Pacific Health Consulting Group

MEDI-CAL MANAGED CARE PLANS AND SAFETY-NET CLINICS UNDER ACA

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ACA Impact on Medi-Cal Health Plans & Safety-Net Clinics

- Issue brief was funded by the California HealthCare Foundation and examines the following questions:
  - How has enrollment in Medi-Cal managed care plans changed over this tumultuous period?
  - How and why are commercial and public Medi-Cal managed care health plans investing in safety-net clinics?
  - What type/level of investment in the safety net is expected by health plans and why is it important?
  - What are the issues facing Medi-Cal managed care and its relationship to the safety net?

Definitions

- **Safety-Net Clinics:**
  - County clinics and community clinics/health centers (CCHCs)

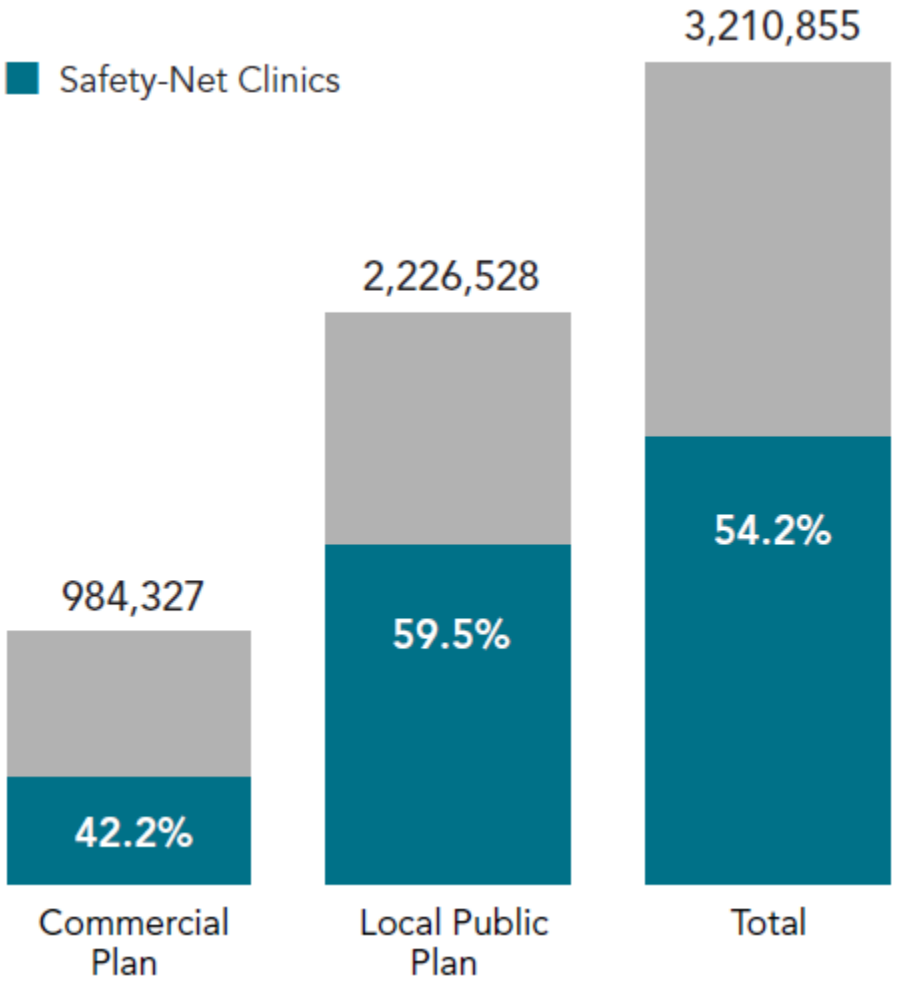
- **Medi-Cal Managed Care:**
  - Previously mostly women and children
  - 2011: Seniors and people with disabilities added to program
  - 2014: ACA Expansion - childless adults added to program

- **Types of Medi-Cal Plans:**
  - **Commercial** plans (30% of Medi-Cal enrollment)
  - **Public** plans (70% of Medi-Cal enrollment)
    - *County-Organized Health System (COHS):* Manage all Medi-Cal lives in their counties
    - *Local Initiatives*: Compete with a commercial plan

Post-ACA Increase in Clinic Market Share

Clinic Market Share

- 54% of ***new*** MC managed care members were assigned to safety-net clinics (over 1.3 million)
- Safety-net clinic share of overall enrollment grew from **33% in 2013 to 41% in 2015**



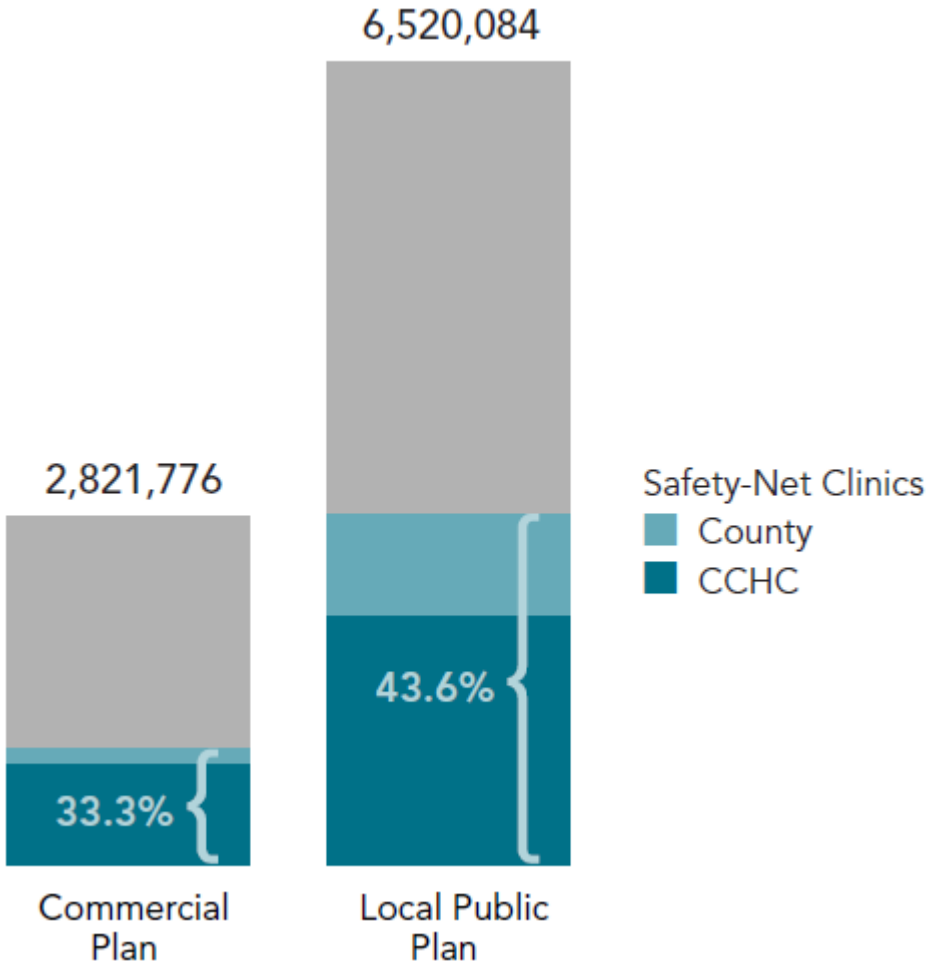
Variation in Clinic Role by Plan Type

Commercial/Public Plans

- Safety-net clinics make up 44% of public plan assignments compared to 33% of commercial plan assignments
- CCHC market share similar in commercial and public plans, but county clinic market share much higher in public plans

Local Initiative/COHS Plans

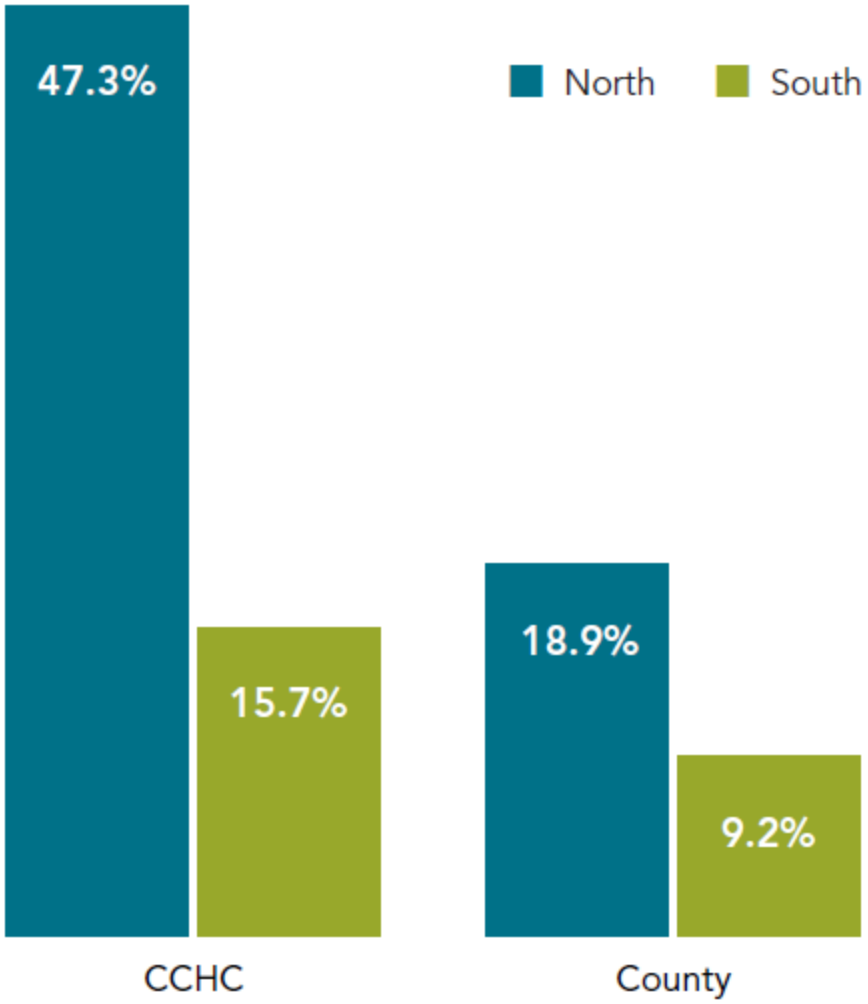
- Within the public plans, safety-net clinics make up a larger percentage of COHS assignments (72%, excluding CalOptima) than in Local Initiatives (42%)
- Wide variation between COHS plans



Variation in Clinic Role by Region

Region

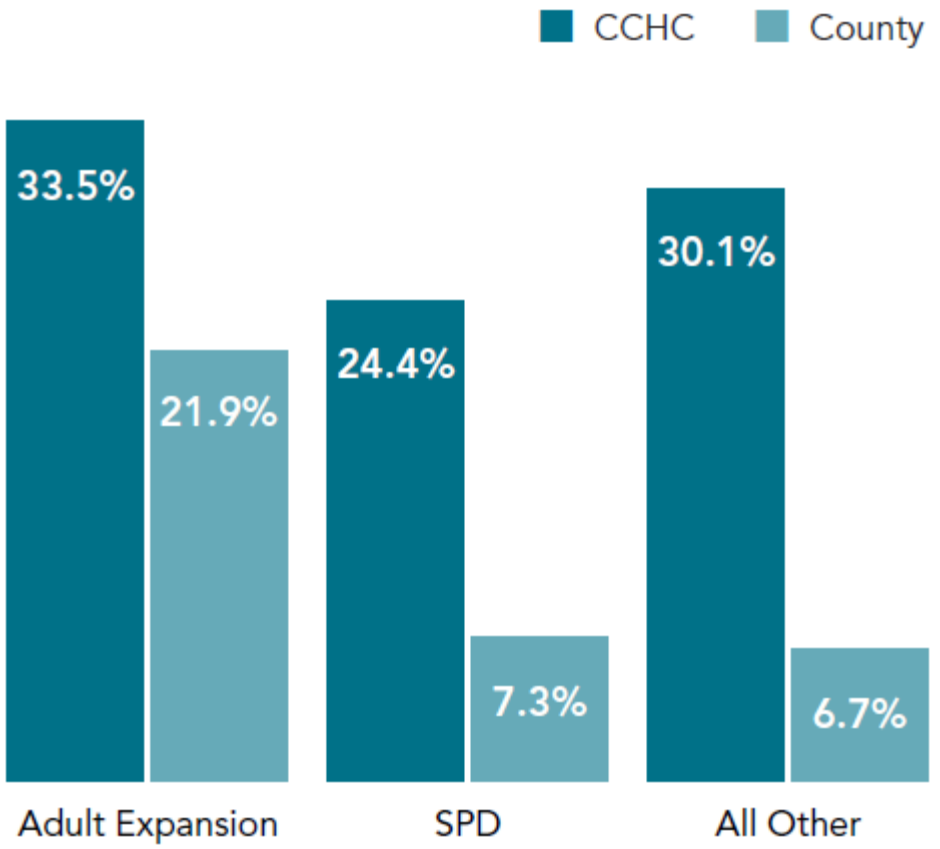
- Safety-net clinics account for a much higher percentage of assignments in Northern California than Southern California



Variation in Clinic Role by Aid Code

Aid Code

- 55% of safety-net clinic market share is in Adult Expansion, 32% in Seniors and People with Disabilities (SPD), 37% in all other aid categories
- A larger proportion of county clinic market share is Adult Expansion
- CCHCs market share distributed among aid categories



New Demands on Clinics

- Patient mix changed: More sick adults
- New expectations in managed care:
  - Chronic care management, instead of episodic care
  - Access standards (appointments within 10 days)
  - Reporting requirements
- Clinics have poor payer mixes (largely Medi-Cal and underinsured) and are poorly capitalized
  - Chronic staff and provider shortages (increased competition for providers)
  - Lack of infrastructure to drive needed change

Increasing Importance of Public Plans

- 3.2 million new Medi-Cal managed care members since 2013
- 70% of Medi-Cal managed care members are assigned to public plans
- HEDIS* Quality Measures required for all Medi-Cal plans:
  - Prevention, well care, chronic disease management, appropriate care
- The 11 highest-scoring Medi-Cal plans (excluding Kaiser) are all public plans
- Public plans made substantial investments in safety-net clinics aimed at improving access and quality

* *Healthcare Effectiveness Data Improvement Set*

The Case for Clinic Investments

- Mission: Public plans founded to support the safety net

- Necessity
  - New access and quality standards
  - Many plans had most of their members in clinics
  - Clinics took in the majority of new Medi-Cal members
  - Clinics lacked enough capital to transform care (improve access and quality with limited resources)

- Doing what works
  - Clinics are complex systems -- corrective action plans don't drive change
  - Funding, technical assistance, and incentives needed to work better, not harder

Types of Investments

- Pay for Performance (P4P) and rate increases aimed at clinics
- Grants to improve quality (improving chronic care and patient experience)
- Grants to improve access (provider recruitment, loan repayment, space expansion)
- Technical assistance (team care, performance improvement, reduction in appointment delays)

Clinic Investments

- Public plan investments were (in general) substantially greater in size, and more varied in type, than commercial plans:
  - Larger sums: one plan reports $116 million to expand clinic capacity
  - Tied with technical assistance: Consultants focused on appointment delays
  - Specific targets: Provider recruitment, access improvement, medical home accreditation

Views from the Field

- Increasing member complexity requires more plan/clinic collaboration
- Clinics are a critical access point for both public and commercial plans
- Value-based purchasing (pay for outcomes): Early, but holds promise
  - Will require dramatic changes in clinic operations
- New pressure and oversight from regulators
  - Improve access, quality, and care coordination

Views from the Field

- Plans are responding creatively to new demands
  - Seeking levers beyond contracting and corrective action to drive change
- Clinics are poorly capitalized, with unfavorable payer mixes (Medi-Cal and uninsured), and recruitment challenges
  - Clinics require outside investment to transform care, expand access, and increase service
  - Tremendous uncertainty about the future, especially with increased competition, rate uncertainty, and perceived indifference from DHCS about viability of the safety net

Views from the Field

- Different challenges face rural Medi-Cal managed care
- Uncertainty ahead
  - Impact of rate reductions
  - Impact of new 1115 waiver renewal (and potential loss of future waiver funding sources for county systems)
  - Managing new risk-based payments

Key Takeaways

- Medi-Cal reliance on safety-net clinics has grown significantly
- Safety-net clinics require continuing investment to meet the demands of the expansion population, while meeting access and quality standards
- Many public plans have made larger and more consistent clinic investments compared to most commercial plans; level of investment may not be stable if rates decrease
- There is considerable variation in the size and purpose of plan investments in the safety net; investment by most plans is fairly small
- Interdependence between public plans and safety-net clinics could be a mechanism to strengthen systems of care for Medi-Cal members
- Regulatory oversight, practice reform imperatives, and rate reductions may reduce plans' ability to invest in the safety net. With few other sources of investment and capital, such changes would threaten viability of the safety net at a time of significant need for the expanded Medi-Cal population

Reactor Panel

Public Plan:

Liz Gibboney, CEO, Partnership Health Plan

Commercial Medi-Cal Plan:

Abbie Totten, Director, Government Programs Policy and Strategic Initiatives, Health Net

Clinic:

Ana Valdés, MD, Chief Medical Officer, HealthRight 360

DHCS:

Sarah Brooks, Deputy Director, Health Care Delivery Systems