



A Close Look at Medi-Cal Managed Care: Quality, Access, and the Provider's Experience Under the Regional Model

OCTOBER 2019



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Acknowledgments

The authors would like to acknowledge the expert contributions to this paper of Athena Chapman, MPP, Caroline Davis, MPP, and Jill Yegian, PhD.

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Executive Summary

Medi-Cal enrollees in 18 rural counties in California receive care under Medi-Cal's Regional model of managed care, in which enrollees have the option of choosing between one of two commercial managed care plans (MCPs). The Department of Health Care Services (DHCS) intends to re-procure all of the commercial Medi-Cal MCPs statewide beginning in 2020, with implementation for the Regional model scheduled for January 2024.¹ This procurement provides an opportunity to review and evaluate the ways in which managed care is implemented in California, to incentivize improvements in MCP performance leading up to the procurement, and to develop and implement specific improvements under new contracts with MCPs following the procurement.

This report examines the performance of the two Regional model MCPs. It compares access to care, quality of care, and both patients' and providers' satisfaction with MCPs in Regional model counties with (1) a "rural comparison" group consisting of 14 other rural counties in California and (2) the "PHC north" group, which includes seven of these rural comparison group counties that joined Partnership HealthPlan of California (PHC) as part of the Medi-Cal rural expansion in 2013. The data analyzed for this report include the following: qualitative data collected through structured interviews with providers, county officials, and MCP representatives; quantitative data from surveys and measures of access and quality; and data from a recent report by the California State Auditor, which conducted an audit of the oversight by DHCS of Regional model MCPs.²

Results

Rural Californians struggle with health care challenges unique to their setting. The state's rural areas tend to have fewer health care providers relative to more urban areas, and many patients need to travel long distances in order to obtain certain types of specialty care. Within the state's rural areas, however, important differences exist. Compared with rural comparison

counties, Medi-Cal enrollees residing in Regional model counties have received somewhat poorer quality of care, have greater difficulty accessing specialty care, and are less satisfied with their health care. The rate of improvement in health care quality and access to primary care has been somewhat better for Medi-Cal enrollees in Regional model counties than for enrollees in the rural comparison group (findings from the comparison of the Regional model with PHC north are presented in the full paper).

Key findings of the analysis include the following:

- ▶ **Medi-Cal enrollees' access to primary care in Regional model counties is comparable to that in other rural regions.** On a survey of Medi-Cal MCP members, those enrolled in the two Regional model MCPs were, on average, more likely to report that they get care quickly and have a usual source of care than those enrolled in MCPs in the rural comparison group. However, Regional model MCP members were somewhat more likely to report that they had difficulty accessing primary care.
- ▶ **Access to specialty care is difficult for Medi-Cal enrollees in Regional model counties.** Many providers in these counties indicated that limited specialty care networks hindered their ability to deliver effective patient care and reported that the commercial MCPs had not invested in attracting and retaining specialty care providers. These providers also indicated that patients had difficulty accessing some benefits, such as the transportation or mild-to-moderate mental health benefits. Analysis of survey data suggests that Medi-Cal enrollees in Regional model counties are somewhat more likely to report difficulty accessing specialty care than residents of other rural areas of the state. Moreover, some enrollees in Regional model counties need to travel very long distances to access care when compared with enrollees in other rural areas.³ State administrative data on network adequacy are of limited value in assessing whether patients are able to access the care they need.

► **The quality of care provided to Medi-Cal enrollees in Regional model MCPs was worse, on average, than for Medi-Cal enrollees of MCPs in other rural counties.** Although the differences were relatively small in percentage terms, the two Regional model MCPs scored, on average, well below the statewide average, whereas the MCPs in the rural comparison group scored, on average, above the statewide average. Quality scores have, however, been improving more rapidly in Regional model counties relative to rural comparison group counties.

► **Overall Medi-Cal enrollee satisfaction with MCP performance was lower in Regional model counties relative to other rural regions of the state.** On the measure of “Rating of All Health Care,” Medi-Cal MCPs in Regional model counties scored worse than Medi-Cal MCPs in the rural comparison group counties.

► **Many providers and county officials in Regional model counties are concerned with the performance of the two Regional model MCPs.** Many providers expressed frustrations with the responsiveness of the MCPs in addressing patient and provider needs. They noted increased demands for staff resources needed to secure pre-authorizations and handle billing and other managed care administrative tasks. They also reported that the MCPs frequently denied claims and were slow to pay approved claims, which put a financial strain on providers.

► **Representatives of the two MCPs serving the Regional model counties said they were taking steps to address the concerns that had been raised by stakeholders.** Representatives from Anthem Blue Cross (Anthem) and California Health & Wellness (CHW) indicated they had sought to increase staff resources dedicated to Regional model counties, respond to provider concerns, reduce the number of procedures requiring pre-authorization, expand the specialty care network, and increase access to telehealth and other electronic means of accessing care.

Considerations for Improvement

This assessment of quality and access to care in Medi-Cal’s Regional model of managed care shows mixed results. Compared with MCPs in other rural regions of the state, MCPs serving Medi-Cal enrollees in the 18 Regional model counties performed better on some measures of access and quality (e.g., primary care access) and worse on others (e.g., specialty care access). What is clear, however, is that provider dissatisfaction is greater in Regional model counties. This should not be ignored: Research suggests that provider satisfaction is an important component of effective patient care and that, conversely, burnout or provider dissatisfaction can lead to poorer patient outcomes.⁴

To ensure that Medi-Cal enrollees in the 18 Regional model counties receive access to timely, high-quality care, state policymakers and program officials should conduct additional research on the nature and extent of provider dissatisfaction and undertake careful monitoring of patient satisfaction, care quality, and health outcomes in Regional model counties. In addition, this assessment identified several opportunities for improvement that could be implemented by the MCPs or by DHCS. These include the following:

- Developing a regional health care provider recruitment strategy
- Increasing use of telehealth and other electronic mechanisms for accessing care
- Improving communication among MCPs, providers, and counties to address challenges associated with having MCPs headquartered outside of the region
- Involving DHCS or another neutral third party in discussions between MCPs and providers regarding unresolved contracting issues
- Developing and enforcing more meaningful network adequacy standards
- Requiring MCPs and their delegates to deploy a valid, reliable, and standardized provider satisfaction survey annually

Finally, some providers in Regional model counties have expressed an interest in changing managed care delivery models, with most indicating a desire to participate in a public MCP, either a County Organized Health System (COHS) or a Local Initiative (LI) as part of a Two-Plan model. Several important obstacles to COHS expansion may limit the ability of counties to change Medi-Cal managed care models, including a federally imposed cap on the number of COHSs and a cap on the percentage of Medi-Cal enrollees who can participate in a COHS. Forming a regional LI or drawing one into the 18-county region might face fewer regulatory obstacles but would still involve significant effort. Regardless of which path is taken, policymakers, program officials, and local stakeholders should take steps in the near term to improve provider satisfaction, hold MCPs accountable for meeting access and quality requirements, and expand the health care workforce in rural counties.

Introduction

In 2013, the state Department of Health Care Services (DHCS) continued the Medi-Cal program shift from traditional fee-for-service to managed care, transitioning a group of largely rural Northern California counties into managed care delivery models. Some of these Northern California counties joined Partnership HealthPlan of California (PHC), an existing County Organized Health System (COHS). Eighteen of the remaining counties were part of a new “Regional model” of managed care delivery created by DHCS. DHCS contracted with Anthem Blue Cross (Anthem) and California Health & Wellness (CHW) to serve these Regional model counties.

This study analyzed the experience of patients and providers in Regional model counties during the period following the transition to managed care and compared those experiences with the outcomes in comparable counties. Specifically, this report examined available data on managed care plan (MCP) quality, access to care, and patient experience as well as qualitative information from interviews with providers, MCPs, and others in order to develop an

assessment of the Regional model. Its intent is to identify opportunities for improvement and to inform the procurement process for commercial MCPs that DHCS will begin in 2020 with the scheduled release of its Request for Proposals.⁵ This procurement is an opportunity to reshape and strengthen the program to accelerate improvements in access to care, quality, consumer experience, and health outcomes.

Issues in Rural Health Care

Rural patients face unique health challenges. Rates for the five leading causes of death nationally — heart disease, cancer, chronic respiratory disease, unintentional injury, and stroke — are higher in rural areas. Additionally, while mortality rates are decreasing nationwide, they are falling at a slower rate in rural regions. Rural residents face higher rates of cancer from modifiable risks, including human papillomavirus, tobacco, and a lack of preventive cervical cancer and colorectal screenings. Opioid overdose deaths are also 45% higher nationwide in rural regions, yet urban centers have more treatment facilities.⁶

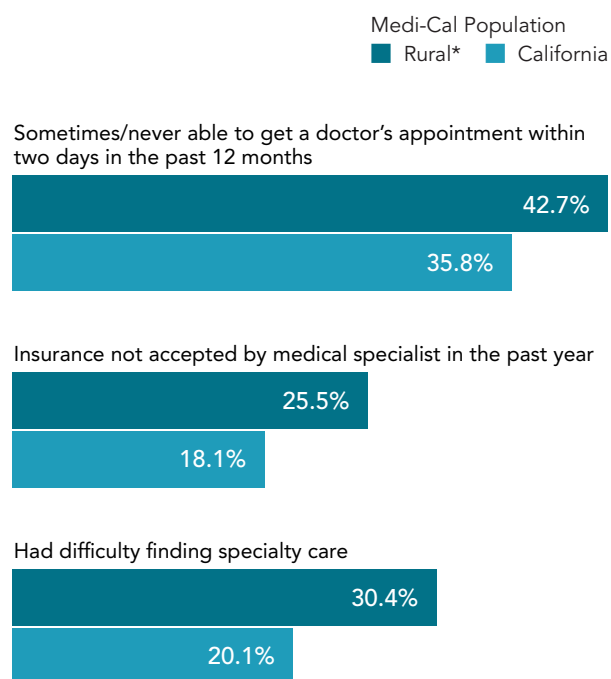
Delivering health care in these rural settings poses unique challenges. Patients must travel long distances to receive care, and access to specialty care can be especially limited. Having to travel long distances can mean taking time off from work and needing to pay for child or elder care, creating delays in or avoidance of treatment. This lack of access sometimes means that residents of rural areas present with diseases in advanced stages. Longer travel times can also lead to longer waits for emergency medical services, putting the lives of patients in danger when they need immediate treatment.⁷ In California, 25% of rural hospitals closed during the two decades prior to 2018.⁸

Physician shortages also contribute to access-to-care difficulties in rural areas. Primary care physicians in rural regions often face heavy patient loads, and access to mental health providers and other specialists can be limited.⁹ Prior studies have found large differences in the number of providers in rural versus urban areas; one study found that rural areas had only 40 primary care physicians per 100,000 people, compared

with urban areas, which had 53 physicians per 100,000 people. This discrepancy is even larger for specialists, with only 30 per 100,000 people in rural areas versus 263 per 100,000 in urban areas.¹⁰

An examination of data from the California Health Interview Survey (CHIS) indicates that rural Medi-Cal patients face more barriers to care than Medi-Cal patients statewide, particularly when attempting to access specialty care. Rural patients are more likely to face issues getting doctor's appointments, having their insurance accepted by specialists, and finding specialty care, as shown in Figure 1.

Figure 1. Difficulty Accessing Care



*Includes the following counties: Butte, Shasta, Humboldt, Del Norte, Siskiyou, Lassen, Trinity, Modoc, Plumas, Sierra, Mendocino, Tehama, Glenn, Colusa, Sutter, Yuba, Nevada, Tuolumne, Calaveras, Amador, Inyo, Mariposa, Mono, Alpine, Placer, El Dorado, Tulare, Merced, Madera, San Luis Obispo, San Benito, and Imperial.

Source: Blue Sky Consulting Group analysis of 2017 CHIS data.

These difficulties in access mean that actions on the part of MCPs such as supporting specialty care networks, making telehealth services available, or facilitating transportation to available facilities can be especially important to bridge gaps in care.

Medi-Cal Managed Care Models

Among the states, California pioneered the use of managed care for Medicaid, launching some of the first pilots to test this delivery system in the 1970s. Beginning in the 1980s with the creation of the COHS model, the state has progressively transitioned all 58 counties and most Medi-Cal populations into managed care.

The Regional model was implemented as part of Medi-Cal's expansion into the remaining, rural areas of the state in 2013. Under the Regional model, Medi-Cal enrollees can choose to enroll in one of two commercial MCPs. Enrollment in the 18 Regional model counties is mandatory for most Medi-Cal enrollees.¹¹

Methodology

This study involved two principal components. First, the study team conducted structured interviews with a range of providers, MCP representatives, county officials, and policy experts. These interviews were aimed at identifying specific strengths and weaknesses in the Regional model approach, and at surfacing suggestions for potential recommendations or improvements. Next, available data regarding patient satisfaction, health care quality, and access to care were analyzed, and the Regional model results were compared with those in other, similar counties. In addition, the study analyzed network adequacy data from DHCS and data from the California State Auditor on travel distance to the nearest provider.

Structured Interviews

The study team conducted more than two dozen structured interviews during the course of the evaluation, including interviews with the following¹²:

- ▶ Providers, including clinics and hospitals
- ▶ MCPs and independent physician associations (IPAs)
- ▶ County officials, advocates, consultants, and others

During the interviews, participants were asked to describe their interactions with the two Regional model MCPs, identify specific strengths and weaknesses of the Regional model, and provide specific examples where MCP performance could be improved. Where participants had information about Regional model and alternative models of delivering managed care, they were asked to comment on the differences.

Data Analysis

As a supplement to the structured interviews, the study team collected and analyzed available data on patient satisfaction and experience, access to care, and measures of MCP performance, including the following:

- ▶ Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- ▶ CHIS
- ▶ Healthcare Effectiveness Data and Information Set (HEDIS)
- ▶ Selected DHCS Medi-Cal Managed Care Performance Dashboard measures
- ▶ Network adequacy reports — Alternative Access Standards

Comparison Groups

Because of the unique challenges of delivering health care in rural areas, two comparison groups of counties that matched the characteristics of the Regional model counties as closely as possible were developed. Specifically, Regional model counties were compared with (1) a “rural comparison” group consisting of 14 other rural counties in California and (2) the “PHC north” group, which includes seven of these rural comparison group counties that joined PHC as part of the Medi-Cal rural expansion in 2013. The rural comparison group includes some counties where Medi-Cal managed care has been in place longer and is the more important comparison group in terms of setting state policy expectations and goals. The PHC north group is more directly comparable to the Regional model counties in terms of geography and

experience with managed care, consisting of relatively remote counties that made the transition to managed care when the Regional model was established.¹³ Table 1 lists the Regional model counties and counties from both comparison groups.

Table 1. Regional Model and Comparison Group Counties

REGIONAL	PHC NORTH	RURAL COMPARISON
Alpine	Del Norte	Del Norte
Amador	Humboldt	Humboldt
Butte	Lassen	Imperial
Calaveras	Modoc	Lassen
Colusa	Shasta	Madera
El Dorado	Siskiyou	Mendocino
Glenn	Trinity	Merced
Inyo		Modoc
Mariposa		San Benito
Mono		San Luis Obispo
Nevada		Shasta
Placer		Siskiyou
Plumas		Trinity
Sierra		Tulare
Sutter		
Tehama		
Tuolumne		
Yuba		

Note: In smaller counties, MCPs report results aggregated by region. For example, PHC reports data for both HEDIS and CAHPS in four regions: northeast, northwest, southeast, and southwest. Although Lake and Napa counties met the criteria to be included in the rural comparison group, the data for these counties are aggregated with other non-rural counties in the PHC southwest region. Therefore, data for these counties were not available for analysis, and these two counties were excluded from the rural comparison group.

Source: Blue Sky Consulting Group, 2019.

Analytic Approach

In order to assess the performance of the Regional model, specific comparison metrics were identified; results from Regional model counties were compared with those from comparison group counties. In addition, data from CHIS were analyzed using a regression analysis in which key outcome measures from the survey were assessed while controlling for factors such as patient demographic characteristics.¹⁴

Findings: Stakeholder Interviews

Structured interviews with stakeholders revealed that many Regional model providers and county health officials were deeply concerned about the performance of the two Regional model MCPs. In contrast, providers in the PHC north group were largely satisfied with the way their MCP has been performing. In addition to the contrast in providers' reactions, interviews also revealed that the two Regional model MCPs acknowledged difficulties associated with the initial transition to managed care and have made efforts since that time to improve both MCP performance and communication with Regional model counties and providers.

Burdensome Processes, Procedures, and Bureaucracy

Many providers expressed frustrations with the processes, procedures, and bureaucracy associated with their interactions with the two MCPs. Interviewees indicated that the MCPs lacked a consistent, formal presence in their communities, especially during the initial transition period from fee-for-service to managed care. Some reported that there was frequent staff turnover among the MCPs' regional staff, which made it difficult to identify the appropriate person to contact. Others reported that the initial contracting process with the MCPs (and Anthem in particular) was long and burdensome, with at least one clinic reporting that it still does not have a contract in place. Several interviewees indicated that the initial rollout

of managed care in Regional model counties was not handled well by the MCPs. These interviewees reported that they received little orientation or education about managed care from the MCPs and that communication was poor.

Interviewees also expressed concern that the MCPs did not engage with or understand the region. For example, some interviewees noted that the two MCPs are headquartered and managed outside of the region and may therefore lack community input at the leadership level. This, they noted, was in contrast to PHC, which has local representation on its governing board and a chief medical officer who is a provider in the community.

Providers also noted poor communication and information sharing around their panels of patients; some indicated that patients had been assigned to their clinics who had not previously been seen at the facility or by its providers, and who were difficult to reach due to inaccurate contact information. Providers also noted that communication, education, and support around efforts to increase HEDIS scores were sporadic and inconsistent, which made the task of improving these scores difficult.

In addition to the concerns about a limited presence in the community, many interviewees expressed concern about what they described as tedious pre-authorization processes required for many procedures and frequent denials of their requests for authorization. A related concern involved slow adjudication of claims for reimbursement. Several interviewees noted that the transition to managed care required adding new staff members to handle the increased administrative requirements of seeking pre-authorization or approval. Interviewees indicated that this process was often opaque, and that obtaining what they believed was simple information, such as whether a particular medication was covered, required making a phone call and waiting on hold for an extended period. Another specific example that was mentioned involved the recently implemented transportation benefit, which covers the cost of transportation for Medi-Cal enrollees who lack

alternative means of transport. When this benefit was initially made available, several interviewees indicated that the procedures for accessing the benefit were burdensome and overly complicated or confusing such that the benefit was very difficult to access and therefore not widely used by enrollees.

One source of potential communication difficulty between providers and MCPs relates to the role of IPAs. These organizations effectively operate in between the providers and the MCPs to aid in managing care. Under this model, the IPA receives a capitated payment for each covered member and is responsible for paying for care for those members through contracts with participating providers. The IPA structure can offer a more locally based connection to providers, and therefore may be more nimble in responding to local concerns than a larger MCP would be. However, the IPA also represents an additional layer of bureaucracy or administration between the providers and the MCPs.

In the Regional model counties, California Health & Wellness generally has not used IPAs, while most care covered by Anthem is provided via the River City IPA. While interviewees generally did not explicitly indicate that problems with River City or the IPA model were root causes of their concerns or frustrations, it is nevertheless possible that this additional layer of complexity (and the difference between Anthem and CHW) was a source of confusion or contributed to difficulties in communication or in identifying the appropriate person to address a problem.

Limited Specialty Care Networks

The second important area where interviewees expressed concerns related to limited specialty care networks. Many interviewees reported that existing referral networks were disrupted by the transition to managed care. This transition (and what interviewees considered to be inadequate efforts to build networks) resulted in poor access to specialty care. Many interviewees highlighted examples where patients had to travel long distances or endure long waits in order to access specialty care. For example, one interviewee reported that there were no rheumatologists accepting patients in his region. Other interviewees reported that access to common specialties such as urology, neurology, gastroenterology, and podiatry was very limited or nonexistent in the region.

Differences in Philosophical Approaches to Providing Services

One final issue that emerged in several interviews relates to differing ideas about how Medi-Cal should be provided. Specifically, several interviewees noted that the two commercial MCPs are seeking to earn a profit through their administration of Medi-Cal benefits. These interviewees identified at least two perceived issues or deficiencies that result from this arrangement. First, some interviewees perceived the profit motive as being responsible for burdensome preapproval processes, denials of claims and authorization requests, and delays in receiving reimbursement from the MCPs. Second, several interviewees noted that PHC (a COHS that does not seek to earn a profit) had made significant community investments, such as in affordable housing or grants for clinic construction. Interviewees equated these investments to the lack of need for profits, in effect suggesting that commercial MCPs have resources that could be invested in the community rather than going to shareholders.¹⁵ Together with concerns about MCP leadership being based outside of the region (in contrast to PHC, where the MCP is locally based and providers and counties have representation on the governing board), these more philosophical objections provide important context for evaluating the other practical concerns raised by interviewees.

Other Perspectives Regarding Regional Model MCPs

In order to put the concerns of Regional model providers and counties in perspective, interviews were conducted with providers in rural counties that had direct experience with PHC, including some who also have experience with one or both Regional model MCPs. In addition, interviews were conducted with representatives of both Anthem Blue Cross and California Health & Wellness as well as other experts familiar with Medi-Cal managed care in rural Northern California. These interviews suggest a somewhat more complex and nuanced situation that defies easy characterization.

Experience with Partnership HealthPlan Has Been Positive

All of the providers interviewed that had experience with PHC as a payer, including those with direct experience of both Regional model MCPs and PHC, described the experience in positive terms. Interviewees indicated that PHC provided important training and shared important information during the transition to managed care. Some interviewees indicated that the specialty care network improved following the transition to managed care when compared with the fee-for-service provider network (reportedly as a result of higher rates paid by PHC to specialists). Interviewees also indicated that PHC had logical and reasonable requirements for pre-authorizations that were not viewed by providers as overly burdensome. Moreover, interviewees reported that exceptions to rules, such as the requirement to try a generic medication as a first-line treatment, were granted if a compelling reason could be provided. Interviewees also indicated that it was easy to contact the appropriate person at PHC regarding any issues that needed to be addressed and that communication around the rollout of new benefits, such as the transportation benefit, was timely and effective. Many interviewees stated that PHC is a “true partner” in their shared efforts to deliver care to their patients. In sum, the comments received about PHC were in stark contrast to many of the comments made about Anthem and CHW.

The positive reputation that PHC has earned appears to have paid dividends. When problems arise, providers interviewed were usually willing to give PHC the benefit of the doubt. These same issues, when they have emerged in Regional model counties, have frequently resulted in conflicts or criticisms. For example, providers in both PHC and Regional model areas described an issue in which patients were assigned to a clinic but could not be reached due to inaccurate contact information. In the case of one PHC provider, this was viewed as an inevitable outcome and one that provided an unanticipated benefit in the form of assistance with the clinic’s cash flow. That is, while capitation payments received for patients not seen at the clinic eventually had to be returned, their initial receipt helped the clinic to manage its intra-fiscal-year cash flow. In contrast, the Regional model provider that described this same situation viewed the assignment of these “unseen patients” as an avoidable MCP error, and one that caused increased administrative burden as the clinic fruitlessly attempted to contact them. Furthermore, while providers viewed the assignment of these unseen new patients as MCP mismanagement, MCP interviewees reported that this was simply part of their mandate to assign all patients to a primary care provider in their area.

A similar circumstance surrounded the transportation benefit, with providers in both PHC and Regional model areas describing difficulty in accessing the benefit. However, the PHC provider mostly viewed this difficulty as stemming from a lack of reliable transportation providers, while the Regional model providers viewed these issues as due to MCP bureaucracy or intransigence.

This goodwill that PHC has earned may help to explain at least some of the differences in attitudes among providers in the PHC and Regional model areas. Interviewees indicated that at least some of the issues identified with respect to the Regional model MCPs have been addressed, while the lack of goodwill that early problems generated may have lingered.

Some Concerns Have Been Addressed

Over time, both Regional model MCPs have reportedly responded to concerns raised by counties and providers. MCPs reported both an increased effort to make staff available and the addition of dedicated staff to support providers and counties in the region. Both MCPs also reported that they had made efforts to expand the available specialty care network, and that they were prepared to contract with “all willing providers.” In addition, both MCPs reported making investments in telehealth or other electronic means of expanding access to care as well as efforts to reduce the number of zip codes with Alternative Access Standards. In response to concerns about burdensome pre-authorization requirements, Anthem reported that, in conjunction with River City IPA, the number of procedures and services requiring pre-authorization had been significantly reduced (reportedly by 80%).

Interviewees from the MCPs also suggested that at least some of the concerns about the Regional model do not relate specifically to MCP performance, but instead to the transition from a long-established fee-for-service model to the more tightly controlled managed care model. This transition inevitably resulted in significant changes to the way care was delivered and paid for, and required changes to the ways some providers treated specific patients or conditions. Interviewees reported that these types of changes were precisely the reason DHCS has promoted the switch to managed care (i.e., to promote value-based payment methods, increase evidence-based practice, and better align provider incentives).

At least some interviewees acknowledged that some of these efforts on the part of the MCPs have been successful. While most interviewees continued to be concerned about specialty care access, some reported that the situation had improved relative to the initial period following the implementation of managed care. Others reported that the initial difficulties associated with accessing the transportation benefit had been addressed, and at least some of the initial contracting difficulties have reportedly been resolved

(although at least some providers reportedly still do not have contracts in place).

Despite MCP Improvement Efforts, Stakeholders Remain Concerned

Analysis of interviews with PHC and Regional model providers, MCPs, and others suggests a complex and nuanced picture. Circumstances in Regional model counties appear to have improved at least somewhat since the initial rollout of managed care, and both MCPs reported a willingness and desire to work with counties and providers to continue to make improvements. The MCPs have added staff to support Regional model counties; the number of procedures requiring pre-authorization has decreased at least in some cases; and efforts to address contracting issues, expand the provider network, and expand access to specialty care are ongoing. Nevertheless, many Regional model providers remain deeply concerned with the performance of the two MCPs. The initially troubled relationship between MCPs and providers, combined with the generally glowing reviews of PHC offered by providers in neighboring communities, has led some in the Regional model counties to believe that only a switch to a COHS model (and, ideally, joining PHC) will address their concerns.

Findings: Access, Quality, and Consumer Experience

An extensive data analysis comparing the results in Regional model counties with those in comparable rural counties was conducted as a companion to the structured interviews. This data analysis indicates that patient experience and quality-of-care measures are similar, particularly when comparing Regional model and PHC north counties. On the broadest measures of patient satisfaction and health care quality from HEDIS, the rural comparison group showed somewhat better results when compared with either the Regional model or PHC north. Specific results are discussed below.

Consumer Experience Was a Mixed Bag, but Mostly Worse for Enrollees of Regional Model MCPs

Patient satisfaction was measured through two separate data sources, a patient satisfaction survey and an analysis of grievance data filed with DHCS.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a patient satisfaction survey conducted every three years. The most recent survey covers 2016 and was published in January 2018.¹⁶ The CAHPS survey is administered to patients in all Medi-Cal MCPs and covers patient satisfaction with both their MCP and providers. Results are summarized by MCP, allowing for a comparison across managed care models when results are aggregated by MCP.

Table 2 presents a comparison of Regional model MCPs, PHC north, and the rural comparison group. The values reflect the average score of all MCPs in each region, presented as the statewide percentile score. For example, 20th percentile means that 80% of MCPs performed better.

Table 2. Consumer Experience with MCPs, by Region

	CAHPS PERCENTILE RANKING		
	REGIONAL	PHC NORTH	RURAL COMPARISON
All Health Care	20th	10th	37th
Personal Doctor	26th	18th	53rd
Specialist Seen Most Often	21st	51st	46th
Getting Needed Care	32nd	42nd	59th
Getting Care Quickly	75th	73rd	64th
How Well Doctors Communicate	49th	86th	48th
Customer Service	45th	99th	66th

Notes: CAHPS results are presented as a single value for each health plan. For smaller (generally rural) counties, results are presented for groups of counties. For example, both Anthem and CHW present the results for Regional model counties grouped into two regions. PHC presents results for counties grouped into four regions. Results presented here are the simple average, with one observation per plan/reporting unit. Results for adult and child measures were averaged to simplify presentation of the available data. Results for all measures are reported in Appendix D. Results exclude Kaiser Permanente.

Source: Blue Sky Consulting Group analysis of 2016 CAHPS data.

These results show a mixed picture. Regional model MCPs scored, on average, worse than PHC north on four of seven measures and worse than rural comparison MCPs on five of seven measures. On the broadest measure, “Rating of All Health Care,” Both the Regional model and PHC north counties earned scores well below that of the rural comparison group. Specifically, the result from the rural comparison group placed that region in the 37th percentile when compared with all MCPs statewide (i.e., 63% of MCPs scored better). In contrast, the Regional model earned a result in the 20th percentile and PHC north’s score was in the 10th percentile. Similarly, the rural comparison group outperformed both the Regional model and the PHC north group on the measures “Rating of Personal Doctor” and “Getting Needed Care.” In contrast, both the Regional model and PHC north counties outperformed the rural comparison group on the measure “Getting Care Quickly.” On the measures “Rating of Specialist Seen Most Often” and “Customer Service,” both the PHC north and rural comparison groups outperformed the Regional model.

Other Indicators of Patient Satisfaction

In addition to the CAHPS survey, two additional measures from the DHCS Medi-Cal Managed Care Performance Dashboard were examined that can help to illuminate the satisfaction of patients in Regional model counties. These measures included medical exemption requests and grievances filed.

Table 3. Selected DHCS Dashboard Data, by Region

	REGIONAL	PHC NORTH	RURAL COMPARISON
Medical exemption requests per 10,000 members	1.38	0.04	0.29
Grievances per 1,000 member months	53.6	69.3	46.6

Source: Blue Sky Consulting Group analysis of data from the DHCS Medi-Cal Managed Care Performance Dashboard, 2018.

Medical exemption requests are made by members who seek to remain in fee-for-service Medi-Cal rather than receive care from an MCP. As shown in Table 3, such requests were very rare among PHC north Medi-Cal enrollees. Somewhat more enrollees in the rural comparison group filed such requests in 2018, but by far the largest rate of medical exemption requests came from Regional model county Medi-Cal enrollees. Although this rate (1.38 requests per 10,000 members) substantially exceeded the rate for either comparison group, the rate in Regional model counties was only slightly higher than the average rate of 1.08 requests per 10,000 members across all MCPs statewide (not shown).

The data on grievances presents a somewhat different picture. While PHC north had the lowest rate of exemption requests among the three comparison groups, the rate of grievances filed against MCPs was highest for PHC north members. Grievances for Regional model MCPs were lower than for PHC north and only slightly higher than for the rural comparison group. Both the Regional model and rural comparison groups had grievance rates that were lower than the MCP average statewide, which was 56.8 grievances per 1,000 member months (not shown).

Regional Model MCP Enrollees Fare Worse on Some Measures, but Differences Are Not Statistically Significant

The California Health Interview Survey (CHIS) is a large-scale annual survey of Californians. Respondents are asked detailed questions about health conditions, health insurance, and various economic and demographic characteristics, among other topic areas. Because CHIS is a large-scale survey with detailed questions about these respondent characteristics, it is possible to identify and separately analyze the Medi-Cal population and identify the type of managed care delivery model they are enrolled in.¹⁷

CHIS includes several important questions that can be used to evaluate potential differences among Medi-Cal managed care delivery models. Table 4 presents the results of the CHIS data comparison.

Table 4. CHIS Variables - Regional Model Comparison

	REGIONAL	PHC NORTH	RURAL COMPARISON
Did not have usual source of care	12%	10%	16%
Usual source of care: ER, some other place, no usual place	20%	15%	22%
Had difficulty finding primary care	17%	16%	10%
Had difficulty finding specialty care	35%	40%	32%
Insurance not accepted by medical specialist in past year	37%	35%	27%
Sometimes/never able to get doctor's appointment within two days	38%	31%	47%

Note: Results are pooled across the years 2014–2017 in order to obtain a statistically stable result.

Source: Blue Sky Consulting Group analysis of CHIS data, 2014–2017.

This analysis does not point to clear differences among the three comparison groups. The first two measures provide an indication of whether rural county Medi-Cal enrollees have a usual place to go when sick or needing care. On both of these measures, Regional model enrollees are very slightly less likely to lack a usual source of care (12%) or to use the ER as their usual source of care (20%) when compared with Medi-Cal enrollees in the rural comparison group (16% and 22%, respectively). Members in the PHC north group were the least likely to lack a usual source of care (10%) or use the emergency room as their usual source of care (15%). Although rural comparison county enrollees were the most likely to report that they used the emergency room as their usual source of care, these same enrollees were the least likely to report that they “had difficulty finding primary care,” with only 10% reporting such difficulty as compared with 17% of Regional model enrollees and 16% of PHC north enrollees.

Results were similarly mixed for the two access-to-specialty-care measures. About a third of enrollees in all three groups reported difficulty finding specialty care. A larger share of enrollees in Regional model counties reported that their insurance was not accepted by a medical specialist in the past year (37%) when compared with respondents in the rural comparison group (27%).

In addition to the analysis of CHIS descriptive statistics, each of these CHIS measures was tested using a regression analysis. Regression allows researchers to control for demographic and other variations across populations which may account for any observed differences. Any differences in outcomes due to the managed care model can then be identified. Regression analysis results did not find any reliable, statistically significant differences in outcomes due to the MCP.¹⁸

Overall, the analysis of CHIS data suggests that Medi-Cal enrollees in Regional model counties have experiences that are substantially similar to those in comparable rural counties. Residents of rural areas are more likely to report difficulty in accessing care when compared with Medi-Cal enrollees statewide.

Quality of Care Was Also Comparable Across Groups

The Healthcare Effectiveness Data and Information Set (HEDIS) represents perhaps the most widely used data source for evaluating and comparing MCP performance. According to the Centers for Medicare & Medicaid Services (CMS), HEDIS measures can be used by MCPs “to identify opportunities for improvement, monitor the success of quality improvement initiatives, track improvement, and provide a set of measurement standards that allow comparison with other [managed care] plans.”¹⁹ The state of California uses HEDIS to measure the effectiveness of Medi-Cal MCPs, and publishes the results annually in the *Medi-Cal Managed Care External Quality Review Technical Report*.²⁰

HEDIS includes measures relating to immunization status, cancer screening, heart disease and diabetes management, emergency department utilization, and hospital readmissions. Data are available for more than two dozen separate HEDIS measures for each of California’s Medi-Cal MCPs. In order to facilitate analysis of available data, Medi-Cal MCP HEDIS measures were summarized into four categories for the purposes of this report²¹:

- ▶ **All-measures average.** This measure includes the simple average for all available measures.²²
- ▶ **Child and adolescent access to primary care.** This summary measure includes the average of the following individual measures: Childhood Immunization Status—Combination 3, Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years, Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years, Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years, Immunizations for Adolescents—Combination 2, and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.
- ▶ **Chronic disease management.** This summary measure includes the average of the following individual measures: Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Annual Monitoring for Patients on Persistent Medications—Diuretics, Asthma Medication Ratio—Total, Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg), Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, Comprehensive Diabetes Care—HbA1c Control (<8.0%), Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, Comprehensive Diabetes Care—Medical Attention for Nephropathy, and Controlling High Blood Pressure.
- ▶ **All-cause readmissions.** This measure is reported in its original form.

Table 5. Summary of HEDIS Measures, by Region, 2015–18

	ALL-MEASURES AVERAGE	CHILD AND ADOLESCENT ACCESS TO PRIMARY CARE	CHRONIC DISEASE MANAGEMENT	ALL-CAUSE READMISSIONS
Regional	66%	75%	67%	15%
PHC north	66%	73%	67%	13%
Rural comparison	71%	78%	70%	14%

Source: Blue Sky Consulting Group analysis of HEDIS data from Department of Health Care Services, *Medi-Cal Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2016–June 30, 2017 and July 1, 2017–June 30, 2018), www.dhcs.ca.gov. Results reflect the unweighted MCP average score. Results exclude Kaiser Permanente.

Table 5 presents the results of a comparison of HEDIS scores for Regional model and comparison group counties. As shown in Table 5, Regional model MCPs demonstrate performance that is substantially similar to that of the PHC north group; performance of the rural comparison group was somewhat better across all measures.

An examination of average HEDIS scores over time (Table 6) also finds that performance in Regional model counties was very similar to that of the PHC north group; however, the rural comparison group counties demonstrated somewhat higher HEDIS scores across each of the years examined.

Scores improved slightly for all three comparison groups between 2015 and 2018, although the increase was largest in Regional model counties. The average HEDIS score in Regional model counties improved from 64% in 2015 to 68% in 2018. Other counties in the rural comparison group saw a smaller improvement, from 70% in 2015 to 71% in 2018. Finally, average HEDIS scores improved in the PHC north group from 65% in 2015 to 67% in 2018.

Overall, an examination of HEDIS scores shows that the results are substantially similar in Regional model counties as compared with other comparable parts of the state, particularly in the most recent, 2018 period.²³ The comparison group of rural counties did outperform both the Regional model counties and the PHC north group, both of which implemented managed care relatively recently.

Table 6. Average HEDIS Score, by Region, 2015–18

	2015	2016	2017	2018
Regional	64%	67%	67%	68%
PHC north	65%	67%	66%	67%
Rural comparison	70%	71%	70%	71%

Notes: Results reflect the unweighted MCP average score. Results exclude Kaiser Permanente.

Source: Blue Sky Consulting Group analysis of HEDIS data from Department of Health Care Services, *Medi-Cal Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2016–June 30, 2017 and July 1, 2017–June 30, 2018), www.dhcs.ca.gov.

Some Regional Model Enrollees Need to Travel Long Distances to the Nearest In-Network Provider

DHCS requires (pursuant to federal requirements set forth by CMS) Medi-Cal MCPs to meet specific access standards. The standards measure both the distance and the time required to travel to specific types of providers, including adult and pediatric primary and specialty care, hospitals, outpatient mental health, obstetrics/gynecology, and pharmacies.

According to the most recent *Compliance Assurance Report* from DHCS, all MCPs, including those in Regional model and comparison group counties, are “in full compliance with the Annual Network Certification requirements set forth in 42 C.F.R. section 438.207 or [are] passing with conditions.”²⁴ In cases where MCPs are not able to meet a specific standard, however, they can request an Alternative Access

Standard, which allows for longer travel times in cases where MCPs indicate that the original standard cannot be met. Table 7 presents the most recent data on the percentage of zip codes affected by an Alternative Access Standard in Regional model, PHC north, and rural comparison counties.

Table 7. Percentage of Regions with Alternative Access Standards, by Area of Specialty

	REGIONAL	PHC NORTH	RURAL COMPARISON
Pediatric	28%	27%	53%
Adult	27%	27%	24%
Hospital	14%	30%	31%
Mental health (non-psychiatry) outpatient services	1%	0%	0%
Ob/gyn	1%	0%	0%
Pharmacy	11%	0%	2%
Ob/gyn PCP	69%	0%	7%

Source: Blue Sky Consulting Group analysis of data from Department of Health Care Services, 2019 Approved Alternative Access Standards Report, as of January 30, 2019, www.dhcs.ca.gov (PDF).

As shown in Table 7, Regional model counties required Alternative Access Standards for more service categories when compared with either the PHC north or rural comparison groups, although the percentage of zip codes requiring an Alternative Access Standard was very similar in several cases. All three regions required an Alternative Access Standard for at least some zip codes for pediatric, adult, and hospital care. However, in the Regional model, more zip codes had an Alternative Access Standard for pharmacy and obstetrics/gynecology primary care provider (ob/gyn PCP) in relation to both comparison groups.

Although there were more service categories in the Regional model with an Alternative Access Standard, there were some categories where the frequency of Alternative Access Standard zip codes was lower. For example, nearly twice as many zip codes in the rural comparison group (53%) were affected by an Alternative Access Standard for pediatric care

compared with the Regional model (28%) or the PHC north group (27%). For hospital care, just 14% of Regional model zip codes were affected by an Alternative Access Standard, about half the level in the rural comparison or PHC north groups.

The California State Auditor also examined access to care using the network adequacy data, concluding that “Regional Model health plans have required some beneficiaries to travel excessive distances to obtain medical care from providers.”²⁵ The State Auditor also found that, while both Regional model MCPs cover the same counties, enrollees may face very different travel distances depending on which plan they are enrolled in. For example, the State Auditor reported that some Anthem enrollees needed to travel as far as 239 miles to see a cardiologist, while the maximum distance for CHW enrollees was 115 miles. Conversely, some CHW enrollees needed to travel as far as 85 miles to see a primary care provider, while the maximum distance for Anthem enrollees was just 10 miles.²⁶

There can be many reasons for an Alternative Access Standard, including geographic obstacles to care (i.e., rural areas are difficult to serve). Nevertheless, while the need for an Alternative Access Standard does not in itself demonstrate diminished access to care, a larger fraction of Alternative Access Standard zip codes in a particular region does suggest poorer access to care.

Data Analysis Conclusions

Patients in rural areas can face important challenges in accessing health care (Figure 1). In comparing differences among rural areas, the analysis presented in this report suggests wide variation, depending on the region and measure used. The following are the important findings from this data analysis:

- ▶ On the broadest measures of patient satisfaction from the CAHPS survey and health care quality as measured by HEDIS, results were poorer in the Regional model and PHC north counties when measured against the results in a comparison group of rural counties.

- ▶ While HEDIS scores were generally lower in Regional model counties when compared with the rural comparison group, scores increased more rapidly in Regional model counties over the 2015–2018 period.
- ▶ Using administrative data to examine patient satisfaction showed that Regional model Medi-Cal enrollees had more medical exemption requests than those in either comparison group, but fewer grievances than those in the PHC north group (grievance rates were similar for Regional model and rural comparison group counties).
- ▶ Access to care remains an important challenge for rural Medi-Cal enrollees across the state. However, available data on access to care presents a mixed picture when comparing performance across rural groups. For example, analysis of one survey measure, “Getting Care Quickly,” showed that both Regional model and PHC north MCPs received scores near the 75th percentile statewide (meaning they outperformed three-quarters of the MCPs); rural comparison group MCPs earned an average score at the 64th percentile. An examination of CHIS access-to-care data found that Regional model enrollees reported somewhat more difficulty finding specialty care relative to enrollees in the rural comparison group, but were less likely to report not having a usual source of care.

In general, data analysis suggests that Regional model MCP performance could be improved, at least in some areas, when compared with other, comparable rural counties. Available data are limited, however, and may not be the most appropriate tool for measuring important provider concerns such as difficulty accessing benefits, lack of adequate specialty networks, limited presence in the community, or difficulty obtaining reimbursement. These concerns remain an important aspect of health care delivery in rural California, and challenges in delivering care remain in rural areas throughout the state.

Discussion

Available data show that — at least according to some measures — opportunities exist to improve patient satisfaction, access to care, and other outcomes in Regional model counties when compared with other rural counties in California, although important differences in individual measures exist. Moreover, providers in Regional model counties were more likely to report serious frustrations with and concerns about the two Regional model MCPs, Anthem Blue Cross and California Health & Wellness. Higher levels of provider dissatisfaction, if not addressed, may lead to poorer patient outcomes in the future.²⁷ In addition, provider concerns have led some in Regional model counties to seek an alternative Medi-Cal managed care delivery model. Specifically, several interviewees indicated a desire to join with Partnership HealthPlan, form a regional COHS, or develop another alternative to the current Regional model arrangement with two commercial MCPs. The depth and extent of these provider concerns, therefore, suggest that changes or improvements to the current system should be considered.

Further Research

Although important provider concerns were identified, this identification was based on structured interviews with a selected group of providers. In order to more systematically identify the breadth of these provider concerns, establish whether they are different from provider concerns in other comparable counties, and determine whether they have persisted over time, further research would be required. The most suitable vehicle for this research would be a survey of providers in both Regional model and comparison group counties. Such an analysis of provider satisfaction can supplement a continued monitoring of patient satisfaction and outcome data, and determine if poor provider satisfaction (if confirmed) is translating into poorer outcomes for patients.

In addition, while this study has sought to incorporate all available, relevant data sources, the analysis presented nevertheless is subject to important limitations. Most important, very limited data on access to

specialty care exist. HEDIS largely addresses quality measures subject to primary care intervention and, to a more limited extent, hospitalization. In general, however, these data do not address access to specialty care. DHCS network adequacy standards are intended to ensure that an adequate network is available; however, the available data do not directly allow for an analysis of whether such a network is in fact available to most enrollees. The survey data sources (CHIS and CAHPS) do more specifically address access to care, but these data are not a complete substitute for clinical or administrative data measuring access to care directly.

Considerations for Improvement

Given the numerous and vociferous provider and county concerns, combined with the fact that no model change is likely before the current contract expires in 2023,²⁸ state policymakers and program officials should consider a variety of approaches to improving the current model's performance. Changing the Regional model to another managed care model (e.g., COHS or Two-Plan model with a Local Initiative) could also be considered; considerations associated with this approach are discussed in Appendix C.

During the course of the interviews, the following suggestions for improvement emerged. The two MCPs could devote resources to these improvements, and DHCS could use its regulatory power to enable and enforce them.

Develop a regional recruitment strategy for improving access to care. Numerous interviewees highlighted the difficulties associated with accessing care due to provider shortages, most importantly for specialty care. While the MCPs are responsible for ensuring adequate networks, there is no explicit requirement for MCPs to recruit new providers to the region, and neither of the two Regional model MCPs makes significant investments in provider recruitment (although PHC does make such investments). Because all MCPs in the region (including commercial and Medicare MCPs) would potentially benefit from recruiting additional providers, it makes sense

for multiple MCPs to share the costs associated with recruiting and retaining providers. A regional pool or fund dedicated to provider recruitment could help to lower the cost (for any individual MCP), while simultaneously increasing the total available resources for this purpose. These resources could be supplemented with state resources, potentially from Proposition 56. In addition, developing a more general mechanism for the two MCPs to address issues of mutual concern could be beneficial in terms of improving performance and responding to provider concerns. Leadership from state officials is likely to be needed to help MCPs develop a shared regional strategy and overcome strong incentives to differentiate themselves from competitors.

Increase use of telehealth and other electronic mechanisms for accessing care. Because of the large distances that many patients must travel and the relative lack of providers in the region, tools such as telehealth have the potential to make an important difference in access to care. MCPs are already making investments in telehealth and other similar tools to increase access to care. However, additional investments in telehealth (including the development of mechanisms that allow individual clinics to finance and receive reimbursement for services) have the potential to dramatically improve access to care.

Improve communication between MCPs, providers, and counties. One of the most important concerns raised by providers was the difficulty associated with communicating with large commercial Medi-Cal MCPs headquartered outside of the region. Both commercial MCPs do have dedicated staff assigned to interfacing with providers and counties, and the MCPs report that the level of investment in such staffing has increased since the initial implementation of managed care in the region. Nevertheless, effective communication remains an important goal, and increased investment in MCP staffing for purposes of ensuring effective two-way communication, providing provider education about MCP features or changes, and other matters remains an important goal. Scheduling more regular contact or meetings between MCPs and providers could help to improve communication. In addition,

providers and counties might see an improvement in the responsiveness of the MCPs if they identify common concerns that span multiple clinics or counties and present these issues to MCPs as a group rather than on an ad hoc or individual basis.

Involve a neutral third party or DHCS in discussions regarding unresolved contracting issues. Although many of the contracting issues that characterized the initial rollout of managed care have been addressed, interviews identified a handful of cases in which individual clinics or hospitals do not have contracts with one of the MCPs. These negotiations appear to have reached a stalemate, suggesting that involvement of a neutral facilitator, mediator, or other third party might be a fruitful step toward resolving these outstanding issues.

Develop and enforce more meaningful network adequacy standards. Network adequacy standards could be designed to require MCPs to monitor and incentivize service delivery to Medi-Cal enrollees by providers in the network rather than a “head count” of providers as currently measured. This could necessitate higher rates or additional incentives paid to providers to increase the share of their practice serving Medi-Cal enrollees.

Require MCPs and their delegates to deploy a valid, reliable, and standardized provider satisfaction survey annually. DHCS could incorporate this survey into its Medi-Cal Managed Care Quality Strategy. The survey goals would be developed with the input of MCPs, providers, advocates, and other stakeholders. DHCS could incorporate the results from an annual survey into its Quality Improvement Reports and included them on the Medi-Cal Managed Care Performance Dashboard.

The rural expansion of Medi-Cal, particularly in the 18 counties that are part of the Regional model, brought with it a dislocation of established provider networks and business arrangements, which has resulted in important concerns on the part of many local providers and county officials. An investigation of available data suggests that the state’s rural areas do face numerous challenges in delivering care to patients, although many of these difficulties extend beyond the Regional model counties. Opportunities for improvement exist, however, such as developing cooperative mechanisms for recruiting providers and addressing issues of mutual concern to rural MCPs. In developing its procedures for the Medi-Cal procurement, DHCS should pursue an array of approaches to accelerate improvements in access to and quality of care in the state’s rural areas.

Appendix A. Structured Interview Participants

T. Abraham, Regional Vice President, Hospital Council Northern and Central California

Sean Atha, Senior Vice President, Business & Network Development, River City Medical Group

Doreen Bradshaw, Executive Director, Health Alliance of Northern California

Lynn Dorroh, CEO, Hill Country Community Clinic

Kimberli Frantz, MD, President, Red Oaks Medical Group, Lassen Medical Clinic

Beatrice Garcia, Imperial County Rural Legal Assistance

Dean Germano, Shasta Community Health Center

Michelle Gibbons, County Health Executives Association

Joel Grey, Anthem Blue Cross

Robin Hodgkin, Imperial County Public Health Officer

Dave Jones, CEO, Mountain Valleys Health Centers

Barsam Kasravi, Anthem Blue Cross

Lee Kemper, Former Executive Director, County Medical Services Program

Valerie Lucero, Tehama County

Meaghan McCamman, California Primary Care Association

Scott McFarland, CPCA Board and Western Sierra

Andy Miller, MD, Health Officer, Butte County

Jane Ogle, Consultant and Former Deputy Director for Healthcare Delivery Systems, Department of Health Care Services

Robert Oldham, MD, Public Health Officer and Public Health Director, Placer County

Paul Pakuckas, Anthem Blue Cross

Alicia Pimentel, Anthem Blue Cross

Tim Reilly, Pacific Health Consulting

Liza Thatranon, Staff Attorney, LSNC Health Program

Abbie Totten, California Health & Wellness

Dick Wickenheiser, MD, Public Health Officer, Tehama County

Mike Wiltermood, CEO, Enloe Regional Medical Center, Chico, Butte County

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting

Appendix B. Regression Analysis Methodology and Results

Regression analyses using patient-level data from the California Health Interview Survey (CHIS) were conducted to assess whether the managed care model was correlated with specific measures of access to care. The CHIS survey is a random-dial telephone survey conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health and the Department of Health Care Services, and includes over 20,000 Californians each year across all 58 counties. The survey includes adults, teens, and children, and it collects detailed demographic information from the respondents, such as age, gender, and level of educational attainment. The survey also asks questions on a variety of health-related topics, such as health insurance coverage and access to health-related services. The data used in the regressions included annual survey responses for the years 2014 through 2017.

Several models were developed comparing members of the Regional model MCPs against members of Medi-Cal MCPs in both the PHC north and rural comparison groups. Specifically, models were developed to test whether these MCP members differed with regard to their responses for the following survey questions:

- ▶ Member had a usual place to go to receive health care when feeling sick or needing health advice
- ▶ Member had used the ER in the past 12 months for any reason
- ▶ Member had a preventive care visit in the past 12 months
- ▶ Member had difficulty getting a doctor's appointment within two days (if needed)
- ▶ Member had difficulty finding a primary care provider
- ▶ Member had difficulty finding a specialty care provider (if needed)
- ▶ Member had difficulty understanding his or her doctor

Note that these responses are all binary, or yes/no answers to the survey question. Because of this, it was necessary to use a specialized form of regression called a logistic (or logit) regression, where the dependent variable is categorical rather than continuous. Using these responses as dependent variables, logistic models were developed that included a dummy variable to indicate whether the member belonged to a Regional model MCP (based on respondent's county of residence). A variety of other explanatory variables were also tested, including demographic variables such as the member's age, gender, race, income, and level of educational attainment, in addition to variables to capture whether the member was married or had a partner, was a native English speaker or had a high level of English proficiency, worked full-time, was clinically obese, or was a smoker. Other variables included whether the member had diabetes, asthma, high blood pressure, heart disease, or psychological distress in the past year or needed help for emotional or mental issues or alcohol or drug problems. Finally, dummy variables for the year of the survey were also included.

Testing of numerous specifications using various combinations of these explanatory variables revealed no statistically significant difference in outcomes based on the respondent's Medi-Cal managed care model (i.e., Regional model versus PHC north or rural comparison group). An example of one specification is presented in Table B1 (see page 22).

Table B1 presents numerous statistics from the logistic regression. The coefficient estimate is calculated using maximum likelihood estimation, or MLE. The odds ratio is the exponential of the coefficient estimate and can be used to compare the relative importance of the explanatory variables. The "Pct Increase in Odds" is the transformation of the logit coefficient using the formula $100(e^b - 1)$, where b is the logit coefficient, and expresses the result as a percentage. Therefore, if this value is x , one may say, "Each additional unit of the explanatory variable results in an increase of about $x\%$ in the odds of the dependent event occurring."

Table B1. Sample Regression Results

- ▶ Dependent variable: 1 if member had visited an ER in the past 12 months, otherwise 0
- ▶ Number of observations: 3,843
- ▶ Number of observations where dependent variable is 1: 1,304
- ▶ Pseudo R-square: 0.10081
- ▶ Max rescaled R-square: 0.14083

	COEFFICIENT	ODDS RATIO	PERCENT CHANGE IN ODDS	WALD PROB>CHI SQ
Intercept	(2.2737)			0.0000 [†]
Regional Plan Member	0.2350	1.2649	26.4885	0.2029
Year: 2015	(0.0053)	0.9947	(0.5262)	0.9821
Year: 2016	(0.0350)	0.9656	(3.4355)	0.8857
Year: 2017	0.0849	1.0886	8.8600	0.7500
Age	0.0126	1.0127	1.2696	0.0668*
Gender: Male	(0.0107)	0.9894	(1.0647)	0.9549
Race: White	0.1118	1.1183	11.8283	0.5479
Diabetes	0.1178	1.1250	12.5026	0.6474
Asthma	0.5935	1.8103	81.0332	0.0069 [†]
High Blood Pressure	0.4517	1.5710	57.1011	0.0428 [†]
Emotional or Drug Problem	0.6916	1.9969	99.6906	0.0010 [†]
Married or Has Partner	(0.1790)	0.8361	(16.3879)	0.3507
English Speaker (Well/Very Well)	0.6941	2.0019	100.1912	0.0263 [†]
Education of BA or Higher	(0.6367)	0.5290	(47.0960)	0.0272 [†]
Works Full Time	(0.0947)	0.9096	(9.0375)	0.6614

*Indicates significance at the 90% level. [†]Indicates statistical significance at the 95% level.
 Source: Blue Sky Consulting Group Analysis of California Health Interview Survey data, 2019.

Finally, the “Wald Prob > Chi Sq” value represents 1 minus the confidence level at which the hypothesis that the coefficient value equals zero cannot be rejected — that is, the data do not indicate whether the characteristic makes it more or less likely that the event represented by the dependent variable will occur. Thus, a value of 0.05 indicates that the coefficient estimate is statistically significant at the 95% confidence level.

In this model, the dependent variable was assigned a 1 if the member’s survey response indicated he or she had visited the emergency room in the prior 12 months. The CHIS data had 3,843 responses from Medi-Cal members in counties with Regional model MCPs or in similar rural counties, and 1,304 (34%) of

those respondents said they had visited the ER. Of the explanatory variables tested, the only significant explanatory variables were age, whether the member had asthma or high blood pressure, whether the member had an emotional or drug problem, English proficiency, and whether the member had a bachelor’s degree or higher. For example, those members who had a BA or higher were 47% less likely to respond that they had visited an ER in the past 12 months. As the results also show, members with asthma were on average 81% more likely to have visited the ER, and those with high blood pressure were 57% more likely. The variable denoting whether the respondent was a member of a Regional model MCP (“Regional Plan Member”), however, was not statistically significant.

Appendix C. Pursuing a Change in Managed Care Models

Provider frustration and concerns with the current Regional model have led some to express an interest in leaving the Regional model and joining Partnership HealthPlan of California (PHC) or forming their own County Organized Health System (COHS). While switching to a COHS model is one possibility, the Regional model counties could also switch to a traditional Two-Plan model, with one commercial MCP and a regional Local Initiative (LI). To date, no county has changed from one managed care model to another. In general, county leadership (e.g., board of supervisors, county public health and hospitals, providers) has considerable influence over the type of managed care model in their county or region. Other stakeholders in model choice would include the executive branch (California Health and Human Services Agency and DHCS) and MCPs themselves. Before a change in the model could proceed, careful consideration would need to be given to a number of issues and obstacles. Perhaps most importantly, given the lack of quantitative data suggesting systematic differences in outcomes between Regional model and comparison group counties, a stronger case would need to be made that a change is warranted. This would potentially require additional data collection and development of new measures or data sources beyond those available currently. In addition, several additional practical limitations to a model change exist, as discussed below.

Considerations for Partnership HealthPlan Expansion

Historically, the state has followed local preference when determining which model operates in a county. Moving the Regional model to a COHS structure therefore would likely require support from the various boards of supervisors and regional providers before DHCS would embark on such a change. Furthermore, the limitations in federal statute regarding the COHS model would need to be evaluated to determine whether sufficient room exists under the 16% enrollment cap to allow a COHS to enroll the Regional model population. Based on current (November 2018) enrollment data, it appears that adding the Regional

model population to the existing COHS population would exceed the 16% limit on total enrollment in the COHS model.²⁹

Assuming the enrollment requirement in federal statute can be met, an expansion of Partnership HealthPlan's service area would require federal approval by the Centers for Medicare & Medicaid Services (CMS). PHC also would need to assess whether expansion is viable. While the MCP already operates in many areas of rural Northern California, adding approximately 300,000 members could require significant investments in staff, information technology (IT), and other operational infrastructure. Before proceeding, the MCP would need to understand how DHCS would set the capitation rates for the Regional model members and evaluate the financial impacts of expansion.

Considerations for Creating a New COHS or LI

If PHC did not expand into the Regional model counties, the counties could explore creation of a regional governing entity to operate a new COHS. While federal statute allows for seven COHSs in California, the remaining COHS is designated for Merced County, necessitating a change in federal statute to allow another county (or group of counties) to operate the new COHS. Similar to an expansion of Partnership HealthPlan's service area, creating a new COHS would likely require changes to state statute and CMS approval of the change in the managed care model. The Regional model counties also would need to evaluate the costs of establishing a COHS. If the decision were made to proceed, implementation would still take several years (e.g., one to two years to obtain the necessary change in federal statute and an additional one to two years to launch the new COHS).

Alternatively, state and local stakeholders could consider moving to a traditional Two-Plan model structure, with one LI and one commercial MCP offering coverage to Regional model enrollees. This would require multiple counties to work together to create a regional LI through a Joint Powers Authority (JPA) or regional

health authority that would manage the LI on behalf of all the counties. These would be similar to the governance structures used by CalViva Health and Inland Empire Health Plan.³⁰

If the regional counties chose not to operate the LI, they could contract with an MCP. For example, Stanislaus County's LI contracts with the Health Plan of San Joaquin, and Health Net serves as the commercial MCP. Under this approach, it is possible PHC could serve as the Local Initiative, although this would require significant operational changes at the MCP, which may not be economically feasible. In addition, as state licensure is required for all Two-Plan model MCPs, PHC would need to complete the licensure process for each of the counties, further adding to the complexity and costs of serving as the regional counties' LI.

While significant obstacles to establishment of a new COHS or LI exist, either approach would provide for local control by the counties. Implementation of the Two-Plan model also would maintain beneficiary choice, which may be important to local stakeholders.

Appendix D. Additional Measures

Table D1. Average HEDIS Score, by Category and Region, 2015–18

	REGIONAL	RURAL COMPARISON	PHC NORTH
Childhood Immunization Status — Combination 3	62%	67%	57%
Children and Adolescents' Access to Primary Care Practitioners — 12–24 Months	94%	95%	94%
Children and Adolescents' Access to Primary Care Practitioners — 25 Months–6 Years	85%	87%	84%
Children and Adolescents' Access to Primary Care Practitioners — 7–11 Years	87%	88%	83%
Children and Adolescents' Access to Primary Care Practitioners — 12–19 Years	86%	87%	84%
Immunizations for Adolescents — Combination 2	23%	31%	18%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents — Nutrition Counseling — Total	53%	70%	59%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents — Physical Activity Counseling — Total	47%	61%	52%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64%	74%	64%
Breast Cancer Screening	48%	55%	49%
Cervical Cancer Screening	49%	56%	49%
Prenatal and Postpartum Care — Postpartum Care	65%	60%	57%
Prenatal and Postpartum Care — Timeliness of Prenatal Care	82%	82%	80%
Annual Monitoring for Patients on Persistent Medications — ACE Inhibitors or ARBs	83%	86%	82%
Annual Monitoring for Patients on Persistent Medications — Diuretics	84%	86%	84%
Asthma Medication Ratio — Total	58%	64%	51%
Comprehensive Diabetes Care — Blood Pressure Control (<140/90 mm Hg)	66%	65%	63%
Comprehensive Diabetes Care — Eye Exam (Retinal) Performed	46%	55%	45%
Comprehensive Diabetes Care — HbA1c Control (<8.0%)	48%	48%	50%
Comprehensive Diabetes Care — HbA1c Poor Control (>9.0%)	41%	43%	39%
Comprehensive Diabetes Care — Hemoglobin A1c (HbA1c) Testing	84%	86%	88%
Comprehensive Diabetes Care — Medical Attention for Nephropathy	84%	87%	86%
Controlling High Blood Pressure	58%	59%	56%
All-Cause Readmissions	15%	13%	13%
Ambulatory Care — Emergency Department (ED) Visits per 1,000 Member Months	52.77	50.81	58.02
Ambulatory Care — Outpatient Visits per 1,000 Member Months	283.44	302.46	232.45
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	24%	27%	32%
Screening for Clinical Depression and Follow-Up Plan — Performance Rate	0%	8%	0%
Screening for Clinical Depression and Follow-Up Plan — Reporting Rate	5%	2%	0%
Use of Imaging Studies for Low Back Pain	74%	75%	81%

Source: Blue Sky Consulting Group analysis of HEDIS data from Department of Health Care Services, *Medi-Cal Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2016–June 30, 2017 and July 1, 2017–June 30, 2018), www.dhcs.ca.gov. Results reflect the unweighted MCP average score. Results exclude Kaiser Permanente.

Table D2. CAHPS Measures Comparison, by Region

	REGIONAL		RURAL COMPARISON		PHC NORTH	
	ADULTS	CHILDREN	ADULTS	CHILDREN	ADULTS	CHILDREN
Rating of All Health Care	2.1	2.4	2.3	2.4	2.1	2.2
Rating of Personal Doctor	2.4	2.6	2.5	2.6	2.4	2.5
Rating of Specialist Seen Most Often	2.4	2.6	2.5	2.6	2.4	2.8
Getting Needed Care	2.1	2.3	2.2	2.3	2.2	2.2
Getting Care Quickly	2.2	2.4	2.2	2.4	2.3	2.4
How Well Doctors Communicate	2.5	2.6	2.5	2.6	2.6	2.7
Customer Service	2.5	2.4	2.5	2.4	2.7	2.5

Source: Blue Sky Consulting Group analysis of 2016 CAHPS data.

Appendix E. Calculation of Average CAHPS and HEDIS Measures

CAHPS results are presented using a “three-point mean” calculation. Survey respondents are asked to provide a rating on a scale of 1 to 10. These responses are then rescaled as follows: response values of 9 and 10 were given a score of 3; response values of 7 and 8 were given a score of 2; and response values of 0 through 6 were given a score of 1. These three-point scores are then averaged to create the three-point mean result reported in *2016 CAHPS Medicaid Managed Care Survey Summary Report* and presented here.

Unweighted average CAHPS and HEDIS scores were then calculated across MCPs for each regional comparison group.

Endnotes

1. Department of Health Care Services, *Medi-Cal Managed Care Request for Proposal (RFP) Schedule by Model Type*, updated March 11, 2019, www.dhcs.ca.gov.pdf. Note that re-procurement of managed care services in Regional model counties likely could not take place until current contracts expire in 2023.
2. Elaine M. Howle, *Department of Health Care Services: It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care*, California State Auditor, August 2019, www.auditor.ca.gov (PDF).
3. Howle, Department of Health Care Services, 16.
4. See, for example, Maria Panagioti, Keith Geraghty, Judith Johnson, et al., "Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction," *JAMA Internal Medicine* 178, no. 10 (October 2018): 1317–1330.
5. DHCS, *Medi-Cal Managed Care Request for Proposal (RFP) Schedule by Model Type*.
6. Robin Warshaw, "Health Disparities Affect Millions in Rural U.S. Communities," *AAMCNews*, October 31, 2017, news.aamc.org.
7. Warshaw, "Health Disparities Affect Millions in Rural U.S. Communities."
8. Xenia Shih Bion, *A Long Road to Care for Rural Californians: Stories That Caught Our Attention*, California Health Care Foundation, June 8, 2018, www.chcf.org.
9. Warshaw, "Health Disparities Affect Millions in Rural U.S. Communities."
10. National Rural Health Association, *About Rural Health Care*, accessed September 18, 2019, www.ruralhealthweb.org.
11. A list of the Regional model counties is provided in Table 1 on page 7.
12. A complete list of interviewees is provided in Appendix A.
13. Several of the data sources analyzed for Partnership HealthPlan of California (PHC), including CAHPS and HEDIS, are only available as regional reports with aggregated data across a group of counties. Specifically, PHC data are aggregated into four regions: northeast, northwest, southeast, and southwest. Because several of the counties in the two southern regions are more urbanized than the rural Northern California counties included in the Regional model, the two northern PHC regions were selected as the most directly comparable to the Regional model counties. The counties in the northern PHC regions ("PHC north") include Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity.
14. Additional details of the data analysis approach and regression results are presented in Appendix B.
15. Interviewees from the commercial MCPs commented that, while they do earn a profit, they also believe that their large size allows for economies of scale, which lower costs. In addition, effective July 1, 2019, a Medical Loss Ratio (MLR) requirement will take effect, requiring Medi-Cal MCPs to spend a minimum of 85% of revenue on patient care expenses (thereby limiting profits and administrative expenses).
16. California Department of Health Care Services, Managed Care Quality and Monitoring Division, *2016 CAHPS Medicaid Managed Care Survey Summary Report*, January 2018, www.dhcs.ca.gov.
17. Managed care model was identified based on reported county of residence.
18. Detailed regression results are presented in Appendix B.
19. Centers for Medicare & Medicaid Services, Healthcare Effectiveness Data and Information Set (HEDIS), last modified July 6, 2017, www.cms.gov.
20. For the latest report, see California Department of Health Care Services, Managed Care Quality and Monitoring Division, *Medi-Cal Managed Care External Quality Review Technical Report* (July 1, 2017–June 30, 2018), April 2019, www.dhcs.ca.gov (PDF).
21. Data on all available HEDIS measures are presented in Appendix D.
22. For measures where a lower score is better (e.g., hospital readmissions), the score was rescaled to make it comparable with the other measures by subtracting the reported value from 1.
23. Note that differences in HEDIS scores can be caused by any number of factors, only some of which are related to health plan performance or the structure of the managed care delivery model. In fact, differences due to patient characteristics, geography, the provider network, and other factors may all have larger impact on HEDIS scores.
24. Department of Health Care Services, *Compliance Assurance Report: 2018 Annual Network Certification*, accessed May 28, 2019, www.dhcs.ca.gov (PDF).
25. Howle, Department of Health Care Services, 15.
26. Howle, Department of Health Care Services, 16.
27. See, for example, Lotte N. Dyrbye, Tait D. Shanafelt, Christine A. Sinsky, et al., *Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care*, National Academy of Medicine, July 5, 2017, nam.edu.
28. In *Blue Cross of California v. Maxwell-Jolly* (December 2013), a settlement agreement over Medi-Cal rates extends the Anthem contract with the Department of Health Care Services in the Regional model counties until October 31, 2023.

29. As of November 2018, total Medi-Cal enrollment was 12,995,647 enrollees, with 1,837,938 enrollees enrolled in COHS plans (excluding enrollment in Health Plan of San Mateo and CenCal Health per federal law). If the 294,850 enrollees enrolled in the Regional model were transitioned into the COHS model, total COHS enrollment (excluding Health Plan of San Mateo and CenCal Health) would equal 16.4% of the total Medi-Cal population.
30. Fresno, Kings, and Madera Counties created a regional health authority to manage their LI, CalViva Health. Riverside and San Bernardino Counties created a JPA to operate their LI, Inland Empire Health Plan.