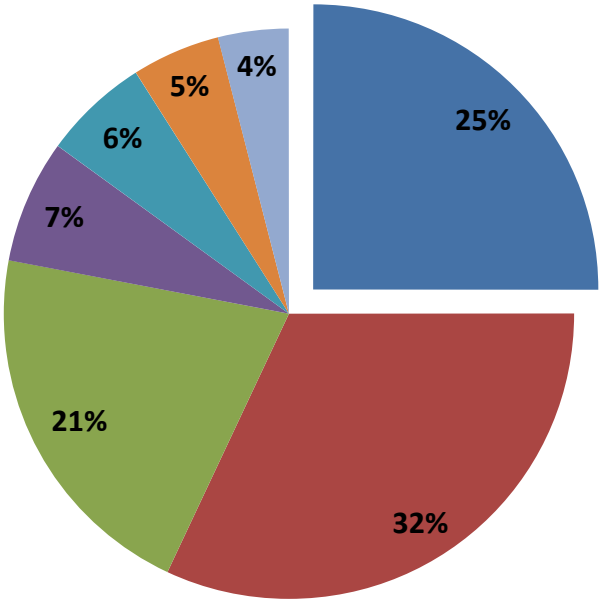
Note: "Other" includes: dental, mental health, audits/lawsuits, EPSDT, Medicare payments, state hospital/developmental centers, miscellaneous services, recoveries, and Drug Medi-Cal.

Source: *Medi-Cal Local Assistance Estimates, DHCS.*

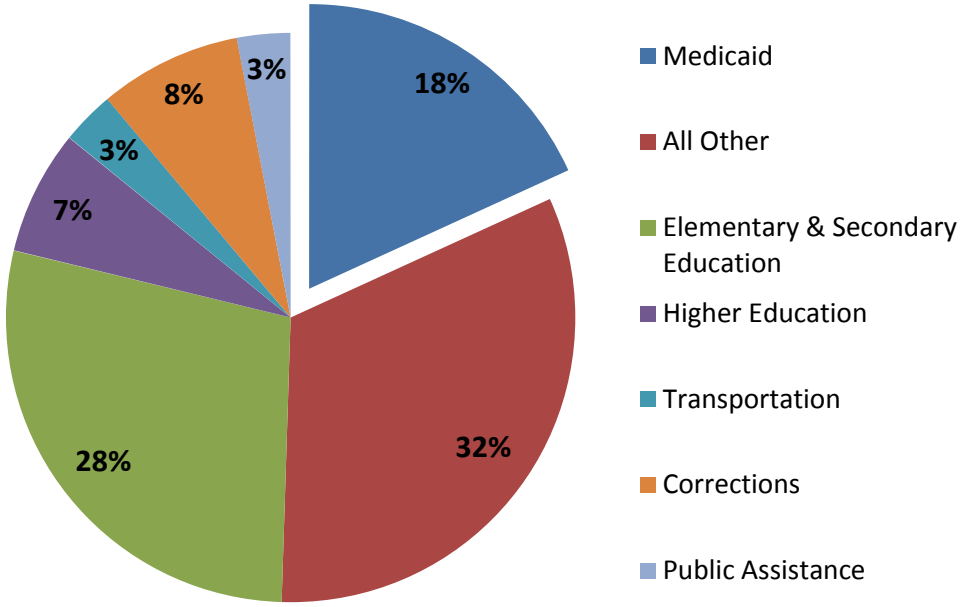
Medi-Cal Spending as Share of the California Budget

Medi-Cal accounts for one quarter of the state budget when federal funds are considered, but 18% of the budget when only state funds are considered.

California State Budget (State & Federal Funds), FY 2013



Medicaid as a Share of California's Total State Budget (Non-Federal Funds Only*), FY 2013



*Includes intergovernmental transfers, provider taxes, fees, donations, assessments

Note: In 1988, California voters passed Proposition 98, requiring that a minimum percentage of the state's General Fund revenues be spent on K-14 education. The formula for calculating the Prop. 98 minimum guarantee of education funding is complex and varies depending on weak or strong economic growth. Prop. 98 reduces the state's budgetary flexibility because it requires a significant percentage of any additional General Fund revenue to fund K-14 education. In response to Prop. 98, California has become increasingly reliant on local funding sources to fund the non-federal share of Medi-Cal expenditures because local funding sources are not subject to Prop. 98 requirements.

***Source**: State Expenditure Report: Fiscal 2012-2014 Data, National Association of State Budget Officers, 2014.*

Use of Supplemental Payments

California's Medi-Cal program relies on supplemental payments that are passed through to hospitals through retroactive adjustments to the capitated rates of managed care plans and through FFS payments. Hospitals supply the nonfederal share of these payments.

Supplemental Payments for Private Hospitals	Supplemental Payments for Public Hospitals	Supplemental Payments for Public Hospitals for Seniors and Persons with Disabilities (SPDs)
Financed by hospital fee revenue.	Financed by intergovernmental transfers (IGTs) between the county and the state.	Financed by intergovernmental transfers between the county and state to bring rates for the SPD population to the equivalent of the fee-for-service rate.

- Newly released federal managed care regulations may constrain the state's ability to make supplemental payments retroactively to hospitals that are being paid through the managed care.

Source: *Financing Medi-Cal's Future: The Growing Role of Health Care-Related Provider Fees and Taxes, CHCF, November 2009; Hospital Quality Assurance Fee Program, DHCS, 2014; Medicaid Managed Care Final Rule, CMS, April 2016.*

Medi-Cal Reimbursement Levels (FFS)

Although Medicaid provider fees are generally low, California's provider fees are particularly low, ranking 47th overall.

Medicaid Physician Fee Index for All Services (2012) *(from Low to High)*		
50)	Rhode Island	.58
49)	Michigan	.76
48)	New Jersey	.77
47)	**California**	**.80**
44)	New York	.87
44)	Missouri	.87
44)	Indiana	.87
43)	Florida	.89
42)	New Hampshire	.91
41)	Ohio	.92

Medicaid-to-Medicare Fee Index for All Services (2012) *(from Low to High)*		
50)	Rhode Island	.37
49)	New Jersey	.45
47)	Michigan	.51
47)	**California**	**.51**
46)	New York	.55
45)	Florida	.57
44)	New Hampshire	.58
43)	Missouri	.59
42)	Ohio	.61
39)	Indiana	.62

Notes: Approximately 20% of Medi-Cal beneficiaries remain in fee-for-service.

The Medicaid fee index measures each state's physician fees relative to national average Medicaid fees. The data are based on surveys sent by the Urban Institute to the forty-nine states and the District of Columbia that have a FFS component in their Medicaid programs (only Tennessee does not). These fees represent only those payments made under FFS Medicaid. The Medicaid fee index is a weighted sum of the ratios of each state's fee for a given service to the corresponding national average fees, where the weight for each service was its share of total Medicaid physician spending among all the surveyed services.

The Medicaid-to-Medicare fee index measures each state's physician fees relative to Medicare fees in each state. The Medicaid data are based on surveys sent by the Urban Institute to the forty-nine states and the District of Columbia that have a FFS component in their Medicaid programs (only Tennessee does not). These fees represent only those payments made under FFS Medicaid. Medicare fees were calculated by the Urban Institute using the relative value units (RVUs), geographic adjusters, and conversion factor from the 30 July 2012 Federal Register and the 2012 Clinical Diagnostic Fee Schedule.

Sources: *Medicaid Physician Fee Index (2012), Kaiser Family Foundation; Medicaid-to-Medicare Fee Index (2012), Kaiser Family Foundation.*

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Medi-Cal Managed Care Today: Key Takeaways

- Over 80% of all individuals enrolled in Medi-Cal are in managed care, with over 1.7 million joining after Medicaid expansion in 2014.

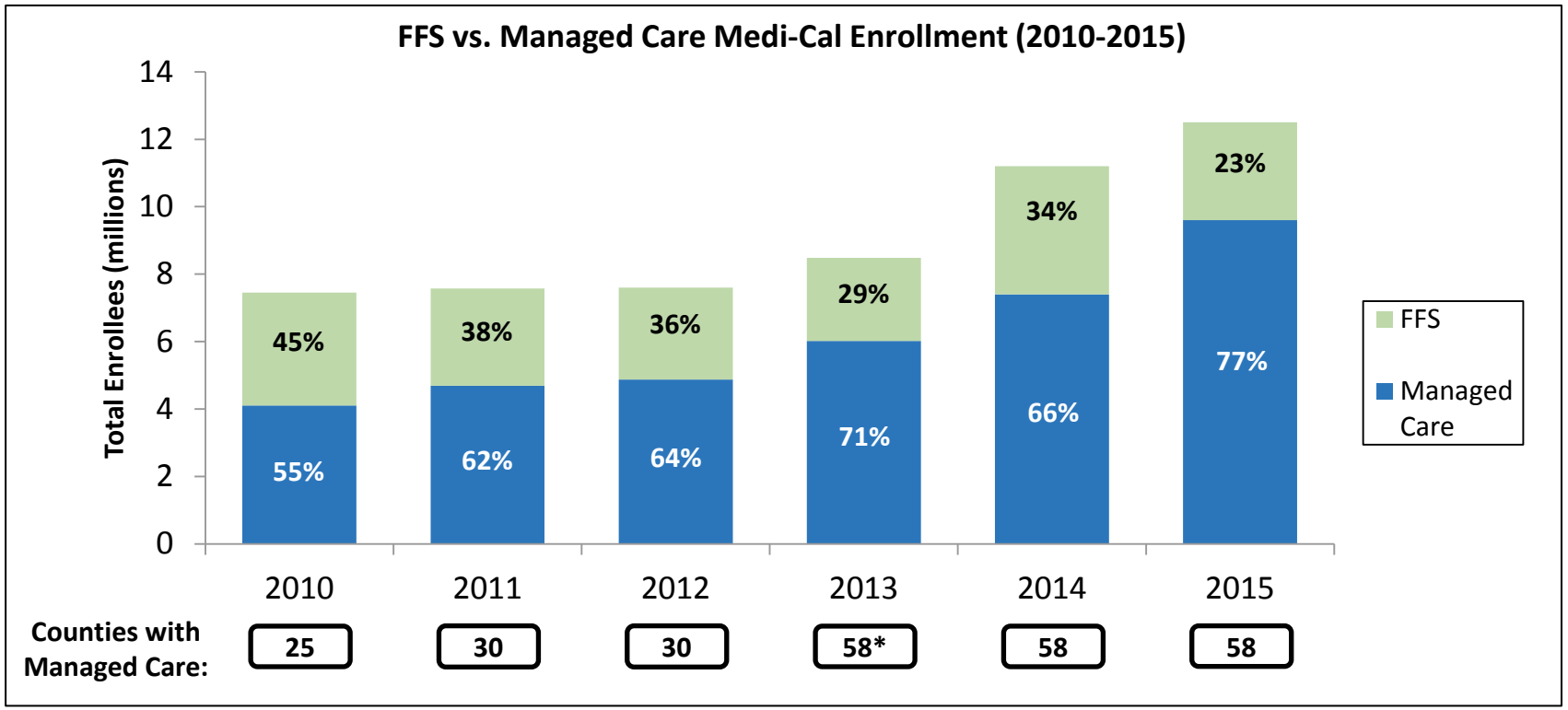
- Certain populations and services are carved out of managed care and remain in the FFS system, such as mental health services for individuals with serious mental health conditions. Behavioral health services for individuals with mild to moderate needs are provided through Medi-Cal managed care plans, which may choose to subcontract with a separate plan to provide these services.

- Four models* of managed care operate throughout the state. In many areas, the county or plans subcontract to other plans and the plans (the primary plan and/or the subcontracted plan) delegate risk to independent physician associations (IPAs), medical groups, and/or hospitals.

**In addition to these four main models, San Benito and Imperial counties each have their own model.*

Managed Care Enrollment Trends

Today, over 10 million of the 12 million Medi-Cal beneficiaries are enrolled in managed care. Managed care enrollment increased nearly 23% between 2012 and 2013, in part due to ~850,000 Healthy Families enrollees transitioning into Medi-Cal.



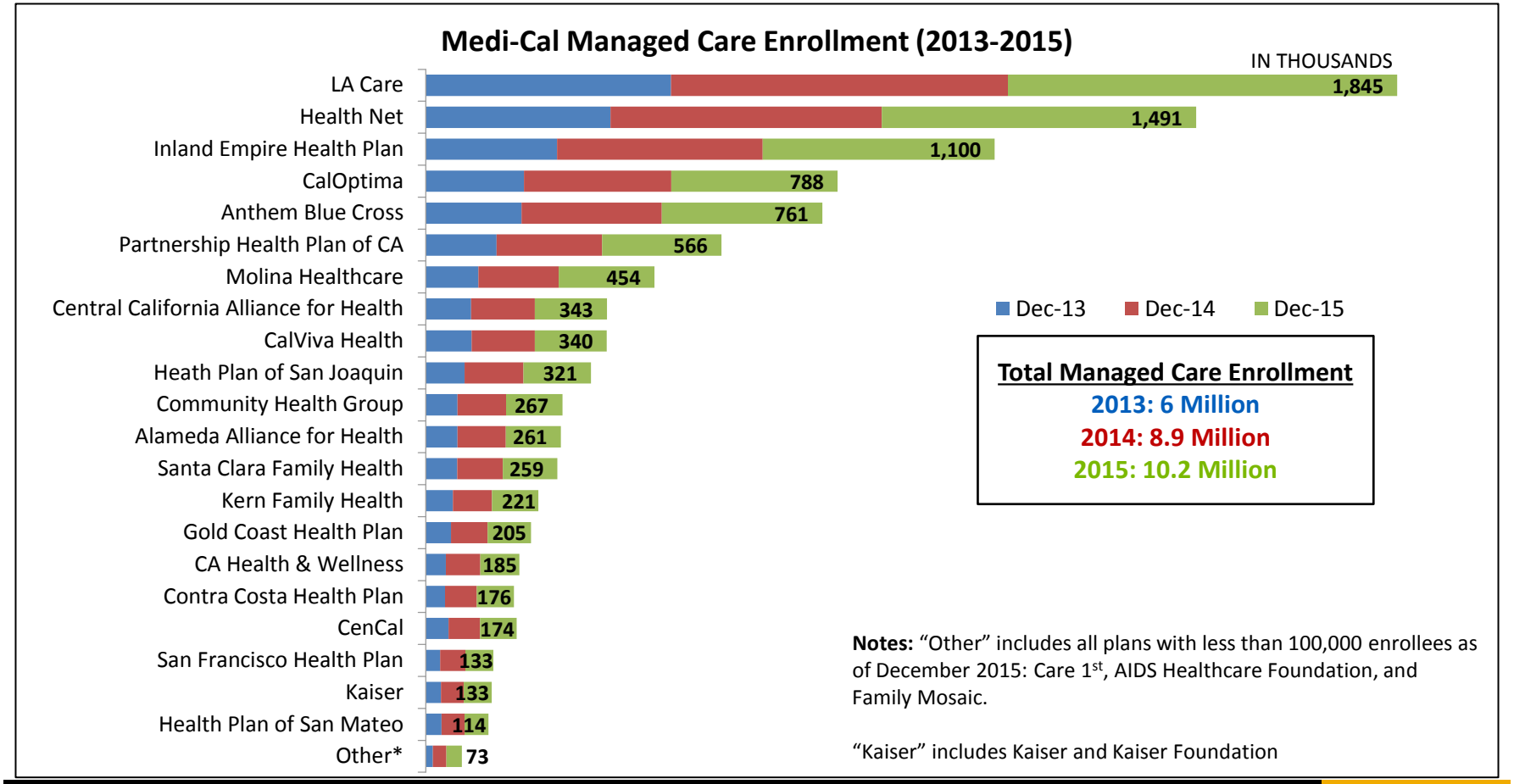
*Medi-Cal managed care expanded to the remaining rural 28 counties in the second half of 2013.

Note: Mandatory transition of SPDs (non-duals) into managed care beginning in 2011 led to managed care enrollment increases in 2011 and 2012.

Sources: *California Health Insurers: Brink of Change, CHCF, Feb. 2015; Medi-Cal Managed Care Enrollment Reports, DHCS; Medi-Cal Statistical Brief: Medi-Cal Monthly Eligibles 24-Month Trend at May 2015, DHCS, June 2015.*

Managed Care Plan Enrollment and Growth in 2014

In 2014, 1.7 million new enrollees joined the program due to expanded eligibility under the ACA. Now, 2 out of every 3 managed care beneficiaries are enrolled in a county-based health plan. Many of these plans subcontract with other health plans, IPAs, medical groups, and/or hospitals.



Notes: "Other" includes all plans with less than 100,000 enrollees as of December 2015: Care 1st, AIDS Healthcare Foundation, and Family Mosaic.

"Kaiser" includes Kaiser and Kaiser Foundation

Sources: *California Health Insurers: Brink of Change, CHCF, Feb. 2015; Medi-Cal Managed Care Enrollment Reports, DHCS.*

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Managed Care Carve-outs

Although 80% of the Medi-Cal population is in managed care, certain populations are "carved out" and access services through the FFS system. In addition, certain services for managed care enrollees are carved out and delivered through FFS.

Carved out services include:

- Specialty mental health services*
- Long-term care in non-county organized health system (COHS) counties and counties not participating in the Coordinated Care Initiative (CCI)
- In-Home Supportive Services (IHSS) in non-CCI counties
- Home and community-based services (HCBS) waiver programs in non-CCI counties
- HIV/AIDS waiver and most HIV/AIDS drugs
- Alcohol/substance use disorder treatment services and outpatient heroin detoxification
- Non-medical dental services
- Major organ transplants
- Most psychotherapeutic drugs

Carved out populations include:

- Dual eligibles in non-CCI counties
- Children with severe and rare diseases enrolled in California Children's Services (CCS)
- Individuals with HIV/AIDS

*Behavioral heath services for individuals with mild to moderate conditions are carved into managed care and may be provided by the managed care organization covering physical health services or subcontracted to another organization.

***Source**: Excluded Populations and Carve-Outs in Managed Care, DHCS Managed Care Quality and Monitoring Division, January 2015.*

Managed Care Carve-outs: Behavioral Health Services

Medi-Cal beneficiaries enrolled in managed care with serious mental health needs must navigate two separate health care delivery systems: the county mental health plan and the Medi-Cal managed care plan. In 2012, passage of Proposition 30 added language to the State's Constitution codifying the counties' role in the delivery of mental health services. Barring a change to the State's Constitution, counties will continue to have a role in the delivery of mental health services.

County Mental Health Plans

Services: Range of interventions to assist beneficiaries with serious emotional and behavioral challenges, including acute psychiatric inpatient care, treatment from psychiatrists and psychologists, and a host of rehabilitation services.

Medi-Cal Managed Care

Services: Beginning in January 2014, interventions to assist beneficiaries with mild to moderate needs, including psychotherapy, psychological testing when clinically indicated, psychiatric consultation, substance use screening and brief intervention for adults.

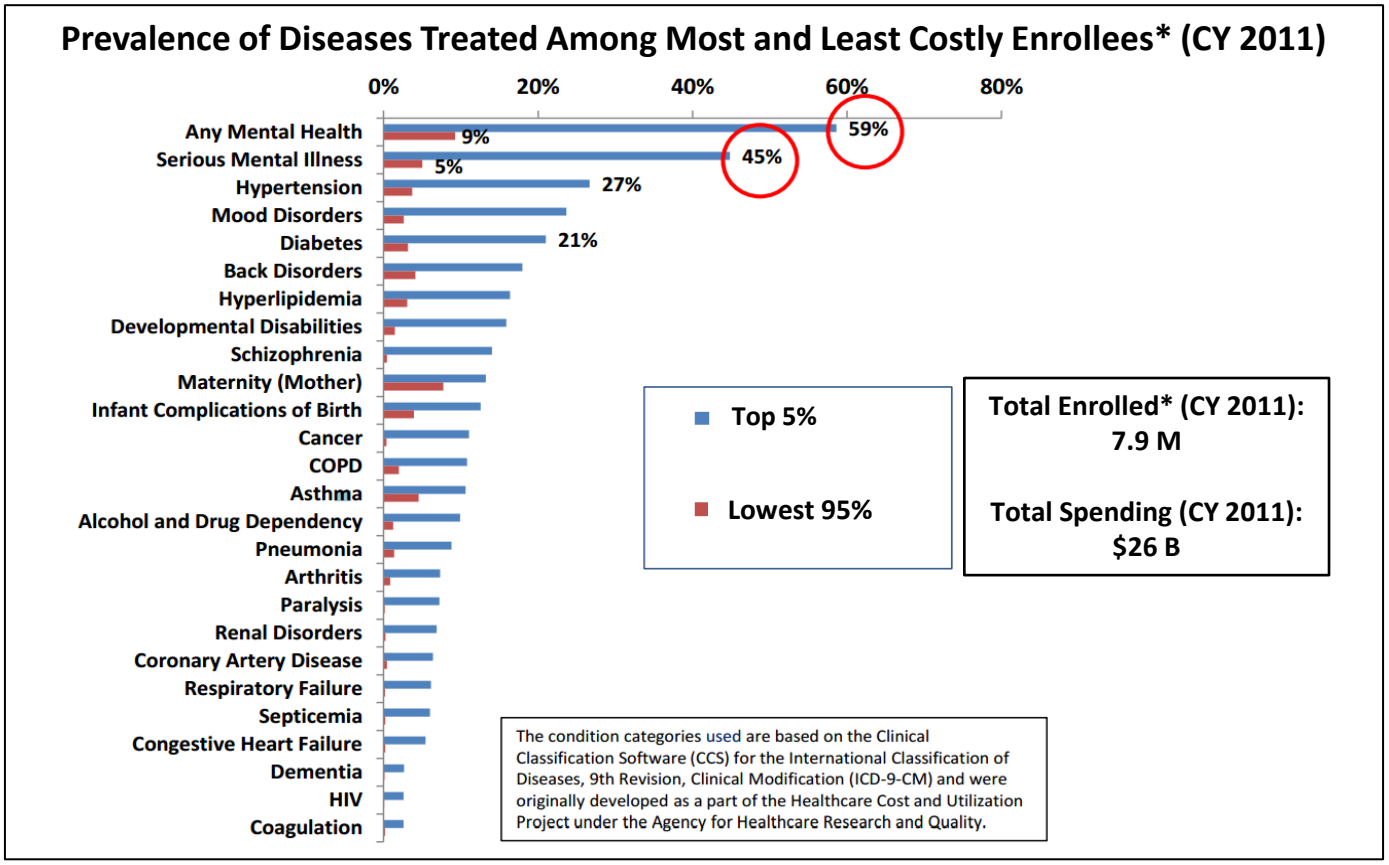
Funding: Medi-Cal spending on mental health services was estimated to be $3.3 billion in FY 2012-13 from federal, state, and county funding sources.

Memorandums of Understanding (MOUs): In each county, the mental health plan and Medi-Cal managed care plan(s) are required by their respective contracts with the state to have an MOU specifying roles and responsibilities for coordinating the delivery of mental health services.

Sources: *A Complex Case: Public Mental Health Delivery and Financing in California, CHCF, July 2013;* Proposition 30 Text of Proposed Law, *California Secretary of State, 2012;* *Behavioral Health Services Transition to Medi-Cal Managed Care, DHCS, Nov. 20, 2103.*

Behavioral Health Needs

Mental health and serious mental illness are some of the most commonly treated conditions among the entire Medi-Cal population, particularly for the most costly cohort.



*Includes individuals eligible for FFS only, FFS and managed care, and managed care only. Does not include individuals eligible for dual eligibles (those who qualify for both Medicare and Medicaid).

Source: *Understanding Medi-Cal's High-Cost Populations, DHCS, March 2015.*

Managed Care Carve-outs: LTSS and CCS

LTSS and CCS have traditionally been administered in the FFS system, but there are plans to transition both populations to managed care.

Long-Term Services and Supports (LTSS)

LTSS refer to Medi-Cal services that are delivered in the home and/or community or in institutional settings (e.g., nursing homes).

Number of Individuals Served: Approximately 450,000 Medi-Cal beneficiaries receive home- and community-based services (HCBS) and about 60,000 enrollees receive institutional long-term care.

Transition to Managed Care: The state integrated LTSS into Medi-Cal Managed Care in 7 pilot counties under the State's Coordinated Care Initiative for seniors and persons with disabilities, both duals and non-duals.

Key Trends:

- Over the next two decades, California's over-65 population will nearly double, suggesting an increasing demand for LTSS.
- Within Medi-Cal managed care, Health Homes for Patients with Complex Medical Needs will seek to coordinate services, including community-based LTSS, for beneficiaries who are high utilizers of medical care

California Children's Services (CCS)

CCS is a program for Medi-Cal children with rare and complicated diseases that has historically been delivered on a FFS basis.

Number of Children Served: 195,000

Transition to Managed Care: In October 2015, legislation was passed (AB 187) delaying the transition of CCS into Medi-Cal managed care until January 1, 2017.

Sources: *The Universal Assessment Tool: Improving Care for Recipients of Home- and Community-Based Services, Legislative Analyst's Office, Jan. 2015; May 2015 Medi-Cal Estimate, DHCS, May 2015; Planning for California's Growing Senior Population, PPIC, Aug. 2015; Health Homes Program, DHCS, Dec. 14, 2015; Bill to Delay Retooling of Children's Services Program Goes to Brown, California Healthline, Sept. 8, 2015.*

Managed Care Program Models

Counties operate managed care through four main models and two additional models only applicable in Imperial County and San Benito.

Model	Description	Enrollment (Dec. 2015)
Two-Plan	The Department of Health Care Services (DHCS) contracts with one county-developed plan called a Local Initiative (LI) and one commercial plan.	6,540,360
County Organized Health System (COHS)	The county operates a single managed care plan, with which DHCS contracts directly.	2,190,182
Geographic Managed Care (GMC)	DHCS contracts with several commercial plans. Only Sacramento and San Diego counties are designated GMC counties.	1,102,804
Regional Model	The Regional Model is a slightly modified version of the Two-Plan approach created for the rural expansion, in which the state contracts with two commercial plans over a geographic region.	294,341
Imperial Model	Two commercial plans contract with DHCS.	72,513
San Benito Model	One commercial plan contracts with the state. In this model, beneficiaries can opt out of managed care.	7,400

Sources: *Medi-Cal Managed Care Program Fact Sheet, DHCS; On the Frontier: Medi-Cal Brings Managed Care to California's Rural Counties, CHCF, March 2015; Medi-Cal Managed Care, CHCF, March 2000; Medi-Cal Managed Care Enrollment Report, DHCS, December 2015.*

Managed Care Program Models, by County

Model	Enrollment (Dec. 2015)
San Benito	7,400
Imperial	72,513
Regional	294,341
GMC	1,102,804
COHS	2,190,182
Two-Plan	6,540,360
TOTAL*	**10,207,600**

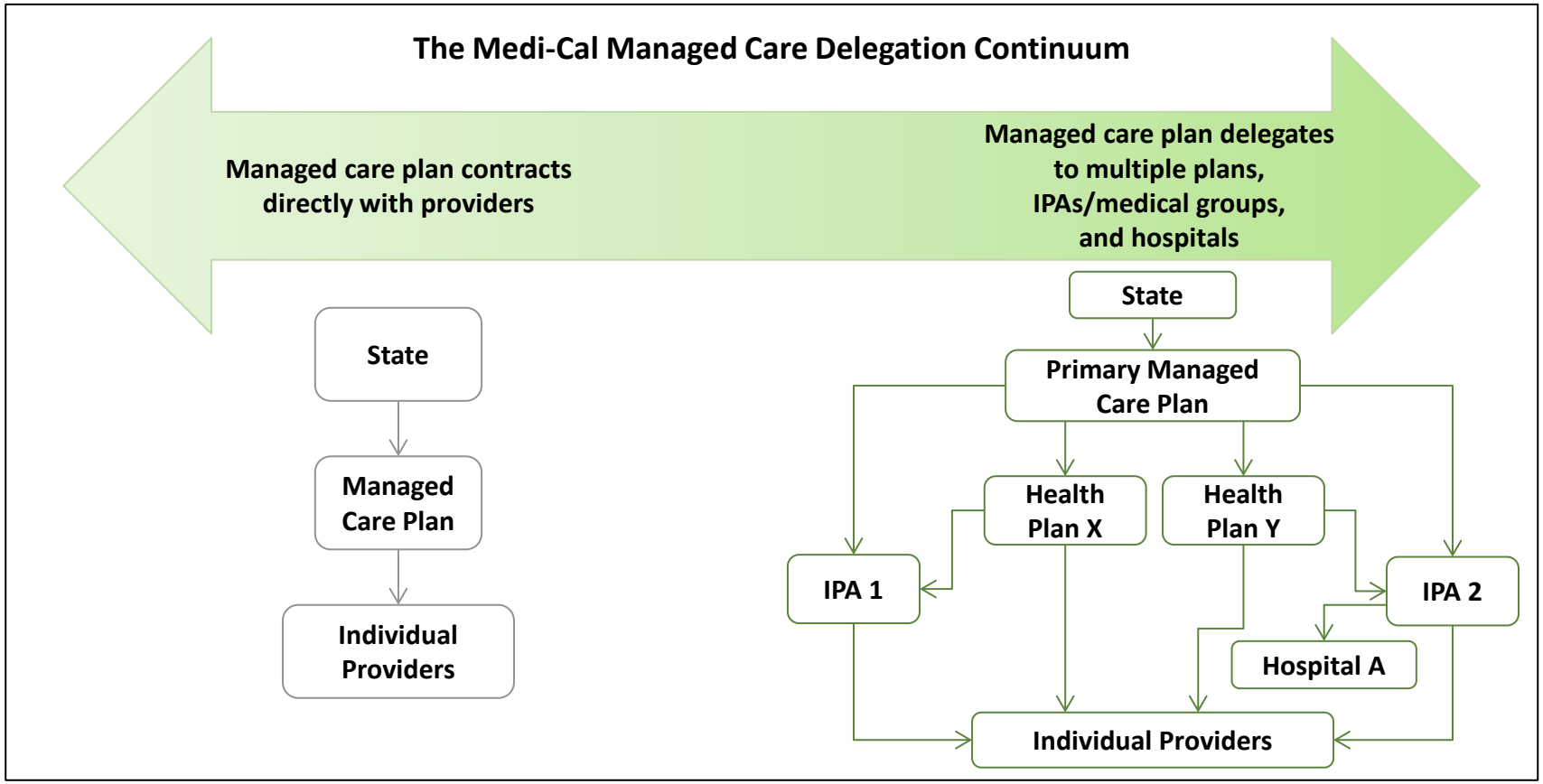
* Total does not include 849 individuals enrolled in Primary Case Care Management (PCCM) models in San Francisco and Los Angeles county.

Note: All striped counties were included in the rural expansion of managed care that began in late 2013.

Source: *Medi-Cal Managed Care County Map, DHCS; Medi-Cal Managed Care Enrollment Report, DHCS, November 2015.*

Managed Care: The Delegation Continuum

Medi-Cal managed care plans may choose to delegate and subcontract to other plans, IPAs/medical groups, and hospitals. Plans vary in the degree to which they choose to delegate the delivery of care.



***Source**: Stakeholder Interviews.*

Examples of Managed Care Delegation

Some managed care plans delegate risk and care to multiple plans, IPAs/medical groups, and hospitals, while others choose to directly contract with providers.

CenCal Health serves Santa Barbara and San Luis Obispo counties and does not delegate any plan responsibilities to other plans, IPAs or medical groups, choosing instead to directly contract with providers.

Molina serves Riverside, San Bernardino, Imperial, Sacramento, and San Diego counties and uses a delegated model.

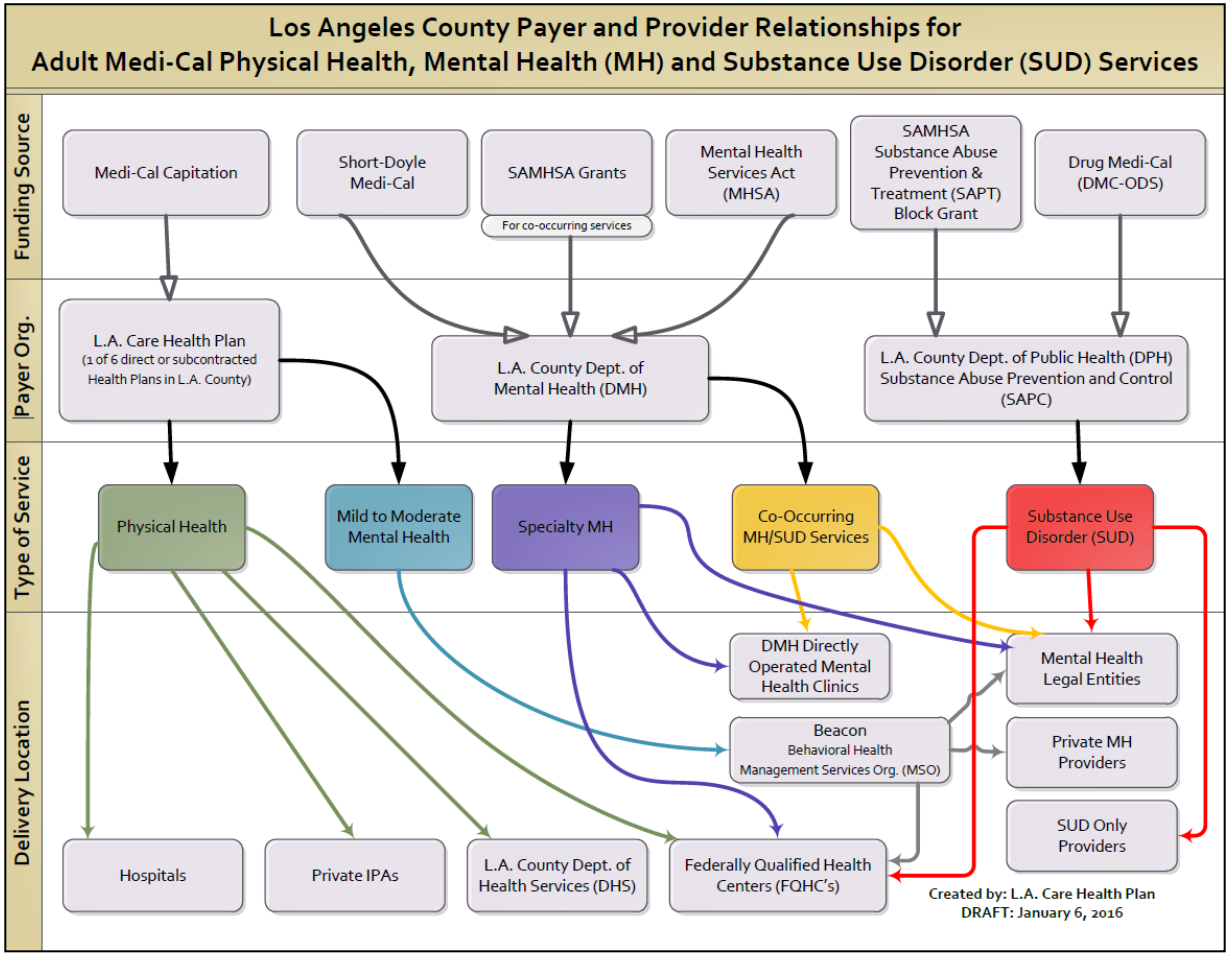
Health Plan of San Mateo (HPSM) delegates care for a small population of its patients, but otherwise only directly contracts with providers.

L.A. Care has three plan partners (Anthem, Care1st, and Kaiser), some of which may sub-delegate. LA Care itself also delegates to more than 30 participating physician groups and to specialty health plan vendors.

***Sources**: Stakeholder Interviews; About L.A. Care Health Plan, LA Care, March 2013.*

Examples of Managed Care Delegation: LA Care

The chart below provides a high level diagram of the funding streams, providers, and payers for the adult Medicaid population in Los Angeles.



Note: This chart is for illustrative purposes only and may not include all relevant providers or funding streams serving this population.

***Source**: LA Care Health Plan, January 2016.*

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Driving Value in Medi-Cal: Key Takeaways

- Medi-Cal does not have a value-based purchasing program in which payments to higher performing plans are any different than payments to lower performing plans. However, selected Healthcare Effectiveness Data and Information Set (HEDIS) measures are used in the auto assignment process; higher performing health plans can receive a higher share of enrollees who do not affirmatively pick a plan themselves.
- California allows each manage care plan to design and operate its own pay-for-performance (P4P) program.
- The new 1115 waiver will continue reforms with a second Delivery System Reform Incentive Payment (DSRIP) program that moves the public hospitals to value-based payments, a global budget system of financing care for the uninsured, and a focus on whole person care.
- The state initially sought federal financing for proposed managed care transformation and improvement programs in the new waiver proposal, however these concepts were not included in the final waiver agreement. Specifically, the state had sought federal financing for: shared savings with plans, standardization of P4P programs, and incentives to promote greater integration of behavioral health between plans and counties.

Medi-Cal Bridge to Reform Waiver

California's last Section 1115 waiver, which expired on October 31, 2015, brought in $10B in additional federal funding and included the country's first DSRIP program. The waiver broadly focused on three areas.

Expanded Coverage

- Created a Low Income Health Program (LIHP) that provided federal funds to counties that expanded eligibility for individuals at or below 200% FPL.
- LIHP aimed to reduce the number of uninsured and allow the state to get experience with expanded coverage prior to ACA Medicaid Expansion in 2014.

Safety-Net Hospital Reform

- Established the DSRIP program to provide up to $3.3 billion in federal funds as incentive payments.
- DSRIP projects were hospital-based and varied widely.
- To receive DSRIP payments, safety-net hospitals had to demonstrate progress in achieving measurable benchmarks.

Expanded Managed Care

- Transitioned the SPD population into managed care.
- Created a pilot to test new models of care for children with special health care needs who are enrolled in Medi-Cal.

Sources: *A Bridge to Reform: California's Medicaid Section 1115 Waiver, CHCF, October 2012. Key Facts on California's "Bridge to Reform" Medicaid Demonstration Waiver, Kaiser Family Foundation, October 2011;*

Value-Based Arrangements in Medi-Cal

California does not have a statewide program for value-based arrangements, including P4P or shared savings programs. Individual managed care plans may implement their own value-based arrangements.

- In Summer 2015, the Integrated Healthcare Association (IHA) surveyed Medi-Cal managed care plans and found that of the 20 plans interviewed, 16 had some program that offered financial incentives or bonuses tied to provider performance.
  - Most plans develop their own programs and measures, but the most common measures include: clinical quality, utilization, encounter submission, access to care, and patient experience.
  - IHA also compared existing performance measures across DHCS's External Accountability Set (EAS), IHA's Value-based P4P, Medicare Stars, and Covered California's Quality Rating System and found that only 2 metrics overlapped in all four programs: controlling blood pressure for people with hypertension and diabetes nephropathy.

- SB 147 authorizes the piloting of an alternative payment methodology for Federally Qualified Health Centers (FQHCs), which are currently reimbursed at cost for each visit. The pilot seeks to transition FQHCs away from the Prospective Payment System (PPS) volume-based model to a more flexible and risk-based payment methodology that provides the flexibility and incentives for FQHCs to deliver value over volume.

Sources: *California's Medi-Cal Managed Care Pay for Performance Landscape, IHA, July 2015; Medi-Cal P4P Advisory Committee, IHA, June 2015; Senate Bill No. 147 (2015-2016).*

Value-Based Arrangements in Medi-Cal

Medi-Cal Managed Care plans in California have created P4P programs that vary in their design, incentive structure, and measurement areas.

Plan	IEHP Inland Empire Health Plan	Partnership HealthPlan of California	San Francisco Health Plan
Performance Measures	Physicians are reimbursed directly under 8 program components: • Immunizations, well child visits, pap tests, perinatal visits, postpartum services, asthma, DualChoice Annual visits, and diabetes	Primary care sites rewarded based on performance in 4 categories: 1. Clinical quality 2. Appropriate use of resources 3. Operations and access 4. Patient experience	Clinical medical groups rewarded based on performance in 4 categories: 1. Clinical Quality 2. Patient Experience 3. Systems Improvement 4. Data Quality
Incentive Design and Payment	Financed through general operating funds and includes: • Event-based payments for certain program components • Outcome-based payments for asthma and diabetes • Fixed performance payments based on meeting HEDIS measure thresholds Estimated payout of $30-$35M in 2015.	Financed through general operating funds and includes: • Fixed-pool incentives distributed based on points accumulated for meeting performance and improvement targets for individual measures • Unit of Service payments based on completion of specific tasks or services (e.g., advanced care planning attestation form submission)	Financed through a capitation withhold estimated at nearly $30M in 2015: • Participants can earn back up to 100% of withheld funds based on performance • Unearned funds are placed into the program for technical assistance and training • Attainment of goals and improvement are rewarded

Source: *California's Medi-Cal Managed Care Pay for Performance Landscape, IHA, July 2015.*

Medi-Cal 2020 Waiver

While the state's original waiver renewal request included $17B in federal funding, the final agreement reached in December 2015 includes total initial federal funding of $6.2B, with the potential for additional federal funding in the global payment program to be determined after the first year.

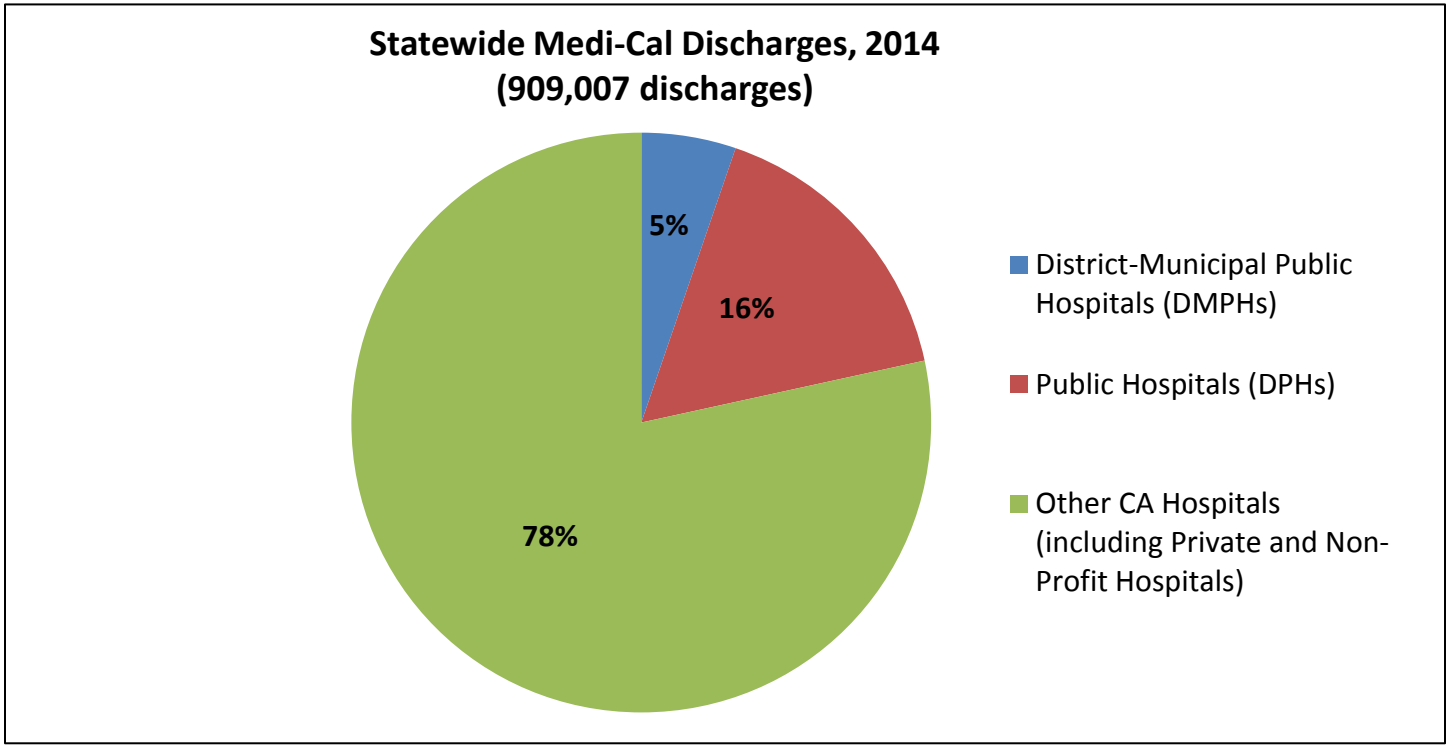
Component	Description	Federal Funding
PRIME (Public hospital Redesign and Incentive in Medi-Cal)	Delivery system transformation and alignment incentive program for designated public hospitals (DPHs) and district/municipal public hospitals (DMPHs).	DPHs: $3.27B over the five years DMPHs: $466.5M over the five years
Global Payment Program (GPP)	Converts existing Disproportionate Share Hospital (DSH) and Safety Net Care Pool (SNCP) uncompensated care funding—which is hospital-focused and cost-based—to a system focused on value and improved care delivery.	Includes 5 years of DSH funding that otherwise would have been allocated to DPHs; and $236M for 1 year of the SNCP component. SNCP component funding for years two through five would be subject to an independent assessment of uncompensated care.
Dental Transformation Incentive Program	Incentive payments to new Medi-Cal Dental providers or to existing providers who increase number of members they treat.	Up to $750M* over five years
Whole Person Care Pilot (WPC) program	A county-based, voluntary program to target providing more integrated care for high-risk, vulnerable populations.	Up to $1.5B over five years
Independent Assessments	• Independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries. • Independent studies of uncompensated care and hospital financing.	

**Amount includes $375 million in federal funding for Designated State Health Programs that enables the state to provide the non-federal share of $375 million for the Dental Transformation Initiative.*

***Sources**: Waiver Approval Letter, CMS, December 2015; Medi-Cal 2020: Key Concepts for Renewal, DHCS, March 2015.*

Medi-Cal 2020 Waiver: PRIME

The PRIME program in the new Medicaid waiver creates an incentive program for DPHs and DMPHs. Although Medi-Cal accounts for a majority of discharges at many DMPHs and DPHs, over three-quarters of all Medi-Cal discharges occur at other hospitals.



Note: Includes data for general acute hospitals only.

Source: *2014 OSHPD Hospital Annual Financial Disclosure data, Manatt Analyses.*

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Oversight, Access, and Quality: Key Takeaways

- Two state agencies oversee California's Medi-Cal program, the Department of Health Care Services (DHCS) and Department of Managed Health Care (DMHC).

- California has explicit network adequacy standards and reporting requirements, but a June 2015 State Auditor's report concluded that DHCS did not perform adequate oversight of Medi-Cal managed care plans. DHCS is actively working to address these issues.

- While managed care organization (MCO) members are generally satisfied with their personal doctor, their overall rating of their health plan and their ability to get care quickly was below national benchmarks.

- California requires full-scope managed care plans to publicly report on a number of different quality measures and performance varies greatly. Quality reports show that MCOs have highly variable performance on quality of care indicators, with many performing below the minimum performance benchmark and national averages.

Oversight & Accountability: State Entities and Roles

California's Medi-Cal program is administered by DHCS and is partially regulated by DMHC.

Agency	Role	Description
Department of Health Care Services (DHCS)	Administrator	Administers Medi-Cal and contracts directly with licensed health plans to provide federally- and state-mandated health programs and has legal responsibility as the Medicaid Agency to ensure network adequacy. DHCS delegates responsibility for conducting network adequacy reviews to DMHC, but is ultimately held responsible as the Medicaid agency.
Department of Managed Health Care (DMHC)	Regulator	Oversees full-service health plans, including all HMOs, that offer both comprehensive coverage and specialized services like dental and vision as authorized by the Knox-Keene Health Care Service Plan of 1975. DMHC conducts quarterly reviews of the network adequacy of all Knox-Keene-licensed health plans. Most Medi-Cal managed care plans are Knox-Keene-licensed, but COHS are not required to be. Nearly all COHS are not licensed.

Sources: *Ready for Reform? Health Insurance Regulation in California Under the ACA, CHCF, June 2011; Types of Plans, DMHC; Health Insurance Oversight in California: Observations on the Post-ACA Environment, Kelch Policy Group, July 2015.*

California's Network Adequacy Standards

Current federal rules require states to ensure access to care based on the expected utilization of services and specific health needs of Medicaid enrollees. States set the standards and are principally responsible for oversight, timely access, and reporting standards.

State Standard	Description
Geographic Access	California mandates that plans make primary care services available within 30 minutes or 10 miles of an enrollee's residence. Knox-Keene-licensed plans must make hospital services and emergency care available within 15 miles or 30 minutes of an enrollee's home or workplace and ensure that ancillary services are available within "a reasonable distance" of primary care facilities.
Timely Access	Federal rules require that states' plan contracts ensure hours of operation no less than offered to commercial enrollees and make services available 24/7 when medically necessary. Knox-Keene Act timely access standards have been adopted into all Medi-Cal managed care plan contracts and require that enrollees have access to services, including urgent care (48-96 hours depending on prior authorization), primary care (10 business days), and specialty care (15 business days).
Reporting Requirements	Plans must report the locations of their contracted providers every quarter or if there is a "significant change" to the network. Knox-Keene-licensed plans must report on their compliance with timely access requirements annually. SB 964, passed into law in 2014, requires DMHC to review reports on compliance with timeliness standards every year instead of every three years. In addition, DMHC must post findings from its review on its website.

Sources: *Network Adequacy Evaluation and Monitoring Efforts, DHCS, May 2014; Network Adequacy Laws in Medi-Cal Managed Care Plans, National Health Law Program, August 2014; Senate Bill No. 964 (2013-2014).*

Access and Network Adequacy Oversight Challenges

Studies point to access issues for Medi-Cal beneficiaries seeking primary and specialty care. In addition, the state's oversight of network adequacy was recently called into question.

Beneficiary Access Challenges

Primary Care: There were 35-49 full time equivalent (FTE) primary care physicians (PCPs) per 100,000 Medi-Cal enrollees in 2013, which falls below the federally recommended standard of 60-80 FTE PCPs per 100,000 individuals.

Specialists: In 2014, individuals covered by Medi-Cal were nearly twice as likely to report having difficulty finding specialty care than those not covered by Medi-Cal (17.5% vs. 9.2%).

Licensed Mental Health Professionals: The state's poorest areas have the highest rates of individuals with mental illness and they are also among the regions with the fewest licensed mental health professionals.

Dentists: In 2013, five counties lacked any active Denti-Cal providers for children and 12 counties had no dentists willing to accept new child patients.

Network Adequacy Oversight Challenges

In June 2015, the California State Auditor found that DHCS did not perform adequate oversight of Medi-Cal managed care plans. The report found that:

- DHCS failed to verify that provider network data it received from plans was accurate and approved inaccurate provider directories.
- DMHC's quarterly network adequacy assessments may not be based on accurate data.
- Thousands of customer complaint calls placed to Medi-Cal were lost or went unanswered.
- DHCS has not always performed required annual medical audits of the health plans.

Sources: *Physician Participation in Medi-Cal: Ready for the Enrollment Boom?, CHCF, August 2014; Mapping the Gaps: Mental Health in California, CHCF, July 2013; Western Dental Won't Take New Denti-Cal Patients, The Sacramento Bee, May 2015. California Department of Health Care Services: Weaknesses in its Medi-Cal Dental Program Limit Children's Access to Dental Care, California State Auditor, December 2014; California; 2014 California Health Interview Survey, UCLA Center for Health Policy Research; Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care, California State Auditor, June 2015.*

Avenues for Consumer Recourse

The state operates two main consumer advocate offices and offers Medi-Cal enrollees several channels to seek recourse if they feel they have been denied care or benefits, or have other complaints.

Medi-Cal Managed Care Office of the Ombudsman

- The Medi-Cal Managed Care Office of the Ombudsman at the state's Department of Health Care Services was established to investigate and resolve complaints.
- A June 2015 report by the California State Auditor found that 7,000-45,000 calls per month from Medi-Cal beneficiaries to the ombudsman office went unanswered because the office's telephone system could not handle the volume of calls it received. The office did not have adequate staff to answer all of the calls that did go through the system.

Independent Medical Review & State Fair Hearing

- Only Medi-Cal enrollees in Knox-Keene-licensed plans can file a complaint for an independent medical review (IMR) if requested medical care is denied, delayed, or modified. Approximately 60% of all consumers that submit IMR requests to DMHC receive the service or treatment they requested.
- All Medi-Cal enrollees are also entitled to request a State Fair Hearing for denial of services or termination of benefits. Generally, requests for a hearing are required within 90 days of denial of service.

Sources: *MMCD Office of the Ombudsman, DHCS; File a Complaint, DMHC; Your Hearing Rights: A Guide to Medi-Cal Fair Hearings, DHCS, April 2009; Appeal Rights, Community Health Group; Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care, California State Auditor, June 2015.*

Quality Measurement and Reporting

CMS requires that states measure and report on plan performance through states' contracts with managed care plans. As such, Medi-Cal managed care plans are contractually required to report on a set of outcomes and performance measures.

Quality Reporting Requirements

- Full-scope Medi-Cal managed care plans are required by contract to report on a set of 15 HEDIS measures, known as the External Accountability Set (EAS).
- Medi-Cal managed care contracts also require that each plan meet or exceed established Minimum Performance Level (MPL), set at NCQA's national Medicaid 25th percentile for each HEDIS measure and any other EAS measures not included in HEDIS. Failure to do so requires the plan to submit a detailed plan to remedy the low performance.
- In counties with more than one managed care plan, DHCS operates an incentive program that increases or decreases the percentage (+/- 5%) of mandatory enrollees auto assigned to a plan (enrollees are auto assigned when they do not select a plan) depending on the plan's performance across 6 HEDIS measures and 2 measures related to the safety net.

Medi-Cal Managed Care Quality Strategy

- In 2013, DHCS developed a strategy for Medi-Cal managed care that aligned with its overall goals to 1) improve the health of all Californians, 2) enhance quality in all DHCS programs, and 3) reduce per-capita program costs.
- DHCS is focused on three key areas for managed care enrollees: maternal child health, chronic disease, and tobacco cessation. Quality and coverage in each of the focus areas are tracked using specific performance measures and the plan is updated each year to provide context on performance and strategies for improvement.

Sources: *Medi-Cal Managed Care Program Quality Strategy Annual Assessment, DHCS, October 2014 (Rev. February 2015); Medi-Cal Managed Care Technical Report: July 1, 2013 - June 30, 2014, DHCS, April 2015; Auto Assignment Incentive Program, DHCS.*

External Accountability Set Measures

1. All-cause readmissions
2. Ambulatory care (outpatient visits, ED visits)
3. Annual monitoring for patients on persistent medications (ACE inhibitors, Digoxin, Diuretics)
4. Avoidance of antibiotic treatment in adults with acute bronchitis
5. Cervical cancer screening
6. Childhood immunization status
7. Children and adolescents' access to PCPs
8. Comprehensive diabetes care (eye exam, HbA1c testing and control, medical attention for nephropathy, blood pressure control)
9. Controlling high blood pressure for ages 60-85 without diabetes
10. Immunizations for adolescents
11. Medication management for asthma
12. Prenatal and postpartum care
13. Use of imaging studies for low back pain
14. Weight assessment and counseling for nutrition and physical activity for children and adolescents
15. Well-child visits in the 3rd, 4th, 5th, and 6th years of life

Source: *External Accountability Set Reporting Years 2015-2016, DHCS.*

Managed Care Plan Performance

Quality across Medi-Cal's 21 managed care plans varies greatly. Performance is reported only for the primary plan as a whole and not individually for subcontracted plans.

HEDIS

- In 2012, Medi-Cal managed care plans performed at an average level across 25+ HEDIS measures:
  - Plans performed very well on three measures: avoiding antibiotic treatment in adults with acute bronchitis, providing comprehensive diabetes care and use of imagining studies for low back pain.
  - Plans performed poorly on eight measures related to annual monitoring for patients on persistent medications (3), access to PCPs for children and adolescents (4), and postpartum care (1).
- Kaiser-Sacramento County and Kaiser-San Diego have been recognized in 2011, 2012, and 2013 as the two highest performing Medi-Cal managed care plans, exceeding national Medicaid 90th percentiles on ~20 performance measures.

CAHPS

- Every three years, DHCS publically reports on the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which is conducted to measure beneficiaries' perceptions and experiences with Medi-Cal .
- The most recent report, conducted in 2013 and released in April 2014, found that while MCO members are generally satisfied with their personal doctor, their overall rating of their health plan and their ability to get care quickly was below national benchmarks.

Table 6-1—Medi-Cal Managed Care 2013 CAHPS National Comparisons Results

Measure	Adult Medicaid	Child Medicaid
Global Ratings		
Rating of Health Plan	★★	★★
Rating of All Health Care	★★	★
Rating of Personal Doctor	★★★	★★★
Rating of Specialist Seen Most Often	★★★	★★★★
Composite Measures		
Getting Needed Care	★★	★
Getting Care Quickly	★	★
How Well Doctors Communicate	★★	★
Customer Service	★★★	★★★

Note: To conduct a national comparison, results for four CAHPS global ratings and four composite measures were aggregated and then compared to NCQA's HEDIS Benchmarks and Thresholds for Accreditation. Based on comparison, each measure received one to five stars, with one being the lowest possible (i.e., "poor") and five being the highest possible rating (i.e., "excellent").

Sources: *2014 HEDIS Aggregate Report for Medi-Cal Managed Care, DHCS, March 2015; Medi-Cal Managed Care 2013 CAHPS Survey Summary Report, DHCS, April 2014.*

Glossary of Terms

- **CAGR** – Compound Annual Growth Rate
- **CAHPS** – Consumer Assessment of Healthcare Providers and Systems
- **CCI** – Coordinated Care Initiative
- **CCS** – Children's Services Program
- **CMS** – Centers for Medicare and Medicaid Services
- **COHS** – County Organized Health System
- **DHCS** – Department of Health Care Services
- **DMHC** – Department of Managed Health Care
- **DMPH** – District/Municipal Public Hospital
- **DPH** – Designated Public Hospital
- **DSH** – Disproportionate Share Hospital
- **DSRIP** – Delivery System Reform Incentive Payment
- **Dual Eligible** – Individuals who qualify for both Medicare and Medicaid benefits. Those who are not dual eligible may be referred to as "**non-duals.**"
- **EAS** – External Accountability Set
- **ESI** – Employer-Sponsored Insurance
- **EPSDT** – Early and Periodic Screening, Diagnostic, and Treatment
- **FFS** – Fee-for-Service
- **FPL** – Federal Poverty Level
- **FQHC** – Federally Qualified Health Center
- **FTE** – Full-time Equivalent
- **GMC** – Geographic Managed Care
- **GPP** – Global Payment Program
- **HCBS** – Home and Community-Based Services
- **HEDIS** – Healthcare Effectiveness Data and Information Set
- **HPSM** – Health Plan of San Mateo
- **IGT** – Intergovernmental Transfer
- **IHA** – Integrated Healthcare Association
- **IHSS** – In-Home Supportive Services
- **IMR** – Independent Medical Review
- **IPA** – Independent Physician Association
- **LI** – Local Initiative
- **LTSS** – Long-Term Services and Supports
- **MCO** – Managed Care Organization
- **MOU** – Memorandum of Understanding
- **NCQA** – National Committee for Quality Assurance
- **P4P** – Pay-for-Performance
- **PCCM** – Primary Care Case Management
- **PCP** – Primary Care Provider
- **PPS** – Prospective Payment System
- **PRIME** – Public Hospital Redesign and Incentive in Medi-Cal
- **SNCP** – Safety Net Care Pool
- **SPD** – Seniors and Persons with Disabilities
- **WPC** – Whole Person Care

About Manatt

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is a fully integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory healthcare practice. Manatt Health's extensive experience spans the major issues reinventing healthcare, including payment and delivery system transformation; health IT strategy; health reform implementation; Medicaid expansion, redesign and innovation; healthcare mergers and acquisitions; regulatory compliance; privacy and security; corporate governance and restructuring; pharmaceutical market access, coverage and reimbursement; and game-changing litigation shaping emerging law. With 80 professionals dedicated to healthcare—including attorneys, consultants, analysts and policy advisors—Manatt Health has offices on both coasts and projects in more than 20 states. For more information about Manatt Health, visit www.manatt.com/HealthcareIndustry.aspx

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