MEDI-CAL: EXPANSION, MANAGED CARE AND THE IMPACT OF REFORM

CALIFORNIA PROGRAM ON ACCESS TO CARE (CPAC)
UC BERKELEY SCHOOL OF PUBLIC HEALTH
CO-SPONSORS: CA MEDICAL ASSOCIATION & CA PRIMARY CARE ASSOCIATION

WEDNESDAY, MARCH 25, 2015
9:30 AM TO 12:30 PM
UC CENTER SACRAMENTO
1130 K STREET, SUITE LL22, CONFERENCE ROOM B

WELCOME AND INTRODUCTIONS:
9:30 AM  Moderator: Gil Ojeda, Director, California Program on Access to Care, UC Berkeley School of Public Health

Panel 1:  The Expansion: Projections, Hard-to-Reach Populations, and Immigrants
9:35 AM  Panel Moderator: Gil Ojeda, Director, CPAC
Miranda Dietz, Policy Analyst, Center for Labor Research and Education, UC Berkeley
"Medi-Cal Expansion Numbers: First Year and Beyond"
Anthony Wright, Executive Director, Health Access California
"Medi-Cal's Makeover: Not Your Mother's Medi-Cal Anymore: Issues for 2015"

10:00 AM  Legislative Perspective: Medi-Cal Budgetary Overview for FY 2015-16
Assemblyman Tony Thurmond, Chair, Sub Committee on Health and Human Services, Assembly Budget Committee

Panel 2:  Network Adequacy: Physicians, Medical Groups, Community Health Centers
10:10 AM  Panel Moderator/Panelist: Eduardo Martinez, Associate Director, Government Relations, CMA
Toni Johnson-Chavis, MD, CEO, Omni Care Medical Group (Los Angeles)
"The Hidden Safety Net: Sole Providers and Small Groups"
Andrew Bindman, MD, Professor of Medicine, Epidemiology and Biostatistics, UCSF School of Medicine; Director, California Medicaid Research Institute (CaMRI)
"Monitoring Physician Participation in Medi-Cal"
Sean South, Associate Director, Policy and Legislation, California Primary Care Association
"Safety Net Challenges with Network Adequacy"

Panel 3:  Expansion of Medi-Cal Managed Care
10:55 AM  Panel Moderator: Albert Lowey-Ball, Health Economics and Medicaid Advisor, CPAC
Steve Melody, President, Medicaid, Anthem-Blue Cross
"Medi-Cal Expansion, Managed Care, and the Impact of Reform"
Shelley Rouillard, Director, California Department of Managed Health Care
"DMHC and Medi-Cal Managed Care"
Lisa Chan-Sawin, Chief, DSRIP Innovations Officer, Harbage Consulting
"Medicaid Managed Care Trends and the Implications for California"
Peter Hansel, Executive Director, CalPACE
“Medi-Cal Managed Care Expansions for Seniors and Persons with Disabilities”

11:40 AM

**STATE PERSPECTIVE: Medi-Cal Directions and Initiatives**

Hannah Katch, Assistant Deputy Director, Health Care Delivery Systems, Department of Health Care Services

Noon

**Comments, Questions & Answers**

12:30 PM

**Adjourn**

(Asistance provided by the Assembly Health Committee - Coffee, pastries, and box lunch will be available)
Miranda Dietz
UC Berkeley Labor Center
March 25, 2015

Medi-Cal Expansion Numbers: The First Year and Beyond
Medi-Cal grew by almost 3.6 million enrollees in 2014.

Source: RASD Medi-Cal Certified Eligibles Statewide Pivot, February 1, 2015
More than 2 million enrolled in Medi-Cal under the new MAGI rules.


1,220,000

LIHP 660,000

Newly Eligible

850,000

Previously Eligible, MAGI

Source: ABx1-1 “California Eligibility and Enrollment Report: Insurance and Affordability Programs”. Excludes those eligible for Medi-Cal via CalWORKs or SSI/SSP.
Delayed renewals mean fewer churned out of Medi-Cal in 2014.

“Good” churn
- Income increase—eligible for Covered California
- Job-based coverage

“Bad” churn
- Failure to receive, understand, or return renewal forms when still eligible
Some undocumented residents eligible for Medi-Cal under State policy due to executive actions.

2,450,000 undocumented Californians

- Not eligible for relief from deportation and work authorization (approximately 50%)
- Eligible for relief, but will not apply due to barriers
- Already privately insured or income above Medi-Cal eligibility threshold
- Potential enrollees in comprehensive State-only Medi-Cal

Several hundred thousand (UCB-UCLA to release estimates on 3/26/15)

Source: Pew Hispanic Center estimates of California undocumented population and share eligible for relief; UC Berkeley Labor Center analysis of likely Medi-Cal eligibility
For further information

- CalSIM resources: http://healthpolicy.ucla.edu/calsim
- UCB-UCLA policy brief on CA immigrants eligible for deferred action: http://laborcenter.berkeley.edu/topic/health-care/ (to be posted on 3/26/15)
- Contact Miranda Dietz, miranda.dietz@berkeley.edu
Medi-Cal's Makeover: Not Your Mother's Medicaid Anymore... Issues for 2015

Anthony Wright
March 2015

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

- A half-century of covering Californians, since 1966.
- About 12 million people enrolled; 1/3 of the state
- Key financing mechanism for virtually all CA hospitals
- Over 40% of births, Over 66% of nursing home care
- Hard to overstate its importance & centrality to our health care system we all rely on.

Medi-Cal not just expanded but transformed

- Expansion of coverage requires renewed focus on access to care & improved quality and equity
- Needed investments and accountability are crucial to continuing the progress to an improved health system
Biggest Congressional Action for Consumer Protections; Coverage Expansion; Cost Containment
Medi-Cal, the ACA & the CA Budget: A Benefit, Not a Burden

- Governor’s 2015-16 Budget: $95.4 Billion for Medi-Cal
  - General Fund: only $18.6 Billion of $113 Billion Overall Budget
  - Federal Funds: $61.6 Billion
  - Other Funds $15.2 Billion (like provider tax)

- ACA-related expansion: 3 million Californians covered:
  - 2 Million newly eligible (100% federally funded; 90% in 2020 and beyond)
  - 1 Million previously eligible (50% federally matched)
  - $18 Billion: $17 Billion federal funds, $950 Million general fund
  - 1 Billion offset from provider tax, AB85 county reallocation
  - Currently, no general fund cost for this historic expansion
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
Not Just Who, But How: Medi-Cal Moves to More Managed Care
WHAT'S NEXT?

Finish the Job: Cover the Remaining Uninsured
Ensure Coverage Offers Meaningful Access to Care
Incentivize Quality, Equity
Improving Medi-Cal Eligibility/Enrollment Systems

- Making Signing Up Easier
  - Not Just an IT Glitch: Last Year’s 900,000+ Enrollment Backlog
  - Conflicting, Confusing Notices
  - Fixing CALHEERS & the 24-Month Roadmap
  - Former Foster Youth
  - Consumer Experience Needs to Be Improved

- The Need to Limit Estate Recovery
  - California: only one of 10 states that requires estate recovery for Medi-Cal managed care applicants aged 55+.
  - Raises little revenue, major barrier to enrollment, inequitable.
  - Governor vetoed bill last year; pointed to budget process; SB33(Hernandez) this year. Senate Health Hearing March 25th
HEALTHCARE 4 all
NO EXCEPTIONS. NO EXCLUSIONS. #HEALTH4ALL
Making #Health4All History *This Year*

- **Continuing California’s Coverage of “Deferred Action” Immigrants:** The President’s executive action had the impact of expanding the category of immigrants covered by state-funded Medi-Cal. **We need to defend and secure this major victory. Also:**

- **Secure and Expand our County Safety-Net Programs:** Counties are the last resort of coverage. Despite AB85’s reallocation, some counties are enhancing their safety-net for the remaining uninsured, with programs like My Health LA. Through the Medi-Cal waiver, we need to encourage more counties to care for the undocumented.

- **Making Progress to a Statewide Solution for #Health4All:** An effort now in its third year, we can take another step to Health4All, expanding Medi-Cal to more immigrants, and setting up the structure for a mirror marketplace so everyone can seek coverage.
Financing #Health4All

LOS ANGELES TIMES:
“Study sees modest costs in healthcare for immigrants here illegally”

By Patrick McGreevy * May 21, 2014

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

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

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 2019. Enrollment in Medi-Cal would increase by up to 730,000 people next year and up to 790,000 in four years.
Once folks are in Medi-Cal, we need to:

Make it work!
Additional Medi-Cal Budget Issues

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

Rates & Access to Care
- In 2010, AB97 cut Medi-Cal fee-for-service rates by 10%; some adjustments by CMS but still not restored;
- ACA included a 2-year primary care rate bump to Medicare levels; 73% increase nationally, around double in CA; Bump expired in the new year, January 2015
California Budget Project Slide

Note: Data reflect fees for primary care, obstetric care, and other services. Tennessee is excluded because its Medicaid program does not have a fee-for-service component.

Source: Kaiser Family Foundation
One of the lowest Medi-Cal reimbursement rates in the nation.
Fewer CA Doctors Accept Medi-Cal Patients

California Budget Project Slide

Source: US Centers for Disease Control and Prevention
Gaps in Realized Access
Use of Care Measures

* Did not have a doctor visit in the prior year
  37% Medi-Cal; 30% Medicaid in other states (CHIS: 16% Medi-Cal, 13% ESI)
* Did not have a specialist visit in the prior year
  48% Medi-Cal; 36% Medicaid in other states
* Did not have a dental visit in the prior year
  59% Medi-Cal; 47% Medicaid in other states
* Did not have a flu vaccination in the prior year
  71% Medi-Cal; 66% Medicaid in other states (CHIS: 69% Medi-Cal; 62% ESI)
* Among women 18 and older, did not have a Pap test in the prior year
  42% Medi-Cal; 38% Medicaid in other states
* Delayed needed medical care because of difficulty getting an appointment in the prior year
  12% Medi-Cal; 8% Medicaid in other states
* Had two or more emergency room visits in the prior year
  15% Medi-Cal; 17% Medicaid in other states (CHIS: 14% Medi-Cal, 11% ESI)
* Most recent emergency room visit in the prior year was because doctor’s office not open
  6% Medi-Cal; 9% Medicaid in other states

2011-12 National Health Interview Survey
Access to Specialists, by Health Status, 2012

Percentage Reporting Difficulty Getting Appointments

Excellent: 23%
Very Good: 27%
Good: 42%
Fair/Poor: 46%
All: 33%

Notes: Excludes Medicare, Medicaid enrollees and enrollees unable to participate in telephone survey. Includes parents responding about their enrolled children.
To Sum Up: Medi-Cal a Key Lifeline, But Real Issues of Access

Medicaid matters:
- Even early results of Oregon study shows increased use of a regular place of care, a usual doctor and use preventive care; and improved mental health, and financial benefits to having coverage.
- 69% said “ Medi-Cal provides access to high quality medical care.” (CHCF)

But access issues remain:
- Clear that Medi-Cal patients don’t have the same access as others to doctors and specialists.
- Issues arise, as expected, with patients with specific needs; with specialists; exacerbated in certain rural/urban geographic areas.
- Can’t risk issues getting worse with a rate cut during expansion.
Accountability on Timely Access

- The promise of “coordinated care” is that Medi-Cal is no longer “a license to hunt,” but a guarantee of access to needed care and adequate networks.
- Managed care plans (including Medi-Cal managed care) are supposed to meet timely access to care standards.
- Department of Managed Health Care has set time standards, including 10 days for a doctor or specialist appointment.
- SB964 (Hernandez), sponsored by Health Access and passed last year, requires annual reviews of network adequacy, by lines of business, including Medicaid managed care plans.
Medi-Cal Waiver

Health Access California Goals:

- More federal $ for a safety-net that survives and thrives
- Improved/coordinated access to remaining uninsured
- Incentives that work for patients on cost/quality/equity
- Better integration with human services
Medi-Cal Waiver

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

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

FINANCING
* State-Federal Shared Savings and Reinvestment
* Budget Neutrality
* Continued Federal Funding Support
Medi-Cal Waiver: Timeline

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

May 20, 2015 • Stakeholder Advisory Committee update

Spring/Summer 2015 • Collaborative program development with stakeholders

July 22, 2015 • Stakeholder Advisory Committee update

Fall 2015 • Final STC development
Nov. 1, 2015 • Start of new Waiver

Post-Approval • Continued stakeholder engagement forums
For more information

Website: http://www.health-access.org
Blog: http://blog.health-access.org

Facebook: www.facebook.com/healthaccess
Twitter: www.twitter.com/healthaccess

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Much thanks to the California Budget Project, the California HealthCare Foundation, and the UC Berkeley Labor Center for use of their slides.
HIDDEN SAFETY NET

Solo and Small Group
(Fewer than 10)

Presented by: Toni Johnson-Chavis MD, MPH, AAP
CEO, Omnicare Medical Group
Wee Care Pediatric Medical Group
PECP's
Private Essential Community Provider's

- We are the Hidden Safety Net - we are not classic "safety net" but we work side-by-side with county and FQHC providers. Our specialists are the same ones FHQC's depend on, so maintaining the Medi-cal "bump" is important for PCP's and specialists.
- There are 3X more doctors in the Hidden Safety Net than there are doctors in the "classic" safety net.
- The 10% cut in place today puts California in 50th place as far as payments to private docs, increased payments are essential.
- PECP's are cost effective providers.
- Low re-imbursement encourages further loss of providers, beneficiaries will experience severe access problems.
Advantages

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

- Culturally sensitive, compassionate competent care
- 70% of ambulatory visits are to medical practices with less than 5 providers
- 1/3 of US physicians practice in solo and two physician practices
- 60% of Medi-cal consumers receive care from (hidden safety net)
Advantages (cont'd)

- Less costly per patient visit (50\textsuperscript{th} state in USA for payment, less likely to have additional incentives; \textbf{no continuation of ACA bump up payment})
- Lower re-hospitalization rates as compares to larger practices (Further need to assess potential better outcomes)
Obstacles

- Financial barriers (because private unable to receive federal/non-profit funding)
- Administrative demands (i.e., HIT integration, more paperwork, and newer practice design models)
- Low reimbursement often contributes to provider’s need to close specific insurance types (e.g. Medi-cal)
- Aging work force with providers choosing early retirement
Solutions

- Create broad community coalitions
- Deploy utilization and reporting tools to improve desired patient outcomes
- Improve reportable outcome measures that include broader stakeholder input
Ask For's

- We need continuation of Medi-cal bump for primary and specialty care because their work together will reduce unnecessary ER, hospitalization, and improve quality in long-term facilities

- These policy initiatives should be part of the Medi-cal Waiver process and pilots for Alternative Payment Methodology
Experience

- Clients with serious, chronic diseases such as diabetes, renal failure, cancer, & cardiac diseases have 2-4 times the incidence of these disease, as compared to those who live in other geographic areas (especially Latino, Afro-American, and some Asian cultures.)

- Recent new lines of business, under the ACA have transitioned a (sick)er population as compared existing lines of existing business
Experience (Cont’d)

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

Should Provider Performance Measures Be Risk-Adjusted For Sociodemographic Factors?

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

Consumers and payers will avoid providers who serve disadvantaged populations because they are labeled poor performers, adjustment would enable all providers to be compared equally.
Those in favor of no adjustment believe it could artificially raise the performance score of providers treating the most vulnerable patients, whereby two doctors might appear equal, even though one’s performance is considerably lower. They say it is not appropriate to have a different standard for providers who treat low socioeconomic status patients.
Current system must be enhanced to serve the most in need: individuals with persistently complex, chronic conditions, predominantly with poor social conditions and often with behavioral health co-morbidities. Capturing the socio-economic determinants will help prioritize and direct care optimization efforts towards the highest risk patients. This will allow the Care Management Team to move from a reactive, fragmented approach to a primary care integrated, proactive approach to care management, thereby reducing the cost of unnecessary care.

Omnicare IPA utilizes the Medical Management and Outcomes Tracking System (MMOTS), a care optimization and data analytics product, and is able to provide its clinicians with a comprehensive value-based quality dashboard. MMOTTS is Conifer Value-Based Care, LLC (Conifer VBC) Risk Stratification application that assists in identifying the target populations: child health and adults with chronic disease, and facilitates pro-active patient specific interventions.
Sources

- ITUP
- California Healthcare Foundation
- Should Provider Performance Measures Be Risk-Adjusted For Sociodemographic Factors? – Health Affairs Blog
- Many other resources
Monitoring Physician Participation in Medi-Cal

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

March 25, 2015
“Is there a doctor who accepts Medicaid in the house?”
Methods

- UCSF has conducted surveys of physician participation in Medi-Cal since 1990s
- Began piggybacking on top of Medical Board’s mandatory survey beginning in 2008
- Most recently completed survey 2013
- Physicians responded by mail or online
- Sample size = 3,499
- Response rate = 63%
Questionnaire

- Voluntary UCSF Questions
  - Whether accepting new patients by payer
  - Distribution of patients in practice by payer
  - Type of practice (e.g., solo, group, clinic)

- Mandatory Medical Board Questions
  - Demographics, specialty, practice location
  - Information linked with voluntary questions
Physicians Accepting New Patients

Payer

- Private Insurance
- Medicare
- Medi-Cal
- Uninsured

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<th>Private Insurance</th>
<th>Medicare</th>
<th>Medi-Cal</th>
<th>Uninsured</th>
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<td>79% - 75%</td>
<td>62%</td>
<td>44%</td>
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<td>PCPs</td>
<td>76%</td>
<td>66%</td>
<td>57%</td>
<td>39%</td>
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<tr>
<td>Non-PCPs</td>
<td>80% - 79%</td>
<td>64%</td>
<td>47%</td>
<td>39%</td>
</tr>
</tbody>
</table>

Source: Analysis of 2013 Medical Board of California supplemental survey.

PCP = Primary Care Physician
Physicians Accepting New Medi-Cal Patients

Practice Type

% Accepting New Medi-Cal Patients

- Community Health Center/Public Clinic: 86%
- Private Group Practice: 66%
- Kaiser Permanente: 68%
- Solo Practice: 44%
- Other: 53%

Source: Analysis of 2013 Medical Board of California supplemental survey.
Distribution of Medi-Cal Visits Across All Physicians

Source: Analysis of 2013 Medical Board of California supplemental survey.
Ratio of FTE Medi-Cal Physicians per 100,000 Medi-Cal Enrollees, 2011 vs. 2013

Source: Analysis of 2011 and 2013 Medical Board of California supplemental survey.
Primary Care Physicians Accepting New Medi-Cal Patients

Region's Relationship to California Average*
- Below range
- Within range
- Above range

*57%, with a confidence interval of 54% to 60%

Source: Analysis of 2013 Medical Board of California supplemental survey.
Non-Primary Care Physicians Accepting New Medi-Cal Patients

Region

Region's Relationship to California Average*
- Below range
- Within range
- Above range

*64%, with a confidence interval of 62% to 66%.

Source: Analysis of 2013 Medical Board of California supplemental survey.
Key Findings and Policy Implications

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

- California’s enhanced investment in Song-Brown funds to train more primary care physicians is on target.

- Nationally primary care payment bump in ACA significantly increased physician participation in Medicaid.

- Not clear that California maximized payment bump opportunity and now payment rates have returned to among lowest in country.
Enhancing Data to Improve Medi-Cal Access

- UCSF survey provides series of snapshots on a sample
  - 2011, 2013 and back in field now for 2015
  - Timing missed window to evaluate primary care bump

- Adding payer questions to mandatory Medical Board survey would increase value of data
  - On going data collection to support rapid cycle evaluation of policies
  - Would remove sample size limitations and enable detailed analysis by specialty and geography
Leveraging Medi-Cal Data

- Medi-Cal required by federal regulations to improve its reporting on providers through T-MSIS

- A state requirement to make up-to-date T-MSIS data readily available to academic researchers could improve state’s capacity to monitor access to care in Medi-Cal
Acknowledgments

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Janet Coffman
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Lena Libatique
Safety Net Challenges with Network Adequacy

Sean South
Associate Director of Policy and Legislation
The Role of CCHCs

- California’s CCHCs serve more than 5.6 million patients each year, including nearly 2 million children. Key services include primary medical care, behavioral health, oral health, pharmacy, vision, health education, care coordination, enrollment counseling, and other services— all delivered under one roof.

- But, beyond this primary care access, our CCHCs help coordinate the care for our patients to ensure they have full access to specialty care, but this is becoming more and more difficult.
Two Solutions

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

- 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.

- 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.
One forecast predicts that more than 300,000 patients may lose access to care in California alone.

We are asking Congress to prevent these cuts and the impact they will have on our communities by restoring the Health Center Trust Fund to 2013 funding levels.
Provider Rate Bump

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

- We need more primary care providers in Medi-Cal to keep these patients out of the emergency room and give them ready access to a primary care provider, because it is the establishment of this primary care medical home, that is key to their health and in bending the health care price curve.
Rates are Only Part of the Answer

- 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.

- 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.
Timely Access to Care

DMHC should establish quantitative network adequacy standards that hold insurers accountable for ensuring a sufficient network of providers.

As it pertains to quantitative standards, carriers should be required to:

- Include a minimum ratio of providers to covered persons for primary care physicians and specialists by specialty (including subspecialists);
- Include a maximum time and distance standard to access primary care and specialists (by specialty);
Timely Access to Care

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

The actual ratio standards, time and distance standards, specialties and subspecialties, and LEP provider ratios that serve as the standard for California’s safety-net networks should be set according to an evidence-based review of the actual patterns of care. Exception requests from regulatory standards should be carefully scrutinized and approved only when necessary.
Helping Consumers Experiencing Access Problems

• We support greater education of enrollees regarding health plan requirements to offer timely access and the consumer right to access all covered medically necessary care. We believe the lack of awareness of access to care regulatory requirements among consumers is a primary contributor to the underreporting of such violations. Many consumers will give up hope, not receive the care they need or bear inconveniences posed by distance or waiting time, without ever thinking that they might be dealing with a non-compliant network.

• In addition, we believe the Department should increase outreach to consumers and providers about how next steps in ensuring access to care and should streamline the grievance process in order to ensure that consistent problems within a network are captured and evaluated by DMHC staff.
Next Steps

- CPCA and our members are dedicated to ensuring the low Medi-Cal rates are addressed in this legislative session. We strongly support SB 243(Hernandez)/AB 366 (Bonta), bills that would provide critical stability to health care provider networks and ensure access to health care services for people receiving services in the Medi-Cal program.

- CPCA is also a proud member of We Care for California, a coalition of physicians, dentists, hospitals, health care workers, community health clinics, health plans, first responders, caregivers and other health providers who are the sponsors of SB 243(Hernandez)/AB 366 (Bonta).
Next Steps

- We look forward to working with DMHC and the health plans to educate consumers and providers on standards for timely access, on the process for ensuring timely access, and on what steps a covered person should take when experiencing access problems inconsistent with timely access standards, including when and how to access applicable Department and insurer helplines.

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

Please contact:
Sean South at ssouth@c pca.org
Medi-Cal expansion, managed care and the impact of reform

Kathleen Koday, President
Medicaid, Anthem Blue Cross
1 in 3 Americans is enrolled in government-sponsored health care

319 million
2014 population

$3 trillion
health expenditures

Employer Based

Population
169 million

Expenditures
$956 billion

Medicare

Population
49.4 million

Expenditures
$635 billion

Medicaid

Population
67.9 million

Expenditures
$400 billion

Uninsured

Population
~35 million

Expenditures
$50-100 billion (est.)

1. National Healthcare Expenditure Projections 2012-2022, Tables 1 and 17. Medicaid population and expenditures includes the Children's Health Insurance Program. Uninsured spending on health care cannot be projected due to data limitations; the figures provided are rough estimates. 2. Kaiser State Health Fast Facts, "Total Medicare Beneficiaries, 2012" data as of Nov. 2014.
Expansion of Medi-Cal Managed Care

- **12 million**
  members covered by Medi-Cal
- **2.5 million**
  members added through the expansion of Medi-Cal
- **$95 billion**
  Medi-Cal’s joint federal-share budget
- **No. 1**
  health care purchaser in the state
- **17%**
  nation’s Medicaid members enrolled in Medi-Cal
Expansion of Medi-Cal Managed Care, cont’d.

Anthem Blue Cross in California

- **1.1 million** Medi-Cal members served
- Serving the Medi-Cal population since 1994

29 counties (1/2014-2/2015)

- **25,000** initial members
- ACA 1202 (PCP bump) implementation
- Outpatient mental health benefit added (1/2014) and additional programs developed/implemented (2014)
- Coordinated with Covered California
- Existing capabilities leveraged, clinical/non-clinical resources expanded
Medicaid pipeline has shifted over the past decade toward high-need populations

As we look beyond 2014:
- Duals
- Additional LISS
- Developmental disabilities
- Serious and persistent mental illness

The high-cost, high-needs population is becoming a greater share of the pipeline.

Anthem’s approach to serving aging adults and people with disabilities

The transition to managed care for these members required a thoughtful approach and voluntary, comprehensive measures to:

- Preserve continuity and timely access to care
- Deliver care coordination and complex case management services
- Minimize the impact on medication regimens, ongoing treatment and care plans, and relationships with PCPs and specialists
Medi-Cal Managed Care rural expansion

- **19**
  rural counties in which Anthem serves members

- **150,000**
  rural members enrolled (11/2013-3/2015)

- **85%**
  rural members residing in northern California

- **15%**
  rural members reside in the central region
Medi-Cal Managed Care rural expansion, cont’d.

Getting ready for these members:

- Coordinated readiness with California Department of Health Care Services
- Leveraged capabilities and local relationships
- Planned member and provider communications
- Expanded role for case management services
- Expanded provider networks to include more community-based providers (e.g., federally qualified health centers)
- Stepped-up provider education and partnership
- Focused on a seamless transition to managed care that promotes access to and continuity of care
Serving aging adults and people with disabilities in the rural expansion

- **9,700** seniors and people with disabilities served by Anthem Blue Cross in 19 rural counties
- **90%** members residing in northern California
- **10%** members residing in the central region
- Transition to managed care for seniors and people with disabilities residing in rural counties began November 2013, completed December 2014
- Health risk assessments for high-risk members completed ahead of schedule
- Eligible members transitioned to short-term care coordination or complex case management
Contact

Steve.Melody@anthem.com
DMHC and Medi-Cal Managed Care

California Program on Access to Care (CPAC)

March 25, 2015
Shelley Rouillard, Director

www.HealthHelp.ca.gov
DMHC Mission

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

www.HealthHelp.ca.gov
About the DMHC

- Established in 2000 through consumer-sponsored legislation
- Funded by assessments on health plans
- Regulates 70 full service health plans and 52 specialized plans
  - All HMO and some PPO/EPO products
  - Some large group, most small group and many individual products
- Authority from Knox Keene Health Care Service Plan Act of 1975

www.HealthHelp.ca.gov
DMHC Key Functions

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

www.HealthHelp.ca.gov
Overview

- DMHC Regulatory Authority
- Network Adequacy
- SB 964 (Hernandez)
- Financial Status of Local Initiatives and County Organized Health Systems
- Consumer Assistance Data

www.HealthHelp.ca.gov
DMHC Regulatory Authority

- Local Initiatives - all authority under Knox Keene Act
- County Organized Health Systems – exempt from Knox Keene Act licensure
- Inter-Agency Agreement (IA) with DHCS
DMHC Access Standards

• Geographic – time and distance
• Provider capacity
• Timely access
• Rural access
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
Financial Status of Local Initiatives and County Organized Health Systems

- All LI and COHS plans reported enrollment increases of at least 35% in 2014
- Upward trend in both revenue and medical expenses
- All plans had positive net income as of December 2014
- Only one LI reported TNE deficiency
- [http://dmhc.ca.gov/Portals/0/AbouttheDMHC/SSB/mmcpf3r031815.pdf](http://dmhc.ca.gov/Portals/0/AbouttheDMHC/SSB/mmcpf3r031815.pdf)
# Medi-Cal Managed Care Consumer Assistance Data

<table>
<thead>
<tr>
<th>2014</th>
<th>Total Contacts (All Coverage)</th>
<th>Total MMC Contacts</th>
<th>MMC % of Total Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls</td>
<td>45,160</td>
<td>3104</td>
<td>7%</td>
</tr>
<tr>
<td>Standard Complaints</td>
<td>9,214</td>
<td>268</td>
<td>3%</td>
</tr>
<tr>
<td>IMRs</td>
<td>3,142</td>
<td>345</td>
<td>11%</td>
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<tr>
<td>Quick Resolutions</td>
<td>1,331</td>
<td>89</td>
<td>7%</td>
</tr>
<tr>
<td>Urgent Nurse</td>
<td>156</td>
<td>46</td>
<td>29%</td>
</tr>
<tr>
<td>Written Correspondence</td>
<td>2,776</td>
<td>28</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61,779</strong></td>
<td><strong>3,880</strong></td>
<td><strong>6%</strong></td>
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</table>
# Medi-Cal Managed Care Access Data

<table>
<thead>
<tr>
<th>2014 Access Related Contacts</th>
<th>Total Access (All Coverage)</th>
<th>Total MMC Access Contacts</th>
<th>MMC % of Total Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calls</td>
<td>1,088</td>
<td>201</td>
<td>18%</td>
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<td>Standard Complaints</td>
<td>457</td>
<td>24</td>
<td>5%</td>
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<tr>
<td>IMRs</td>
<td>0</td>
<td>0</td>
<td>0%</td>
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<tr>
<td>Quick Resolutions</td>
<td>403</td>
<td>31</td>
<td>8%</td>
</tr>
<tr>
<td>Urgent Nurse</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Written Correspondence</td>
<td>13</td>
<td>2</td>
<td>15%</td>
</tr>
<tr>
<td>Total</td>
<td>1,961</td>
<td>258</td>
<td>13%</td>
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</tbody>
</table>
Need Assistance?

Online complaint form @
www.HealthHelp.ca.gov

DMHC Help Center

1-888-466-2219
MED-CAL MANAGED CARE EXPANSIONS FOR SENIORS AND PERSONS WITH DISABILITIES

CPAC Forum
State Capitol
March 25, 2015

Peter Hansel
CEO
CalPACE

Community Leaders for California's Seniors
Several Medi-Cal Managed Care Expansions Include Seniors and Persons with Disabilities

- Medi-Cal-only SPD managed care transition
  - 380,000 beneficiaries in 16 counties
- Coordinated Care Initiative (CCI)
  - 456,000 beneficiaries in 7 counties
- Rural managed care expansion
  - 22,000 beneficiaries in 28 counties
Seniors and Persons with Disabilities Have Significant Health Care Needs

Hypertension
Hyperlipidemia
Diabetes
Arthritis
Ichemic Heart Disease
Atrial Fibrillations
COPD
Mood Disorder
Osteoporosis
Congestive Heart Failure
Renal Failure
Stroke
Dementia
Asthma
Cancer
Schizophrenia

Source: Figure 24, pg. 115 - http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Dual%20Data%20Sets%20Medicare.pdf
Percent of Medi-Cal FFS CCI Population Treated for 16 Significant Conditions With Overlapping Conditions

Source: Figure 28, pg. 119 - http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Dual%20Data%20Sets%20Medicare.pdf
Profile of PACE Population

- Average Age: 78
- Nursing home eligible: 100%
- Percent dually eligible: 83%
- Average number of diagnoses: 15
- Percent with Alzheimer’s or related dementia: 45%
- Average number of ADLs: 3.7
- Average Medicare risk score: 2.24
CCI Implementation Faces Numerous Challenges

- Confusing enrollment materials and process
- Higher than expected opt-out and disenrollment
- Existing provider relationships
- Appropriate rate setting
- Maintaining and expanding access to community-based LTSS
  - IHSS
  - CBAS
  - MSSP
  - PACE
Maintaining and Expanding Access to Community-Based LTSS Faces Special Challenges

- Lack of clear standards for access to services
- Provider payment reductions
- Lack of uniform assessment tool
- Lack of clear policy on plan referrals to PACE
- PACE is not an enrollment option in all managed care counties
State Could Do More to Maintain and Expand Access to Community Based LTSS

- Revisit passive and mandatory enrollment
- Develop clearer standards for access to LTSS
- Restore 10 percent provider rate reduction
- Clarify policies and procedures for referrals to PACE
- Make PACE an enrollment option in all managed care counties
Expansion of Medi-Cal Managed Care

Hannah Katch, Assistant Deputy Director
Health Care Delivery Systems
California Department of Health Care Services
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

- 2011
  - Medi-Cal only Seniors and Persons with Disabilities (SPDs) (Aged, Blind, Disabled (ABDs)) transitioned

- 2012
  - Community Based Adult Services (CBAS) became a managed care benefit

- 2013
  - Healthy Families Program transitioned (SCHIP)
  - Expansion into 28 rural counties

- 2014
  - Medicaid optional expansion implemented
  - Coordinated Care Initiative (duals demonstration & LTSS) implemented
  - Transition of SPDs in 28 rural counties

California Department of Health Care Services
Trend In Medi-Cal Enrollment and Month Over Month Growth
(October 2012 through September 2014)

Certified Eligibles in Millions

Month over Month % Change

Certified Eligibles

Between October 2013 and September 2014, Medi-Cal enrollment grew by over 2.7 million.

Source: Medi-Cal eligibility data as of October 2014

California Department of Health Care Services
Trends in Medi-Cal Enrollment in FFS vs Managed Care

<table>
<thead>
<tr>
<th>Year</th>
<th>Fee-for-Service</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004</td>
<td>51%</td>
<td>49%</td>
</tr>
<tr>
<td>2011</td>
<td>40%</td>
<td>60%</td>
</tr>
<tr>
<td>2014</td>
<td>29%</td>
<td>71%</td>
</tr>
<tr>
<td>2016</td>
<td>22%</td>
<td>78%</td>
</tr>
</tbody>
</table>

California Department of Health Care Services
Trend in Medi-Cal Managed Care Enrollment by Age Distribution (as of July 2014)
California's Diverse Medi-Cal Managed Care Population

- 19% White
- 51% Hispanic
- 10% African-American
- 10% Asian/Pacific Islander
- 10% Other/Unknown
California’s Diverse Medi-Cal Population

13 threshold languages in the Medi-Cal program

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

Beneficiaries and areas served

- Seniors and Persons with Disabilities; single, childless adults; parents and kids; rural and urban areas
Three Linked Goals

Quality improvement is a key component in helping California achieve the Three Linked Goals:

- Improving the health of populations
- Reducing the per capita cost of health care
- Improving the patient experience of care
California Focuses on Quality Improvement

- Develop and implement the Medi-Cal Managed Care Quality Strategy
- Improve HEDIS performance
- Improve encounter data quality
- Strengthen monitoring efforts
- Increase accountability and transparency
- Develop meaningful consumer protections
- Offer performance-based incentives
The Future of Medi-Cal Managed Care

**Medi-Cal 2020**

- Continue to build capacity in ways that better coordinate care and align incentives around Medi-Cal beneficiaries to improve health outcomes and reduce disparities, while also containing health care costs.

- Bring together state and federal partners, county systems, plans and providers, and safety net programs to share accountability for beneficiaries’ health outcomes.
Delivery System Transformation & Alignment
Incentive Programs

Building upon successes under Bridge to Reform and broad innovation in healthcare, reinvent approaches to care delivery and purchasing that will improve health of Medi-Cal beneficiaries.

Ability to target populations in need of specific focus or services.

Establish statewide, regional, or provider level metrics working towards improvements in health equity, integration, and reducing total cost of care.

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
Questions/Open Discussion