AGENDA

10:00 AM
Legislative Perspective: Medi-Cal Budgetary Overview for FY 2015-16
Medi-Cal’s Measure: No More Mothers’ Medi-Cal Anymore: Issues for 2015
Annette Wright, Executive Director, Access California

9:35 AM
Panel 1: The Expansion: Projections, Hard-to-Reach Populations, and Implications
Moderator: Gilly Gifford, Director, California Program on Access to Care, UC Berkeley School of Public Health

9:30 AM
Welcome and Introductions:

8:30 AM
Panel 2: Legislative Agenda: Physicians, Medical Groups, Community Health Centers
Assemblyman Tony Thurmond, Chair, Select Committee on Health and Human Services, Assembly Budget Committee

Panel 3: Network Advocacy: Physicians, Medical Groups, Community Health Centers

10:10 AM
Sean Souda, Associate Director, Policy and Legislation, California Primary Care Association
Monitoring Physician Participation in Medi-Cal

Andrew Blumner MD, Professor of Medicine, Epidemiology, and Biostatistics, UCSF School of Medicine, Director, California Medical Research Institute (CMRI)

Panel 1: The Expansion: Projections, Hard-to-Reach Populations, and Implications
Moderator: Gilly Gifford, Director, California Program on Access to Care, UC Berkeley School of Public Health

10:55 AM
Panel 3: Network Advocacy: Physicians, Medical Groups, Community Health Centers

11:50 AM
Lies Chong-Swain, Chief, DRIP Innovations Officer, Heritage Consulting
DMHG and Medi-Cal Managed Care

Shelley Routt, Director, California Department of Managed Health Care

9:00 AM
Panel 1: The Expansion: Projections, Hard-to-Reach Populations, and Implications
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430 K Street Suite LL22, Conference Room B
UC Center Sacramento
9:00 AM to 12:30 PM
Wednesday, March 25, 2015

Co-Sponsors: CA Medi-Cal Association & CA Primary Care Association
UC Berkeley School of Public Health
California Program on Access to Care (CPAC)
Adjourn
12:30 PM

Comments, Questions & Answers

Hannah Katz, Deputy Director, Health Care Delivery Systems, Department of Health Care Services

STATE PERSPECTIVE: Medical Care Initiatives and Initiatives for Persons with Disabilities

Peter Hanlon, Executive Director, CAPAC
The First Year and Beyond: Medi-Cal Expansion Numbers

March 25, 2015
UC Berkeley Labor Center
Miranda Dietz
enrolled in 2014. Medi-Cal grew by almost 3.6 million Medi-Cal certified eligibles.
Medi-Cal under the new MAGI rules.

More than 2 million enrolled in
Delayed renewals mean fewer churned out of Medi-Cal in 2014.

- "Bad" churn: Failure to receive, understand, or return renewal forms when still eligible
- "Good" churn: Income increase—eligible for Covered California Job-based coverage
- California eligible for Covered
Several hundred estimates on 3/26/23 (UCB-UCLA to release thousand)

Eligible for relief, UC Berkeley Labor Center analysis of likely Medi-Cal eligibility.

Source: Pew Hispanic Center estimates of Californias undocumented population and share

Medi-Cal State-only comprehensive in comprehensive Potential enrollees

Eligibility thresholds above Medi-Cal insured or income
Already privately

Eligible for

Not eligible for

50%
(approximately
work authorization deportation and
relief from

2,450,000 undocumented Californians

Cal under State policy due to executive actions. Some undocumented residents eligible for Medi-

Cal.
Contact Miranda Dietz, care@laborcenter.berkeley.edu

eligible for deferred action:
UCB-UCLA Policy Brief on CA Immigrants

California-and-merged/california-and-california-and-
importance-of-enrollment-churn-in-covered-
http://laborcenter.berkeley.edu/the-ongoing-
http://laborcenter.berkeley.edu/topic/health-

CALSIIM Resources:

For Further Information
March 2015
Anthony Wright

Issues for 2015
Not Your Mother's Medicaid Anymore...
Medi-Cal's Makeover:

www.twitter.com/healthaccess
www.facebook.com/healthaccess
www.health-access.org
Medi-Cal, Central Role in CA

Medi-Cal not just expanded but transformed.

Health care system we all rely on.

Hard to overstate its importance & centrality to our care.

Over 40% of births, Over 66% of nursing home care.

Key financing mechanism for virtually all CA hospitals.

About 12 million people enrolled; 1/3 of the state.

A half-century of covering Californians, since 1966.

Continuing the progress to an improved health system.

Needed investments and accountability are crucial to

to care & improved quality and equity.

Expansion of coverage requires renewed focus on access.
Currently, no general fund cost for this historic expansion
1 Billion offset from provider tax, AB65 county reallocation
$18 Billion: $3 Billion federal funds, $950 Million general fund
1 Million previously eligible (50% federally matched)
2 Million newly eligible (100% federally funded; 90% in 2020 and beyond)
ACR-Related expansion: 3 Million Californians covered:
Other Funds: $15.2 Billion (like provider tax)
Federal Funds: $62.6 Billion
General Fund: only $18.6 Billion of $13 Billion Overall Budget
Governor’s 2015-16 Budget: $95.4 Billion for Medi-Cal

A Benefit, Not a Burden
Medi-Cal, the ACA is the CA Budget:
Medi-Cal: Better, Not Just Bigger

- Medi-Cal no longer just a collection of categorical programs for children, parents, seniors and people with disabilities, but a safety-net for virtually all of us (excluding undocumented).
- Some of the newly-coverage are entirely new to coverage: low-income working adults, homeless, recently incarcerated, others.
- Expansion & elimination of assets test means Medi-Cal is now available as a safety-net for:
  - Middle-class families between jobs
  - College students and those going back for education/training
  - Early retirees

Medi-Cal must respond to a new range of expectations; Demand-driven change
Medi-Cal Moves to More Managed Care
Not Just Who, But How:
Incentivize Quality Equity
Ensure Coverage Offers Meaningful Access to Care
Finish the Job: Cover the Remaining Uninsured
What's Next?
SB33 (Hernandez) this year, Senate Health Hearing March 25th

Governor vetoed bill last year; pointed to budget process;

 Raises little revenue, major barrier to enrollment, ineligible.

Medi-Cal managed care applicants aged 55+.

California: only one of 20 states that requires estate recovery for

The Need to Limit Estate Recovery

Consumer Experience Needs to Be Improved

Former Foster Youth

Fixing CALHEERS & the 24-Month Roadmap

Confusing Notices

Not Just an IT Glitch: Last year’s 900,000+ enrollment backlog

Making Signing Up Easier

Eligibility/Enrollment Systems

Improving Medi-Cal
Refomra
!Migratoria
Para familias
ahora!

CITIZENSHIP
For 11 million

NO EXCEPTIONS. NO EXCLUSIONS. #HEALTHYALL

All

HEALTHCARE
Making Progress to a Statewide Solution for #Health4All: An effort to secure and expand our County Safety-Net Programs. Counties are enhancing their safety-net for the remaining uninsured, some the last resort of coverage. Despite AB85’s reallocation, some counties are needed to encourage more originate to care for the undocumented.

Also: to defend and secure this major victory. Also: category of immigrants covered by state-funded Medi-Cal. We need The President’s executive action had the impact of expanding the Continuing California’s Coverage of „Deferred Action“ Immigrants: Making #Health4All History, This Year.
Enrollment in Medi-Cal would increase by up to 730,000 people next year and up to 790,000 in four years.

The study by the UCLA Center for Health Policy Research estimates that the net increase in state spending would be equivalent to 2% of state Medi-Cal spending, or between $353 million and $369 million next year, while the net increase in spending would be up to $436 million in 2024.

According to a study released Wednesday, extending healthcare to people in the county illegally would cost the state a modest amount more down the road, but would significantly improve health while potentially saving money for taxpayers.

Increased health of poor Californians could reduce costs down the road, the study says.

By Patrick McGee, May 22, 2014

LOS ANGELES TIMES:

Financing #Health4All

"Study sees modest costs in healthcare for immigrants here illegally."

"Illegal"
Once folks are in Medi-Cal, we need to:

Make it work!
Expired in the new year, January 2015.

- 73% decrease nationally, around double in CA!
- ACA included a 2-year primary care rate bump to Medicare
- Adjudications by CMS but still not restored!
- In 2020, AB97 cut Medi-Cal fee-for-service rates by 20%!

Rates & Access to Care

- Competitively not that much money
- Podiatry
- Need to fully restore the package of benefits, from vision to
- Partially restored dental coverage
- In 2009, 10 benefits were cut from Medi-Cal

Benefits

Additional Medi-Cal Budget Issues
$rates$ in the nation.

Medi-Cal

One of the lowest

Physician Payment Rates

Compared to other states, FY2012

Medicaid Rates as a Percentage of Medicare

- % 82
- % 77
- % 65
- % 62
- % 61
- % 57
- % 55
- % 51
- % 51

State
2011-12 National Health Interview Survey

69% Medi-Cal; 92% Medicaid in other states

Most recent emergency room visit in the prior year was because doctor's office not open

71% Medi-Cal; 17% Medicaid in other states (CHIS: 14% Medi-Cal; 11% ESI)

Had two or more emergency room visits in the prior year

12% Medi-Cal; 8% Medicaid in other states

Delivered needed medical care because of difficulty getting an appointment in the prior year

42% Medi-Cal; 38% Medicaid in other states

Among women 18 and older, did not have a Pap test in the prior year

71% Medi-Cal; 66% Medicaid in other states (CHIS: 69% Medi-Cal; 62% ESI)

Did not have a flu vaccination in the prior year

59% Medi-Cal; 47% Medicaid in other states

Did not have a dental visit in the prior year

48% Medi-Cal; 36% Medicaid in other states

Did not have a specialist visit in the prior year

37% Medi-Cal; 30% Medicaid in other states (CHIS: 16% Medi-Cal; 13% ESI)

Did not have a doctor visit in the prior year

Use of Care

Measures

Gaps in Realized Access
Access to Specialists' by Health Status, 2012
Can't risk issues getting worse with a rate cut during expansion.

■ Specialists, exacerbated in certain rural/urban geographic areas.

■ Issues arise, as expected, with patients with specific needs, with
to doctors and specialists.

Clear that Medi-Cal patients don't have the same access as others.

But access issues remain:

(CCHP)

69% said “Medi-Cal provides access to high quality medical care."

mental health, and financial benefits to having coverage.

Even early results of Oregon study shows increased use of a regular

Medicaid matters:

But Real Issues of Access

To Sum Up: Medi-Cal a Key Lifeline,
Accountability on Timely Access

Managed care plans, by lines of business, including Medicaid adequacy, by lines of business, requires annual reviews of network passed last year, requires annual reviews of network standards, including 30 days for a doctor or specialist appointment.

Department of Managed Health Care has set time are supposed to meet timely access to care standards. Managed care plans (including Medi-Cal managed care) needed care and adequate networks.

Longer "a license to hunt", but a guarantee of access to long term "coordinated care" is that Medi-Cal is no longer inadequate.
Medi-Cal Waiver

Better integration with human services

Incentives that work for patients on cost/quality/equity

Improved/coordinated access to remaining uninsured

More federal $ for a safety-net that survives and thrives

Health Access California Goals:
Continued Federal Funding Support
* Budget Neutrality
* State-Federal Shared Savings and Reinvestment

FINANCING

- Whole Person Care Pilots
  - Increased Access to Housing and Supportive Services Program
- Workforce Development Program
- Public Safety-Net System Transformation & Improvement Program
- Fee-for-Service Transformation & Improvement Program
- Managed Care Systems Transformation & Alignment Program
- Delivery System Transformation & Alignment Program
- Public Safety-Net System Global Payment for the Remaining Uninsured

STRATEGIES

"Term sustainable change of the Medi-Cal Program."
"Waiver renewal is critical to ongoing success, viability and long-

Medi-Cal Waiver
Post-Approval Continuued Stakeholder Engagement Forums

Nov. 14, 2015 • Start of new Waiver
Fall 2015 • Final STC development

July 22, 2015 • Stakeholder Advisory Committee Update

Spring/Summer 2015 • Collaborative Program development with Stakeholders
May 20, 2015 • Stakeholder Advisory Committee Update

April – Nov. 2015 • DHCS/CMS Discussions
March 27, 2015 • Target submission date of Waiver application

Medi-Cal Waiver: Timeline
Health Access California

Twitter: www.twitter.com/healthaccess
Facebook: www.facebook.com/healthaccess
Blog: http://blog.health-access.org
Website: http://www.health-access.org

For more information

Foundation, and the UC Berkeley Labor Center for use of their slides.

Much thanks to the California Budget Project, the California HealthCare

233-473-3587
1930 Wilshire Blvd., Suite 916, Los Angeles, CA 90057

540-873-8787
444 3rd Street, Suite 450, Oakland, CA 95622

916-873-6923
1227 23rd Street, Suite 234, Sacramento, CA 95814

223-473-3587
Hidden Safety Net

Wee Care Pediatric Medical Group
CEO, Omniscare Medical Group
Presented by: Toni Johnson-Chaves, MD, MPH, AAP

(Fewer than 10)
Solo and Small Group
beneficiaries will experience severe access problems.
Low-reimbursement encourages further loss of providers,
PECPS are cost effective providers.
as payments to private docs, increased payments are essential.
The 10% cut in place today puts California in 50th place as far
are doctors in the "classic" safety net.
There are 3x more doctors in the Hidden Safety Net than there
specifically maintaining the Medi-Cal "bump" is important for PCP's and
specialists are the same ones FHCoC's depend on, so
but we work side-by-side with county and FQHC providers.
Our

PrivatE Essential Community Providers

PECPS
Advantages

- Increases access points
- Relationship-based community continuity of care
- Geographically and Socioeconomic underserved
- Serve more ethnically diverse communities
Advantages (cont'd)

(0 hidden safety net
60% of Medical consumers receive care from
physician practices
1/3 of US physicians practice in solo and two
practices with less than 5 providers
70% of ambulatory visits are to medical
care
Culturally sensitive, compassionate competent
outcomes

need to assess potential better

compares to larger practices (Further

lower re-hospitalization rates as

ACA bump up payment

additional incentives; no continuation of

USA for payment, less likely to have

less costly per patient visit (50th state in

Advantages (cont'd)
Obstacles

Retirement
Aging workforce with providers choosing early

Types (e.g., Medi-cal)

Low reimbursement often contributes to

Model

Administrative demands (i.e., HIT integration,

receive federal/non-profit funding)

Financial barriers (because private unable to
Solutions

- Deploy utilization and reporting tools to create broad community coalitions
- Improve desirable patient outcomes
- Improve reportable outcome measures
- Include broader stakeholder input
Alternative Payment Methodology
Medi-Cal Waiver process and pilots for long-term facilities
These policy initiatives should be part of the hospitalization, and improve quality in long-term facilities. Together will reduce unnecessary ER, primary and specialty care because their work.
We need continuation of Medi-Cal bump for

ASK FOR
Recent new lines of business, under the ACA, have transitioned a (sicker) population as compared to those who live in other geographic areas (especially Latino, Afro-American, and some Asian cultures). Diseases, such as cardiovascular diseases, renal failure, cancer, and diabetes, have 2-4 times the incidence of these chronic, serious conditions among clients with experience.
care

linkages of care coordination/refusal of
undiagnosed (often without appropriate
health disorders (both diagnosed and
accompanied by significant mental
with severe co-existing illnesses
Our group has experienced new clients

Experience (Cont'd)
comparison. That no one has accurate information to use for scores for a variety of providers, which means in care, and produce misleading performance actually harm patients, exacerbate disparities patients' sociodemographic factors might A wide majority feel that not adjusting for

Factors Risk-Adjusted For Sociodemographic Should Provider Performance Measures Be Watch For
equally enable all providers to be compared poor performers, adjustment would populations because they are labeled providers who serve disadvantaged consumers and payers will avoid

Watch For (Cont'd)
low socioeconomic status patients. Different standard for providers who treat say it is not appropriate to have a performance is considerably lower. They might appear equal, even though one’s vulnerable patients, whereby two doctors score of providers treating the most it could artificially raise the performance those in favor of no adjustment believe Watch for (cont'd)
diseases, and facilitates proactive patient-specific interventions. S
targets include children, adults, and individuals with chronic
conditions. MIBOTS is an initiative with a comprehensive value-based quality dashboard.

MIBOTS is a care optimization and data analytics product, and is able to provide
system-wide insights into healthcare outcomes and financial performance.

By adopting a proactive approach to care management, thereby reducing the cost of
unnecessary care, MIBOTS move from a reactive, fragmented approach to a primary care integrated,
towards the highest risk patients. This will allow the Care Management Team to
focus on patients with high risk factors. Economic determinants will help prioritize and direct care optimization efforts
in a socially and economically disadvantaged population.

Current systems must be enhanced to serve the most in need: individuals with
CMS - https://www.medscape.com
Factors - Health Affairs Blog
Be Risk-Adjusted For Sociodemographic
Should Provider Performance Measures
California Healthcare Foundation
ITUP

Sources
March 25, 2015

University of California, San Francisco
Professor Medicine/Epidemiology & Biostatistics
Andrew Bindmann, M.D.

Monitoring Physician Participation in Medi-Cal
"Is there a doctor who accepts Medicaid in the house?"
Response rate = 63%

Sample size = 3,499

Physicians responded by mail or online

Most recently completed survey 2013

Mandatory survey beginning in 2008

Bayesian backfitting on top of Medical Board’s

Participation in Medi-Cal since 1990s

UCSF has conducted surveys of physician

Methods
Information linked with voluntary questions

Demographics, specialty, practice location

Mandatory Medical Board Questions

Type of practice (e.g., solo, group, clinic)

Distribution of patients in practice by payer

Whether accepting new patients by payer

Voluntary UCSE Questions

Questionnaire
Physicians Accepting New Patients

Payer

Private Insurance
Medicare
Medi-Cal
Uninsured

Pcp = Primary Care Physician

Source: Analysis of 2013 Medical Board of California Supplemental Survey.
Physicians
Distribution of Medi-Cal Visits Across All
100,000 Medi-Cal Enrollees, 2011 vs. 2013
Ratio of FTE Medi-Cal Physicians per HRSA Recommended Ratio

2011-2013

Source: Analyses of 2011 and 2013 Medical Board of California Supplemental Survey.
Region
Medi-Cal Patients
Primary Care Physicians Accepting New

Source: Analysis of 2013 Medi-Cal Board of California Supplemental Survey
Region

New Medi-Cal Patients

Non-Primary Care Physicians Accepting
Not clear that California maximized Medicaid reimbursement.

Nationally primary care payment bump in ACA.

Significantly increased participation in Medi-Cal.

To train more primary care physicians is on target.

California's enhanced investment in Song-Brown funds.

Medi-Cal meets federal standards for non-primary care physicians per enrollee, but falls below federal standards.

Key Findings and Policy Implications.
Detailed analysis by specialty and geography
- Would remove sample size limitations and enable
evaluation of policies
- On-going data collection to support rapid cycle
  survey would increase value of data
  Adding payer questions to mandatory Medical Board
  Bump
  Timing missed window to evaluate primary care
  2011, 2013 and back in field now for 2015
  UC SF survey provides series of snapshots on a sample

Enhancing data to improve Medi-Cal access
to care in Medi-Cal could improve state's capacity to monitor access. A state requirement to make up-to-date T-MISIS data readily available to academic researchers.
Lena Libatique
Denis Huelt
Margaret Fix
Janet Coffman

Research Team

MediCal Board of California

Partner

Services

California Department of Health Care
Robert Wood Johnson Foundation
California HealthCare Foundation

Funders

Acknowledgments
Safety Net Challenges with Network Adequacy

Sean South
Associate Director of Policy and Legislation
becoming more and more difficult. Have full access to specialty care, but this is
coordinate the care for our patients to ensure they
But, beyond this primary care access, our CCHCS help
one root:
- counseling, and other services--all delivered under health education, care coordination, enrollment, behavioral health, oral health, pharmacy, vision,
- children. Key services include primary medical care,
- California’s CCHCS serve more than 5.6 million patients each year, including nearly 2 million

The Role of CCHCS
Regarding timely access to care, appropriate oversight and regulations, and the lack of federal funding support, and the loss of rates that providers are paid, the loss of addressed immediately are the very low we feel that the two issues that must be necessary providers for many reasons, but Medi-Cal system lacks the number of

Two Solutions
If Congress does not take action to restore the Health Center Trust Fund to previous levels, grants will be cut by more than $160 million in 2016, which may force health centers to close some sites, eliminate services, and even lay off health care providers and staff.

A key source of funding for CCHCs is the Health Center Trust Fund, which is comprised of both discretionary and mandatory funding. The mandatory funding is currently scheduled to expire at the end of Fiscal Year 2015.
Funding levels.

Restoring the Health Center Trust Fund to 2013 levels will have an impact on our communities. We are asking Congress to prevent these cuts and cuts.

Patients may lose access to care in California alone.

One forecast predicts that more than 300,000

Fix the Primary Care Funding Cliff

California Association
Primary Care
Key to their health and in bending the health care price curve, the establishment of this primary care medical home, that is ready access to a primary care provider, because it is the patients out of the emergency room and give them more primary care providers in Medi-Cal to keep.

We are seeking care as a result of Medi-Cal expansion, providing care for the millions of additional patients that provider rate bump and agree that this is one key to provider rate bump and offer the extension of the primary care.

We strongly support the extension of the primary care.
Too many of our patients struggle with timely access to care and we believe that additional standards and stronger oversight of the health plans is a key to ensure timely access.

Along with addressing the very low rates in Medi-Cal, we must also push our health plans to create the networks necessary to ensure timely access to care.
Timely Access to Care

- Include a maximum time and distance standard to access primary care and specialists (by specialty), including subspecialists.
- Include a minimum ratio of providers to covered persons required to:
  - As it pertains to quantitative standards, carriers should be sufficient network of providers.
  - Standards that hold insurers accountable for ensuring adequacy

DMHC should establish quantitative network adequacy.
carefully scrutinized and approved only when necessary. Exception requests from regulatory standards should be
according to an evidence-based review of the actual patterns of
standard for California's safety-net networks should be set
and subspecialties, and LEP provider ratios that serve as the
The actual ratio standards, time and distance standards, specialties

individuals with limited English proficiency;
- Include a minimum number of providers to meet the needs of
  hospital, emergency care, diagnostic and ancillary services;
- Include a maximum time and distance standard to access
  or exceed the federal minimum required under the ACA;
- Meet Essential Community Provider (ECP) standards that meet
  enrollees with disabilities;
- Include a minimum number of providers to meet the needs of

Timely Access to Care

California Association of Primary Care
Access Problems:

Helping Consumers Experiencing

By DHIC staff:

- Consistent problems within a network are captured and evaluated.
- Care and should streamline the grievance process in order to ensure consumers and providers about how next steps in ensuring access to outreach to increase. In addition, we believe the Department should increase outreach to networks.
- Without ever thinking that they might be dealing with a non-compliant network, they need or bear inconveniences posed by distance or waiting time, they receive hope, not receive the care violations. Many consumers will give up hope.
- Awareness of access to care regulatory requirements among all covered medically necessary care. We believe the lack of requirements to offer timely access and the consumer right to access.
- We support greater education of enrollees regarding health plan.
SB 243 (Hernandez)/AB 366 (Bonta).

Caregivers and other health providers who are the sponsors of community health clinics, health plans, first responders, coalition of physicians, dentists, hospitals, health care workers, a proud member of We Care for California, a

CPCA is also a proud member of the Medi-Cal program.

Services in the Medi-Cal program, and ensure access to health care services for people receiving Medi-Cal, Cal rates are addressed in this legislative session. We are dedicated to ensuring the law

Next Steps
reach to increase the profile of this important access issue.
relationship with Department staff to leverage our statewide
issue. We look forward to beginning a collaborative
plans to build an outreach and education program on this
We also want to work jointly with the Department and the

helpfulness.
when and how to access applicable Department and Insurer
problems inconsistent with timely access standards, including
steps a covered person should take when experiencing access
access, on the process for ensuring timely access, and on what
educate consumers and providers on standards for timely

Next Steps
Sean South at ssouth@cpcac.org

Please contact:

QUESTIONS?
the impact of reform managed care and Medi-Cal expansion,
1 in 3 Americans is enrolled in government-sponsored health care.
in Medi-Cal

17%

- Nation's Medicaid members enrolled

- Health care purchaser in the state

NO. 1

- Medi-Cal's Joint Federal-Share Budget

$95 Billion

- Of Medi-Cal

2.5 Million

- Members added through the expansion

- Members covered by Medi-Cal

12 Million

Expansion of Medi-Cal Managed Care
Expansion of Medi-Cal Managed Care, cont'd.
Medicaid pipeline has shifted over the past decade toward high-need populations.

A greater share of the pipeline is becoming high-cost, high-need populations is becoming

As we look beyond 2014:
- Duals
- LTSS
- Affordability Care Act
- Temporary Assistance
- Medicaid Integration
- Long-term Care
- SPID
- Developmental Disabilities
- Serious and Persistent Mental Illnesses

($ in millions)
people with disabilities

Anthem’s approach to serving aging adults and
Rural members reside in the central region

- 15%

Rural members residing in northern California

- 85%

Rural members enrolled (11/2013-3/2015)

- 150,000

Members healthcare services in which Anthem serves

- 19

Medi-Cal Managed Care Rural Expansion
Medi-Cal Managed Care Rural Expansion, cont'd.

Getting ready for these members:

- Expanded role for case management services
- Planned member and provider communications
- Leveraged capabilities and local relationships
- Coordinated readiness with California Department of Health Care Services

Focused on a seamless transition to managed care that promotes access

Step-up provider education and partnership

(e.g., federally qualified health centers)
Eligible members transitioned to short-term care coordination or complex case management.

Schedule


Transition to managed care for seniors and people with disabilities residing members residing in the central region 10%.

Members residing in northern California

% 90%.

By Anthem Blue Cross in 19 rural counties seniors and people with disabilities served 9,700.

The rural expansion

Serving aging adults and people with disabilities in
Shelley Rouillard, Director
March 25, 2015

California Program on Access to Care (CPAC)

DMC and Medi-Cal Managed Care
The Department of Managed Health Care protects consumers' health care rights and ensures a stable health care delivery system in California.

DMHC Mission
Plan Act of 1975
Authority from Knox Keene Health Care Service

- Individual products
  Some large group, most small group, and many
- All HMO and some PPO/EP0 products
- Specialized plans

Regulates 70 full service health plans and 52
Funded by assessments on health plans

Established in 2000 through consumer-sponsored

About the DMHC
• Enforcement
• Rate Review
• Financial Oversight
• Medical Surveys
• Plan Licensing
• Consumer Help Center

DMHC Key Functions
Consumer Assistance Data

Systems

and County Organized Health

Financial Status of Local Initiatives

SB 964 (Hernandez)

Network Adequacy

DMHC Regulatory Authority

Overview
DMHC Regulatory Authority

- Local Initiatives - all authority under Knox Keene Act
- Knox Keene Act
- County Organized Health Systems - exempt from Knox Keene Act
- Inter-Agency Agreement (IA) with DHCS
- DHCS
Rural access
Timely access
Provider capacity
Geographic – time and distance
DMHC Access Standards
Network Adequacy Review
SB 964

- Annually review and assess all health plan networks
  - Separate review of Medi-Cal, individual/family and other commercial networks
- Standardize timely access reporting methodology

http://www.dmhc.ca.gov/LicensingReporting/SubmitHealthPlanFilings.aspx#timely

www.HealthHelp.ca.gov
SSB/mmcpsi/031815,pdt

https://dimhc.ca.gov/portals/0/AbouttheDMHC/E

Only one LI reported TNE deficiency

December 2014

All plans had positive net income as of

expenses

Upward trend in both revenue and medical

increases of at least 35% in 2014

All LI and COHS plans reported enrollment

Financial Status of Local Initiatives

and County Organized Health Systems
<table>
<thead>
<tr>
<th>%</th>
<th>Total</th>
<th>Written Correspondence</th>
<th>Urgent Nurse</th>
<th>Quick Resolutions</th>
<th>IMRS</th>
<th>Standard Complaints</th>
<th>Calls</th>
</tr>
</thead>
<tbody>
<tr>
<td>6%</td>
<td>3,380</td>
<td>2,776</td>
<td>156</td>
<td>1,331</td>
<td></td>
<td></td>
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**Access Data**

**Medi-Cal Managed Care**
1-888-466-2219
DMHC Help Center

www.HealthHelp.ca.gov
Online complaint form

Need Assistance?
March 25, 2015
State Capitol
Cpac Forum

Disabilities
For Seniors and Persons with
Med-Cal Managed Care Expansions
22,000 beneficiaries in 28 counties
• Rural managed care expansion
• 456,000 beneficiaries in 7 counties
• Coordinated Care Initiative (CCI)
• 380,000 beneficiaries in 16 counties

Medi-Cal only SPP managed care transition

Include Seniors and Persons with Disabilities
Several Medi-Cal Managed Care Expansions
Significant Health Care Needs
Seniors and Persons with Disabilities Have

Significant Conditions With Overlapping Conditions
Percent of Medi-Cal FFS CCI Population Treated for 16
• Average Medicare risk score: 2.24
• Average number of ADLs: 3.7
• Percent with Alzheimer’s or related dementia: 45%
• Average number of diagnoses: 15
• Percent dually eligible: 83%
• Nursing home eligible: 100%
• Average Age: 78

Profile of PACE Population
Challenges
CCI Implementation Faces Numerous

- PACE
- MSSP
- CBAS
- IHSS

Based LSS
Maintaining and expanding access to community

- Appropriate rate setting
- Existing provider relationships
- Higher than expected opt-out and disenrollment

- Confusing enrollment materials and process
COUNTIES

- PACE is not an enrollment option in all managed care
- Lack of clear policy on plan referrals to PACE
- Lack of uniform assessment tool
- Lack of clear standards for access to services
- Provider payment reductions

BASED LTSS Needs Special Challenges

Maintaining and Expanding Access to Community
Make PACE an enrollment option in all managed care

Clarity policies and procedures for referrals to PACE

Restore 10 percent provider rate reduction

Develop clearer standards for access to LTSS

Revisit passivate and mandatorily enrollment

Access to Community Based LTSS

State Could Do More to Maintain and Expand

Counties
Expansion of Medi-Cal Managed Care
Presentation Overview

1. Medi-Cal Managed Care Expansion
2. California’s Quality Improvement Focuses
3. The Future of Medi-Cal Managed Care
Medi-Cal Managed Care Expansion

- Transition of SPPS in 28 rural counties
- Optional expansion implemented
- Duals demonstration (Coordinated Care Initiative)
- Medicaid optional expansion implemented
- Expansion into 28 rural counties
- Healthy Families Program transitioned (CHIP)
- Managed care benefit
- Medi-Cal only seniors and persons with disabilities (SPPS) (AGED, Blind, Disabled [ABD]) transitioned

2014
2013
2012
2011
Trend in Medi-Cal Enrollment and Month Over Month Growth
Trends in Medi-Cal Enrollment in FFS vs Managed Care
Distribution (as of July 2014)

Trend in Medi-Cal Managed Care Enrollment by Age
Medi-Cal Managed Care Population
California's Diverse
### Areas

- Seniors and Persons with Disabilities
- Single, Childless Adults
- Parents and Kids
- Rural and Urban

### Beneficiaries and Areas Served

- Vietnamese
- Tagalog
- Spanish
- Russian
- Korean
- Khmer
- Hmong
- Farsi
- English
- Chinese
- Cambodian
- Armenian
- Arabic

### Threshold Languages in the Medi-Cal Program

California's Diverse Medi-Cal Population
Three Linked Goals:

- Improving the experience of care for patients
- Reducing the per capita cost of health care
- Improving the health of populations

Quality Improvement is a key component in helping California achieve the Three Linked Goals.
Offer performance-based incentives
Develop meaningful consumer protections
Increase accountability and transparency
Strengthen monitoring efforts
Improve encounter data quality
Improve HEDIS performance
Develop and implement the Medi-Cal Managed Care Quality Strategy

California Focuses on Quality Improvement
The Future of Medi-Cal Managed Care

- Beneficiaries' health outcomes
- Shared accountability for providers, and safety net programs, partners, county systems, plans and
  - Bring together state and federal costs.
- While also containing health care outcomes and reduce disparities, beneficiaries to improve health
- Align incentives around Medi-Cal that better coordinate care and
  - Continue to build capacity in ways

Medi-Cal 2020
Incentive Programs
Delivery System Transformation & Alignment

1. Managed Care Systems Transformation & Improvement Program
2. Fee-for-Service Transformation & Improvement Program
3. Public Safety Net System Transformation & Improvement Program
4. Workforce Development Initiatives
5. Access to Housing and Supportive Services
6. Whole-Person Care Pilots

- Equity, Integration, and Reducing Total Cost of Care
- Establishing statewide, regional, or provider-level metrics working towards improvements in health
- Ability to target populations in need of specific focus or services
- Approaches to care delivery and purchasing that will improve health of Medicaid beneficiaries
- Building upon successes under Bridge to Reform and broad innovation in healthcare, reinvent