



## Raising the Bar: How California Can Use Purchasing Power and Oversight to Improve Quality in Medi-Cal Managed Care

Over the past decade, the California Department of Health Care Services (DHCS) has dramatically increased the reach of the Medi-Cal managed care program through the successful expansion of Medicaid under the Affordable Care Act, the integration of the Children's Health Insurance Program into Medi-Cal, and a significant expansion of managed care to seniors and persons with disabilities and to rural areas of the state. With 10.8 million enrollees and expenditures of \$49 billion, the Medi-Cal managed care program is larger than the entire budget of all but two other states.

To ensure that Californians are getting the best value possible from this critically important program, it is imperative that oversight and monitoring of Medi-Cal managed care by DHCS is effective and efficient. With this goal in mind, the California Health Care Foundation (CHCF) engaged Bailit Health to research and make recommendations for how DHCS could strengthen its purchasing strategy and oversight of Medi-Cal managed care plans (MCPs).

In approaching this work, Bailit Health drew from its value-based purchasing perspective, consultations with CHCF, knowledge of other states' Medicaid managed care contracts, prior experience as state Medicaid managed care staff, consulting experience with many Medicaid agencies, and knowledge of other state and private purchasers' use of tools with contracted MCPs. Value-based purchasing is an ongoing process that begins with defining a procurement approach and vision, and then continually monitoring, measuring, and modifying the approach to improve quality and outcomes, including using financial and nonfinancial incentives and penalties. At its core, the value-based purchasing model encourages purchasers to move beyond a compliance-based oversight model to one in which they have a collaborative partnership with MCPs to help improve performance and advance the purchaser's vision.

Bailit Health employed a multipronged research approach, including identifying potential types of health care purchasing tools and strategies, reviewing managed health plan contracts of select public

purchasers, and interviewing public purchasers and stakeholders in California as well as senior Medicaid managed care staff in select other states. The authors conducted research in the fall of 2018, prior to Governor Newsom's administration taking office. This research work was informed by examining health plan contracts and other available material from Medi-Cal, Covered California, and the California Public Employees' Retirement System (CalPERS) as well as interviewing staff responsible for oversight of these purchasers' MCP contracts. Similarly, the authors reviewed Medicaid MCP contracts in Florida, Massachusetts, Tennessee, Texas, and Washington. To supplement the authors' knowledge, interviews were also conducted with Medicaid staff from those states and Oregon.

## MCP Monitoring and Oversight Process

### Strengths

DHCS's recent success implementing a significant expansion of Medi-Cal and several innovative pilots through a series of groundbreaking Section 1115 waivers speaks to the strength of the Medi-Cal managed care program upon which these achievements were built. Similarly, the agency's recent implementation of significantly increased oversight of MCPs to implement the 2016 revisions to the federal Medicaid managed care rule, codified in California's Assembly Bill 205, demonstrates DHCS's capability to develop, coordinate, and execute large-scale change in its monitoring and oversight approach. Given the size and scope of the Medi-Cal managed care program, the state's ability to "keep the trains running" during

these multiple changes is a significant accomplishment. Implementation of any changes, including modifications to Medi-Cal benefits, involves coordination across all plans and regions of the state. The state's many communication channels with MCPs and other stakeholders appears to work well in terms of sharing Medi-Cal policies with different levels and types of MCP personnel. Stakeholders cited the well-organized implementation of Medi-Cal's palliative care benefit, which involves extensive provider education and outreach, as an example of a successful DHCS initiative.

### Challenges

The size, scope, and complexity of the Medi-Cal managed care program also presents unique challenges. DHCS directly oversees 22 MCPs through six different models, and covered services differ across the MCPs.<sup>1</sup> For these reasons, some managed care monitoring approaches that work well in smaller states may not be feasible in California or may only work in certain regions of the state.

While DHCS could consider employing additional tools used by other California public purchasers, such as Covered California and CalPERS, some approaches used by these purchasers might require explicit federal approval and others might not be possible or recommended for Medi-Cal. For instance, DHCS must comply with federal Medicaid managed care rules related to cost-sharing limitations for enrollees, provider incentive arrangements, alternative payment models (APMs), provider-directed payments, and annual actuarial soundness of MCP rates, which may make it more difficult for Medi-Cal to innovate in these areas. In addition,

DHCS is specifically required to comply with federal waiver terms and conditions as well as certain state laws and regulations that apply only to Medicaid managed care plans,<sup>2</sup> or that apply differently to Medicaid plans, such as those related to annual audits and assessing network adequacy of MCPs.

### Opportunities for Improvement

The Newsom administration has already identified a number of ways in which it plans to improve the MCP monitoring and oversight process, including expanding oversight of plan performance to include every adult and child Healthcare Effectiveness Data and Information Set (HEDIS)<sup>3</sup> measure, and requiring that plans achieve the National Committee for Quality Assurance (NCQA) 50th national performance percentile for these measures. The authors applaud the administration for taking quick action to show it is committed to continuing to improve the quality of care provided to Medi-Cal beneficiaries.

In developing recommendations for Medi-Cal, Bailit Health considered limitations in purchasing options for Medi-Cal due to federal and state restrictions applicable specifically to Medicaid managed care programs and contracts, and the feasibility of options based on the size of the Medi-Cal program. The authors also focused on prioritizing activities and tools, or modifications of tools, expected to result in better value from MCPs participating in Medi-Cal.

Bailit Health recommends that DHCS consider adopting the following specific purchasing and contracting tools and approaches to strengthen Medi-Cal's monitoring and contracting with MCPs, including some which build upon initiatives already underway.

## Priority Recommendations

In the short term, the authors recommend that DHCS focus on the following priority recommendations:

**Articulate a strategic vision for managed care and translate to policy requirements within the MCP contract.** The upcoming, anticipated procurement process for certain Medi-Cal contracts provides DHCS with an important opportunity to review its vision of the Medi-Cal managed care program. While not all MCPs will be reprocured, DHCS can leverage the procurement activity to make clear its aligned vision for all managed care plan models and to renegotiate updated MCP contracts, regardless of plan type. DHCS should use this opportunity to clearly define and broadly communicate its goals and priorities for Medi-Cal managed care over the next five years (coinciding with the term of the upcoming MCP contracts). Building off the 2017 DHCS Strategy for Quality Improvement in Health Care, the department should articulate a clear and aligned vision specifically for Medi-Cal managed care plan oversight, shifting the focus from minimal MCP contract compliance to one of excellence and ongoing performance improvement. Massachusetts's recent procurement provides an excellent example of a clear strategic vision and accompanying goals.<sup>4</sup>

**Strengthen oversight of MCPs that delegate risk to another entity.** As part of the forthcoming commercial plan reprocurement and related County Organized Health System (COHS) and local initiative revised boilerplate contracts, DHCS should consider new requirements for MCPs. Specifically, the authors encourage DHCS to consider:

- ▶ Enhancing oversight requirements for MCPs that delegate services and/or risk to subcontractors, similar to the new Florida Medicaid MCP contracts.
- ▶ Adding new MCP oversight approaches in coordination with the Department of Managed Health Care (DMHC) related to delegated entities' financial solvency, impact on overall MCP network adequacy, and on an individual beneficiary's ability to access care.
- ▶ Requiring MCPs to report on their use of risk-based alternative payment models with provider entities, the impact of these APMs on encounter data, and MCP and provider performance on quality and efficiency measures.

Florida's acute care managed care organization (MCO) contract provides example language regarding additional requirements and oversight of delegated entities and reporting on APM arrangements.<sup>5</sup>

**Enhance the current focus on quality measurement and reporting.** The authors recommend that DHCS take the following steps to enhance the focus of MCP performance on quality metrics, and specifically performance improvement:

- ▶ Involve MCP representatives, consumer advocates, and other stakeholders in the selection of MCP External Accountability Set (EAS) measures and specifically consider aligning EAS measures with MCP measures used by other purchasers in the marketplace, including Covered California and CalPERS, as appropriate.
- ▶ Regularly and consistently use data on plan performance to prioritize MCP oversight activities, and compare MCP performance on all prioritized measures to state, and where available, regional or national benchmarks.
- ▶ Ensure that contracted MCPs achieve objective, measurable improvements in performance, above current performance and above the currently set Minimum Performance Level of the NCQA 25th percentile for national Medicaid performance. Governor Newsom has indicated that his administration will require MCPs to meet the NCQA 50th percentile. It may be difficult for MCPs to make that big of a leap initially. One approach toward moving to that 50th percentile may be, consistent with the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) approach, to expect MCPs to seek and over time obtain a 10% gap closure between the difference of current performance and the 50th percentile, or as required within PRIME, the 75th or 90th percentile for NCQA Medicaid MCO performance. It is recommended that DHCS phase in the 50th percentile requirement and look to see whether it is realistic for MCPs to meet that standard for every measure or if there should be individualized benchmarks for certain measures. When phasing in the increased performance standard, DHCS could focus on improvement over time and that the Minimum Performance Level for a given measure be based on current Medi-Cal MCP quality scores rather than adoption of a single benchmark (e.g., 50th percentile for every measure).

- ▶ Require more granular population data collection and analysis and the development of a plan to address identified disparities, similar to DHCS efforts in the PRIME program.<sup>6</sup>
- ▶ Where appropriate, seek alignment with Covered California, CalPERS, and the Integrated Healthcare Association on performance measure reporting and improvement expectations.
- ▶ Make quality, and specifically MCP performance on quality metrics, an integral part of ongoing MCP contract management and a focus of discussion between MCPs and senior DHCS leaders, beyond the chief medical officers and the quality improvement staff.

**Use a combination of financial and nonfinancial incentives to improve performance.** The authors recommend that DHCS follow the lead of many other state Medicaid purchasers and its sister public programs, Covered California and CalPERS, to create meaningful consequences for MCP performance and follow through using a combination of financial and nonfinancial incentives for contracted plans that fail, meet, or exceed DHCS performance expectations.

DHCS creating and using a meaningful combination of financial and nonfinancial incentives makes a business case for MCPs to invest in improved performance on behalf of Medi-Cal beneficiaries. In terms of nonfinancial incentives for plans to improve performance, the authors encourage DHCS to:

- ▶ Continue to use performance-based auto-assignment.

- ▶ Continue to develop and update its MCP performance dashboard.
- ▶ At least annually develop and share MCP-specific performance data on its website and as part of its MCP and workgroup meetings, including with consumer advocates.

Similarly, the authors encourage DHCS to develop and use a menu of financial incentives linked to MCP performance, including:

- ▶ Financial penalties on MCPs performing below state-defined minimum benchmarks.
- ▶ Positive financial incentives for MCPs that are high performing and/or those that demonstrate significant improvement over time.

DHCS should consider a range of positive financial incentives commensurate with the effort required by MCPs to meet the performance goals, the availability of funds to support positive financial incentives for MCP performance, and the potential impact of the Medicaid managed care rule.

**Establish regular meetings between DHCS and MCP leadership.** DHCS conducts a significant number of audits of its MCPs and receives a large amount of information on a regular basis from its plans to allow it to oversee MCP performance. These formal audits are largely paper reviews focused on compliance and minimum contractual expectations for MCP performance. To promote higher performance, quality improvement, and joint problem solving, regularly scheduled in-person leadership meetings with senior executives of DHCS and the individual MCPs

may be more effective and meaningful for improving performance than lengthy audits and Corrective Action Plans. In the authors' experience, this type of senior-level engagement helps to build a culture of collaboration and partnership between states and MCPs similar to what has reportedly occurred in some smaller DHCS-led workgroups on specific issues. Most states reviewed do conduct in-person meetings with MCP leadership individually at least annually.

Given the size of the Medi-Cal program and the number of MCPs across the state, the authors recognize that it is difficult for senior DHCS leadership to meet regularly with individual MCPs. However, the authors believe that one-on-one meetings with MCPs — particularly those serving large numbers of Medi-Cal beneficiaries — are an essential tool for DHCS to use in partnering with its MCPs to implement its vision, goals, and objectives. Ideally, the authors recommend annual management meetings led by senior DHCS staff with each MCP. The agenda should include a review of plan performance on a variety of metrics aligned with DHCS priorities, such as HEDIS measures, member satisfaction results, member services telephone response times, and network adequacy issues.

## Longer-Term Recommendations

Over the next two years, the authors recommend that DHCS:

**Continue to improve operational simplification and coordination of MCP oversight.** It is recommended that DHCS simplify and improve Medi-Cal MCP oversight through continued coordination with other agencies to use resources more efficiently and to reduce duplication related to oversight of the managed care plans, particularly with DMHC. Since all Medi-Cal plans except COHS are required to be licensed under the Knox-Keene Act, DHCS shares responsibility for the oversight of many of its MCPs with DMHC.

The authors understand that DHCS and DMHC do make an effort to coordinate MCP audits when they overlap to reduce the burden on the MCPs. However, it is believed that greater efficiencies are possible by reducing duplication in DHCS and DMHC oversight, particularly related to managed care network adequacy, basic financial standards, the scheduling of audits, and the alignment of audit tools and scope. In doing so, the authors recognize that there are differences in state and federal requirements for Medi-Cal and other Knox-Keene plans. However, the recent surprise collapse of a provider organization raises the question to stakeholders of how DHCS and DMHC are coordinating and overseeing health plans that subdelegate certain functions to other provider organizations, including the financial strength of provider entities that have taken on a meaningful level of financial risk. The authors also recommend that

the legislature consider allowing DHCS to reduce its auditing of MCPs based on meeting certain performance standards. For example, if a MCP is also licensed under Knox-Keene and has clean audits for a certain number of years, the legislature could provide DHCS with discretion to skip or narrow audit oversight.

The authors also recommend that, similar to CalPERS, DHCS require MCPs to timely submit to DHCS a copy of any financial audit report and any public quality-of-care study or access study prepared by a federal or state regulatory agency, or by an accrediting body (e.g., The Joint Commission, NCOA, or the Utilization Review Accreditation Commission [URAC]).

**Pursue greater alignment with other large purchasers in California.** The authors recommend that DHCS align select Medi-Cal MCP policy, performance, transparency, and/or incentive approaches with other DHCS initiatives and with large purchasers in the California marketplace where feasible and appropriate.

As the largest purchaser of health care in California, the state has incredible leverage to influence health policy and purchasing decisions. Within the Medi-Cal program there are a number of different initiatives to improve health care access and quality while containing costs. In many instances, these efforts occur outside of or parallel to the MCPs. If reform initiatives, such as Delivery System Reform Incentive Payments (DSRIP) funding, were more closely aligned with the managed care program, then the initiatives may be more effective in the short term, and more sustainable in the long term, provided they are shown to be cost-effective.

Where Medi-Cal aligns with CalPERS and Covered California, it allows the state to further move the needle on improved health care access and quality, as well as on activities to contain costs. Although Medi-Cal sometimes works with other state health purchasers to pursue specific activities, ongoing attention to alignment of policies and approaches across purchasers has been limited. Opportunities for improved alignment include the development of a common quality measure set across public programs in California, similar financial incentive (and penalty) approaches for MCPs meeting specific quality benchmarks, and more consistent and frequent transparency of MCP performance compared to peers, statewide benchmarks, and national standards. Tennessee is one example of a state that has embraced alignment across its public and private sector to improve population health.

**Build upon recent efforts to improve access to care and MCP network adequacy.** The authors recognize that DHCS has invested significant time and effort in new MCP network adequacy standards and health plan reviews and that it is no easy or small task. It is recommended that DHCS:

- ▶ Continue to improve, routinely use, and synthesize different types of access reporting and monitoring to better identify access issues. Beyond provider miles and minute analyses, secret shopper appointment availability, member satisfaction data, emergency department utilization, and out-of-network volume all help to assess network adequacy within plans and across regions.

- ▶ Consider modifying MCP reporting requirements and create performance incentives specific to access to care as part of the upcoming reprocurement and contract revisions.
- ▶ Expand its capabilities to assess primary care provider (and ideally other provider) participation across plans.
- ▶ Work with MCPs to explore why so many alternative access arrangements are necessary, particularly for specialty care. Continue to monitor this situation to improve access and reduce the need for alternative arrangements, and require MCPs to create short-term and longer-term interventions to address and, where feasible, resolve network deficiencies over time.

**Implement a calendar of activities to reflect goals and priorities.** A calendar of activities is a simple tool that can improve communication with plans and increase the predictability of DHCS activities. DHCS already posts a calendar of events on its website that stakeholders can review by month.<sup>7</sup> The authors recommend that DHCS implement an enhanced calendar of activities, specifically focused on activities and an improvement cycle related to the Medicaid managed care program and MCP performance. This type of performance-driven calendar can also become a part of specified DHCS responsibilities that are delineated within the MCP contract. Key elements that could be included in such a calendar for both internal DHCS and MCP use are as follows:

- ▶ Timing of reports on managed care performance (including clinical, administrative, financial, and consumer satisfaction metrics).

- ▶ Planned updates to MCP performance metrics and related meetings and deadlines.
- ▶ Periodic meetings with MCP CEOs, chief financial officers (CFOs), and chief medical officers (CMOs).
- ▶ All Plan Letters under development, with anticipated publication dates.
- ▶ Contract amendment timelines.
- ▶ Medi-Cal budget and contract rate development timelines.

This level of transparency would serve multiple purposes. Most simply, it would provide staff at both DHCS and the plans with a more comprehensive view of interactions between the state and the MCPs related to plan performance and quality improvement. In addition, such a calendar can help with identifying competing priorities and draw attention to the interaction between different oversight and management activities.

**Continue to invest in staff.** For several years, DHCS has used the DHCS Academy to train potential leaders on cross-agency functions. The DHCS Academy appears to be a best practice among Medicaid agencies that often struggle to hire and retain staff and to support long-term skill and leadership development.

In addition to training through the DHCS Academy, the authors recommend that DHCS provide management training to all staff that liaise with managed care staff and/or who have responsibility for MCP contract management. Such training will provide staff with the necessary tools and skills to most effectively

provide consistent oversight and support to MCPs. Specifically, the managed care program staff would benefit from training focused on the issues unique to managed care oversight, including an introduction to the contract and the extensive supporting materials; education about key managed care issues like network adequacy, customer service standards, and quality metrics; and a primer on how DHCS divisions work with one another and in concert with DMHC. Texas's ongoing training and teaming model for staff may provide some additional insight for DHCS.

## Conclusion and Next Steps

California has taken numerous steps over the past decade to improve timely access to high-quality care for Medi-Cal enrollees. Despite these efforts, quality of care for Medi-Cal managed care enrollees varies widely and lags behind that of many other states. If California is to fulfill the promise of Medi-Cal managed care, it will need to take bold action. The Newsom administration has taken promising early steps to increase monitoring of performance measures and raise the MCP performance standards. The authors recommend that DHCS continue this effort by actively defining and promoting its vision and expectations for MCP performance improvement across a variety of metrics and by offering plans positive and negative incentives to achieve improved performance.

The upcoming Medi-Cal reprocurement offers a unique opportunity to broaden and solidify DHCS's Medi-Cal managed care orientation from a focus on

compliance to more of a value-based purchasing, performance improvement perspective. However, as this report makes clear, the procurement is only one of several tools available to DHCS to improve performance among contracted MCPs. If it adopted the recommendations in this report, DHCS would use its enormous purchasing power more effectively and improve health outcomes for nearly 11 million Californians who rely on Medi-Cal managed care for their care.

### About Bailit Health

Bailit Health Purchasing, LLC (Bailit Health) is a health policy consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies. The firm primarily works with states to take actions that positively influence the performance of the health care system and support achievement of measurable improvements in health care quality and cost management.

For more information, visit [www.bailit-health.com](http://www.bailit-health.com).

### About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and 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](http://www.chcf.org).

### Endnotes

1. In determining the number of MCPs that DHCS oversees, all contracts with the same parent organization were counted as a single plan, with the exception of Health Net and California Health and Wellnesses, which recently merged. For example, Kaiser Permanente is counted as a single plan, although its Northern California and Southern California regions operate separately. Specialty managed care plans are excluded. Some MCPs operate in multiple regions and some operate in both the GMC and the Two-Plan models. In addition to these Medicaid plans, DHCS has some level of oversight and/or responsibility for a separate dental managed care system, a Drug Medi-Cal Organized Delivery System, and county mental health plans.
2. Such as California's Assembly Bill (AB) 205.
3. HEDIS is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance.
4. The Massachusetts MCO procurement is available at: "Bid Solicitation: BD-17-1039-EHS01-EHS01-10209," Commonwealth of Massachusetts, last modified September 19, 2017, [www.commbuys.com](http://www.commbuys.com).
5. More detailed information is included in Florida's Medicaid MCO core contract provisions in Attachment II and Exhibit II-A at "2012–2018 SMMC Plans," Florida Agency for Health Care Administration (AHCA), n.d., [www.fdhc.state.fl.us](http://www.fdhc.state.fl.us).
6. More information on how PRIME measures disparities is available in *Medi-Cal Managed Care External Quality Review Technical Report, July 1, 2016–June 30, 2017*, DHCS, April 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF); and *2015–16 Disparities Focused Study 12-Measure Report*, DHCS, July 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
7. "Calendar of Events," DHCS, last modified March 21, 2019, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).