Medi-Cal Managed Care and the Hospital Waiver

Joint Hearing of the:

Assembly Health Committee
Assemblymember Wilma Chan, Chair

Assembly Budget Subcommittee #1 on Health and Human Services
Assemblymember Hector de la Torre, Chair

Senate Health Committee
Senator Deborah Ortiz, Chair

Senate Budget Subcommittee #3 on Health and Human Services
Senator Denise Ducheny, Chair

Tuesday, August 16, 2005
10:00 a.m. – 2:00 p.m.
Room 4202

Expansion of Medi-Cal Managed Care and the Hospital Waiver

The Assembly and Senate Health Committees and Budget Subcommittees 1 and 3 held an informational hearing on July 13, 2005 regarding the hospital waiver that the Administration and the Centers for Medicare and Medicaid Services (CMS) are currently finalizing.

The state's current waiver authority, which provides over $2 billion in supplemental federal funds to safety net hospitals through the Disproportionate Share Hospital Program, the Emergency Services and Supplemental Payments Program, the Graduate Medical Teaching Program and the Capital Project Debt Reimbursement Program, expired December 30, 2004, but has received a series of extensions, and now expires August 15, 2005. California must come to agreement with the CMS on final waiver terms so that critical federal funds that support care to the uninsured, trauma centers and medical education can be distributed to California's hospitals.

The Administration and CMS are still engaged in negotiations on the Terms and Conditions that constitute the basis and requirements for receipt of federal dollars contained in the five year waiver. One of the more significant requirements of the Terms and Conditions is the linkage of $360 million in federal funds to mandatory enrollment of the aged, blind and disabled population in Medi-Cal into managed care within the first two years of the waiver agreement.

What Is CMS Requiring In Order to Claim $360 million in Hospital Waiver Funds?

CMS is requiring the following steps:

For Demonstration Year 1 (July 1, 2005 – June 30, 2006),

1. $90 million of the Safety Net Care Pool funds will be available if managed care legislation is enacted to expand the number of counties in California covered by Medi-Cal Managed Care *and* to require the enrollment of Medi-Cal only seniors and persons with disabilities into Medi-Cal Managed Care no later than September 30, 2005.
2. An additional $90 million will be available if the state submits a Medicaid State Plan amendment, or submits Medicaid waiver requests associated with managed care expansion, by May 31, 2006.

• If managed care expansion legislation is enacted after September 30, 2005, but before June 30, 2006, a pro rata portion of the initial $90 million will be available based on the number of months that elapse after September 30, 2005, before managed care expansion legislation is enacted.

• In the event Medicaid State Plan amendments, or Medicaid waiver requests associated with managed care expansion, are submitted after March 31, 2006, but before June 30, 2006, a pro rata portion of the second $90 million will be available based on the number of months that elapse after May 31, 2006, before the amendments or waiver requests are submitted.

• If managed care legislation is not enacted during Demonstration Year 1, none of the $180 million of the Safety Net Care Pool finds will be available to the State.

For Demonstration Year 2 (July 1, 2006—June 30, 2007)

1. $60 million of the Safety Net Care Pool funds will be available if the state continues submission of Medicaid State Plan amendments, or Medicaid waiver requests associated with managed care expansion, beginning July 1, 2006, through March 31, 2007.
2. An additional $60 million will be available if the state makes managed care contract and rate submissions between July 1, 2006, and June 30, 2007.
3. A third $60 million will be available if expanded enrollment in managed care begins by January 2007.

• If expanded enrollment in managed care begins after January 2007, but before June 30, 2007, a pro rata portion of the third $60 million will be available based on the number of months that elapsed after January 31, 2007, before the expanded enrollment begins.

• If managed care legislation is not enacted in Demonstration Year 1, but is enacted in Demonstration Year 2, all terms applicable to Demonstration Year 1 will apply in Demonstration Year 2 in order for the state to access Demonstration Year 2 Safety Net Care Pool funds, and Demonstration Year 1 funds will not be available to the State.

• If managed care legislation is not passed by June 30, 2007, Demonstration Year 2 funds will not be available to the state.

The $180 million portions of the Safety Net Care Pool for each of the first two demonstration years are considered annual allotments and are not available for use in subsequent demonstration years (i.e., Demonstration Year 1 funds are not available for use in Demonstration Year 2). This does not preclude the state from using Demonstration Years I or 2 funds to pay for activities performed or services rendered during Demonstration Years I or 2 after the end of the respective demonstration year.

What is California's current experience with Medi-Cal managed care?

There are 3 major types of Medi-Cal managed care plans currently offered in California.

County Organized Health Systems

County Organized Health Systems (COHS) are health-insuring organizations that are organized and operated by an independent governing board appointed by the county's Board of Supervisors. All Medi-Cal beneficiaries residing within COHS counties are required to enroll, regardless of their eligibility category, including individuals who are Medicare/Medi-Cal dual eligibles. There is no Medi-Cal fee-for-service delivery system in these counties. Five County Organized Health Systems plans operate in the following eight counties: Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo. As of June 2005, total enrollment for COHS' is 563,325.

Two-Plan Model

Under the Two-Plan Model, the Department of Health Services contracts with one locally developed health care service plan known as the Local Initiative and one Commercial Plan selected through a competitive procurement process. Generally, enrollment is mandatory for families and children. The non-mandatory eligible groups (mostly seniors and persons with disabilities) access services through Medi-Cal's fee-for-service delivery system or can choose to enroll in a health plan. Individuals who are Medicare/Medi-Cal dual eligibles are excluded from enrollment.

The Two-Plan model of Medi-Cal managed care is available in twelve counties. In 1996, Alameda County became the first Two-Plan managed care county. The other Two-Plan counties include Contra Costa, Fresno, Kern, Los Angeles,

Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Fresno County did not develop a Local Initiative and has two Commercial Plans. Approximately 2.4 million Medi-Cal recipients are enrolled in these counties.

Geographic Managed Care

Under Geographic Managed Care (GMC), the Department of Health Services contracts with multiple health plans in the county. In contrast to the competitive procurement for the commercial plans in the Two-Plan model, contracts for GMC are secured via a non-competitive application process in which any plan meeting specified state requirements/standards is permitted to negotiate a contract with the state. Medi-Cal beneficiaries in GMC counties choose from multiple commercial managed care plans. Sacramento and San Diego counties are the only two GMC counties in California. In these two counties, enrollment is mandatory for families and children. The non-mandatory eligible groups access services through the Medi-Cal fee-for-service system. Individuals who are Medicare/Medi-Cal dual eligibles are excluded from enrollment. Approximately 340,000 persons are currently enrolled in GMC's.

Current Enrollment Figures for Medi-Cal Managed Care

According to the DHS, of the approximate 6.5 million Medi-Cal beneficiaries, 3.2 million are currently enrolled in managed care. The DHS is the largest purchaser of managed health care services in California. Of the 3.2 million Medi-Cal managed care enrollees residing in 22 counties, about 280,000 enrollees, or about 9%, are seniors and individuals with developmental disabilities. The remainder is families and their children.

Table 1 shows these enrollment figures by county.

Table 1

Medi-Cal Managed Care Enrollment

As of June 2005

County	Type of Mandate	Date of Mandate	Health Plans	Medi-Cal Enrollment June 2005
Santa Barbara	COHS	9/83	Santa Barbara Regional Health Authority	54,146
San Mateo	COHS	12/87	Health Plan of San Mateo	48,378
Solano	COHS	5/94	Partnership Health Plan	49,141
Orange	COHS	10/95	CalOPTIMA	295,711
Santa Cruz	COHS	1/96	Central Coast Alliance	28,387
Napa	COHS	3/98	Partnership Health Plan	10,045
Monterey	COHS	10/99	Central Coast Alliance	54,142
Yolo	COHS	11/02	Partnership Health Plan	23,375
Sacramento	GMC	4/94	Blue Cross, Health Net, Kaiser, Molina, Western Health Advantage	170,204
San Diego	GMC	7/98	Blue Cross, Community Health Group, Health Net, Kaiser, Sharp, Universal Care, UC San Diego Healthcare	170,016
Alameda	Two-Plan	1/96	Alameda Alliance for Health, Blue Cross	109,172
San Joaquin	Two-Plan	2/96	Health Plan of San Joaquin, Blue Cross	81,986
Kern	Two-Plan	7/96	Kern Health System, Blue Cross	113,850
San Francisco	Two-Plan	7/96	San Francisco Health Plan, Blue Cross	45,596
Riverside	Two-Plan	9/96	Inland Empire Health Plan, Molina Healthcare	154,634
San Bernardino	Two-Plan	9/96	Inland Empire Health Plan, Molina Healthcare	196,034
Santa Clara	Two-Plan	10/96	Santa Clara Valley Health Plan, Blue Cross	104.550
Fresno	Two-Plan	11/96	Health Net, Blue Cross	166,410
Contra Costa	Two-Plan	2/97	Contra Costa Health Plan, Blue Cross	54,103
Stanislaus	Two-Plan	2/97	Blue Cross	31,099
Los Angeles	Two-Plan	4/97	LA Care Health Plan, Health Net	1,221,495
Tulare	Two-Plan	2/99	Health Net, Blue Cross	86,479

(source: DHS)

Populations that would be affected by this Proposal

The DHS has identified 36 Medi-Cal aid codes which they would require to enroll into a managed care plan. Dual eligibles (those enrolled in both Medicare and Medi-Cal) would *not* be included in this mandated group but could be voluntarily enrolled at the individual's option.

Key facts regarding these aid codes:

- The 36 Medi-Cal aid codes have a combined statewide eligible population of 1.6 million.
- Of this total, about 290,000 or 18% are presently enrolled in some form of Medi-Cal Managed Care.
- Based on the Administration's Medi-Cal Managed Care expansion proposal, about 540,000 fee-for-service Medi-Cal eligibles (for these aid codes) would be eligible to be enrolled in a Medi-Cal Managed Care plan. (This also accounts for the factor that 27 counties are slated for the aged, blind and disabled expansion.)
- Among the 36 aid codes constituting this population, the SSI/SSP aid to the disabled code represents 74% of the total eligibles.
- The "aid to the aged who are medically needy" code and the "SSI/SSP aid to the aged" code constitute the next highest eligible populations representing 8% and 4% of the total eligibles respectively.
- Almost half of all the disabled and close to 60 % of the blind populations are Medicare eligible.
- About two-thirds of the aged population in these categories is female.
- Los Angeles County accounts for about 34% of the aged, blind and disabled eligibles.
- San Diego and San Bernardino have about 6.8% and 6.4% of these eligibles.

According to data recently analyzed by the Lewin Group through a project under the management of the California Healthcare Foundation (CHF), Medi-Cal enrollees who are in fee-for-service and are categorically aged, blind or disabled are much more likely to have chronic conditions than all other Medi-Cal aid codes. For example, they note the following:

- At last 45% have pulmonary disease (compared to 20% of other Medi-Cal enrollees).
- 40% have musculo-skeletal concerns (compared to less than 10% of other Medi-Cal enrollees).
- Almost 30% have significant mental health concerns (compared to less than 5% for other Medi-Cal enrollees).
- 25% have hypertension (compared to less than 5% for other Medi-Cal enrollees).

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- 20% have cardiovascular disease (compared to less than 8% for other Medi-Cal enrollees).

The Department of Health Services has provided the following information regarding Medi-Cal expenditures for the aged, blind and disabled population:

- Between 67% and 74% of total Medi-Cal health care expenditures were distributed among 5 vendor codes: (1) Pharmacist, (2) Hospital Inpatient, (3) Nursing Facility, (4) Physician groups, and (5) Physicians.
- Pharmaceutical expenditures represented the greatest cost for the aged, blind and disabled populations. Between 24% and 34% of total expenditures were allocated to pharmaceuticals (i.e., 24% for the blind, 27% for the aged, and 34% for the disabled).
- Hospital inpatient costs were a close second. About 20% to 26% of all expenditures were allocated to hospital inpatient services (i.e., 19% for the blind, 24% for the aged, and 26% for the disabled.

What Has the Legislature Done This Past Year Related to Medi-Cal Managed Care?

In his 2005-06 Budget, the Governor proposed significant changes in the Medi-Cal program. One of the central features of these proposed changes was statewide expansion of Medi-Cal managed care, including the mandatory enrollment of aged, blind and disabled persons.

The Legislature ultimately rejected several parts of the proposal, including mandatory enrollment. However, the final budget agreement did expand Medi-Cal managed care in the following 13 additional counties:

1. El Dorado.
2. Imperial
3. King
4. Lake
5. Madera
6. Marin
7. Mendocino
8. Merced
9. Placer
10. San Benito
11. San Luis Obispo
12. Sonoma
13. Ventura

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The adopted budget for 2005-2006 provided funding to shift 257,000 families and children into managed care in the 13 new counties, and funded the transition of approximately 65,000 seniors and disabled persons into managed care as an expansion of the COHS model in the following counties:

- Lake
- Marin,
- Mendocino
- San Benito,
- San Luis Obispo,
- Sonoma,
- Ventura,

In addition, the Legislature adopted statutory language to require the DHS to meet certain milestones to ensure plan readiness prior to commencing enrollment.

The Legislature did not authorize the Administration to include the remaining 385,096 seniors and disabled persons in managed care. Under current law, seniors and disabled persons can voluntarily enroll in managed care except for those residing in COHS counties. The option of enrolling in managed care by the Aged, Blind and Disabled has been available for several years, but the Aged, Blind and Disabled outside of COHS' have generally not taken advantage of the option to enroll.

Questions for Discussion

1. Please explain why more Aged, Blind and Disabled have not voluntarily enrolled in managed care where that is an option?
2. Why isn't the legislative action taken in the budget sufficient to get the $360 million?

~~and Healthcare Environ~~**Major Issues for Consideration**

~~The Legislature adopted part of the Administration's proposal. The budget for 2005-2006 provided funding for the shifting the 257,000 families and children into managed care in the 13 new counties (Ventura, Sonoma, San Luis Obispo, San Benito, Placer, Merced, Mendocino, Marin, Madera Lake, Imperial, King and El Dorado). The Legislature also provided funding for approximately 65,000 seniors and disabled persons to be included in those counties where the Administration was proposing a County Organized Health Services model of managed care (Ventura, Sonoma, San Luis Obispo, San Benito, Marin, Mendicino and Lake). The Legislature did not authorize the Administration to include the remaining 385,096 seniors and disabled persons in managed care. Under current law, the seniors and disabled persons can voluntarily enroll in managed care and they are mandated to enroll in managed care in County Organized Health System~~

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~~counties. The option of enrolling in managed care by the Aged, Blind and Disabled has been available for several years, but the Aged, Blind and Disabled have not taken advantage of the option to enroll.~~

Readiness

The transition of people from Medi-Cal fee-for-service into managed care requires the exploration of many considerations for individuals with chronic illness and disabilities to ensure that health care delivery through Medi-Cal managed care will improve, rather than compromise, access to high quality health care services.

Aged, blind and disabled individuals require more extensive specialty medical care services, personalized durable medical equipment, and rehabilitation therapists who have experience with serving these medically involved individuals. As such, issues pertaining to physician networks, access to durable medical equipment and related needs will need to be comprehensively addressed prior to any transition for these individuals.

To that end, and given its approval of managed care expansion into 13 additional counties, the Legislature required the Department of Health Services in the 2005-06 trailer bill to perform an evaluation of the readiness of Medi-Cal Managed Care Plans prior to commencement of operations. The evaluation must include, at a minimum, all of the following:

- The extent to which the Medi-Cal managed care plan demonstrates the ability to provide reliable service utilization and cost data;
- The extent to which the Medi-Cal managed care plan has an adequate provider network;
- The extent to which the Medi-Cal managed care plan has to demonstrate the ability to meet accessibility criteria, including applicable time and distance standards for enrollees;
- The extent to which the Medi-Cal managed care plan has developed procedures for the monitoring and improvement of quality of care;
- The extent to which the Medi-Cal managed care plan has met all standards and guidelines established by the department that demonstrates readiness to provide services to enrollees;
- The extent to which the Medi-Cal managed care plan has submitted all required contract deliverables to the department
    - Deliverables are a written policy, procedure or other document the health plan submits to the Department of Health Services for demonstration of understanding and ability to comply with program requirements. Deliverables are submitted under the following categories:
        - ✓ Organization and Administration;

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- ✓ Financial Information;
- ✓ Management Information System;
- ✓ Quality Improvement System;
- ✓ Utilization Management;
- ✓ Provider Network;
- ✓ Provider Relations;
- ✓ Provider Compensation Arrangements;
- ✓ Access and Availability
- ✓ Scope of Services;
- ✓ Case Management and Coordination of Care;
- ✓ Local Health Department Coordination; Member Services;
- ✓ Member Services;
- ✓ Member Grievance System; Marketing; and
- ✓ Enrollments and Disenrollments.

- The extent to which the Medi-Cal managed care plan's Evidence of Coverage and/or Member Services Guide conforms to federal and State statutes and regulations, is accurate, and easily understood; and
- The extent to which the Medi-Cal managed care health plan's primary care and facility sites have been reviewed and evaluated.

Questions to consider:

1. Can the Department discuss its plan readiness and performance standards?
2. Does the Department have a realistic timeline for this proposal? And does it believe it can meet the timeline imposed by CMS?
3. What are the stakeholder concerns with regards to readiness issues?
4. What will be the process for incorporating stakeholder concerns and suggestions?
5. Can the health plans please discuss their plan for readiness and network capacity?
6. What are the lessons learned from the initial process for moving individuals into managed care in the 90's? What problems were identified, and how can those problems be avoided in the future?

Quality

Given the significant health concerns and high utilization rates of this medically needy population, provider quality and continuity of care issues are of significant concern.

How Does the Department Currently Measure Quality in Managed Care?

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To evaluate the performance of the managed care plans with which it contracts, the Department of Health services introduced an annual quality measurement program using nationally recognized health care measures. The Health Plan Employer Data and Information Set (HEDIS) is the set of performance measures recognized as industry standard to compare and measure health plan performance. HEDIS was developed and is maintained by the National Committee for Quality Assurance (NCQA).

DHS has contracted with Health Services Advisory Group as the External Quality Review Organization (EQRO), to objectively analyze Medi-Cal managed care plan HEDIS results and evaluate current performance levels relative to national benchmarks. The Department of Health Services utilizes seven HEDIS measures from the standard Medicaid set as the External Accountability Set for evaluating performance of the Medi-Cal managed care plans. They include:

- Childhood Immunization Status, Combinations 1 and 2;
- Well-Child visits in the first 15 months of life;
- Well-Child visits in the third, fourth, fifth and sixth year of life (Non-COHS Plans only);
- Adolescent Well-Care Visits;
- Prenatal and Postpartum Care
- Eye exams for people with Diabetes (COHS only).

Medi-Cal managed care predominately serves women and children, and thus HEDIS measures focus on these populations. County Organized Health Systems, however, also serve the aged, blind, and disabled in managed care, and two measures address issues relevant to those populations. The measurement, eye exams for people with diabetes, is reported only by County Organized Health Systems in place of the measurement, well-child visits in the third, fourth, fifth, and sixth year of life. If Medi-Cal managed care is expanded to the aged, blind, and disabled, additional HEDIS measures would need to be collected to monitor how the health plans are serving this population.

Performance levels have been established for all of the measures in the DHS External Accountability Set. The performance levels have been set specific rates and are based on national bench marks. The Health Services Advisory Group categorized the DHS External Accountability Set of measures by three dimensions of care: Pediatric Care, Women's Care and Living with Illness.

Quality Strategy

In May 2004, the Department of Health Services released a Quality Strategy for the Medi-Cal Managed Care Division. The purpose of developing a Medi-Cal Managed Care Quality Strategy was to define a framework for health care quality improvement for the Department of Health Services and its managed care partners. The strategy involved input from contracted managed care plans,

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advocacy organizations and staff from the Department. The goals of the Department's Quality Strategy are:

- Increase and maintain accountability for the quality of care;
- Improve the quality of care for Medi-Cal enrollees;
  - ✓ Develop and implement mechanisms to increase collaboration for quality;
  - ✓ Work with plans to initiate quality improvement projects, which specifically seek to implement the "Care Model" at the practice level;
  - ✓ Develop an implement financial and non-financial incentives for quality;
  - ✓ Improve monitoring of plan Quality Improvement projects;
  - ✓ Develop a partnership with stakeholders to improve the quality of care;
- Develop and Implement programs to reduce health disparities;
- Continually improve performance in order to fulfill the Department's commitment to improving the quality of care for Medi-Cal Managed Care enrollees;

The Quality Strategy provides a "road-map" for the Medi-Cal Managed Care Division, outlining key strategies available to the Department of Health Services to work toward improved quality of care for managed care enrollees. One of these strategies is to increase accountability for the quality of care, through monitoring and measuring quality of care. HEDIS performance measures are key tools for measuring the quality of care. The Quality Strategy includes suggestions for expanding measurement - both through use of other tools, and through the use of additional HEDIS measures (e.g. rotation of HEDIS measures).

Questions to Consider:

1. What does the HEDIS data indicate about the level of quality found in the Medi-Cal Managed Care plans?
2. What additional HEDIS data does the department intend to collect to measure the aged, blind, disabled population?
3. Can the department please discuss the performance measures it intends to implement?
4. How much of the Quality Strategy has the Department implemented?
5. Can the CA Healthcare Foundation discuss its current project on quality measures?

Impact on Safety Net

Hospitals, clinics and health care providers make up the health care safety net. These are the providers that serve predominately Medi-Cal and uninsured patients. The aged, blind and disabled population accounts for 50% of public hospitals' inpatient revenue. One of the results of a major shift into managed care is that many of the new managed care enrollees may no longer be treated at public hospitals, and thus an even greater percentage of patients treated at

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public hospitals would be the uninsured. The public hospitals, while benefiting from the $360 million in additional safety net care pool funds that would be available if mandatory enrollment was enacted, may end up with overall less net revenue due to the decline in aged, blind and disabled inpatient revenue. Public hospitals make up 6% of California hospitals, yet provide more than half the hospital care to the state's 6.5 million uninsured.

Given their precarious financial situation, a significant decline in revenue makes it more difficult for safety net providers to offer a broad spectrum of services to a large and varied population. If done incorrectly, a mandatory expansion of managed care to the aged, blind and disabled could exacerbate this situation. If depleted, public hospitals would be weakened and unable to fulfill their essential role in the state's health care system. The impact of shifting 500,000 patients into managed care would not be limited to the aged blind and disabled, but also could affect access to health care for 13 million uninsured and Medi-Cal patients in California, who rely on the safety net.

Questions for Consideration:

1. What is the impact of this proposal on the safety net?
2. How will the department reduce the harm to public hospitals and other safety net providers that might result with this proposal?
3. How might mandatory enrollment disrupt important patient provider relationships?

Medi-Cal Managed Care Capitation Rates

An issue of some concern is the financial ability to meet the medical needs of the Medi-Cal Aged, Blind and Disabled patients under a managed care system. The rate setting process continues to lack accurate information about the cost and utilization of health services provided by the Medi-Cal managed care plans. As a result, several of the Medi-Cal managed care plans have experienced significant financial instability. For example, in the 2004-05 budget, five COHS were given a 3% rate increase to stave off financial insolvency. In the 2005-06 Budget, the Legislature provided four plans additional rate increases, two of which were vetoed by the Governor.

In its January proposal, the Administration assumed 5% net savings as a result of mandatory enrollment into managed care. There has been a significant amount of concern that given the financial difficulties currently experienced by Medi-Cal managed care plans, access to services, appropriate care and stability for this medically fragile population could be threatened.

Questions for Consideration:

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1. How does the department plan on a financially sustainable system of rate setting, given the current financial difficulties being experienced by Medi-Cal managed care plans?
2. Can the current Medi-Cal managed care plans discuss their experience with the rate setting process?
3. Can the health plans discuss their ability to provide a quality product based on current rates?

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