LHPC
Local Health Plans of California

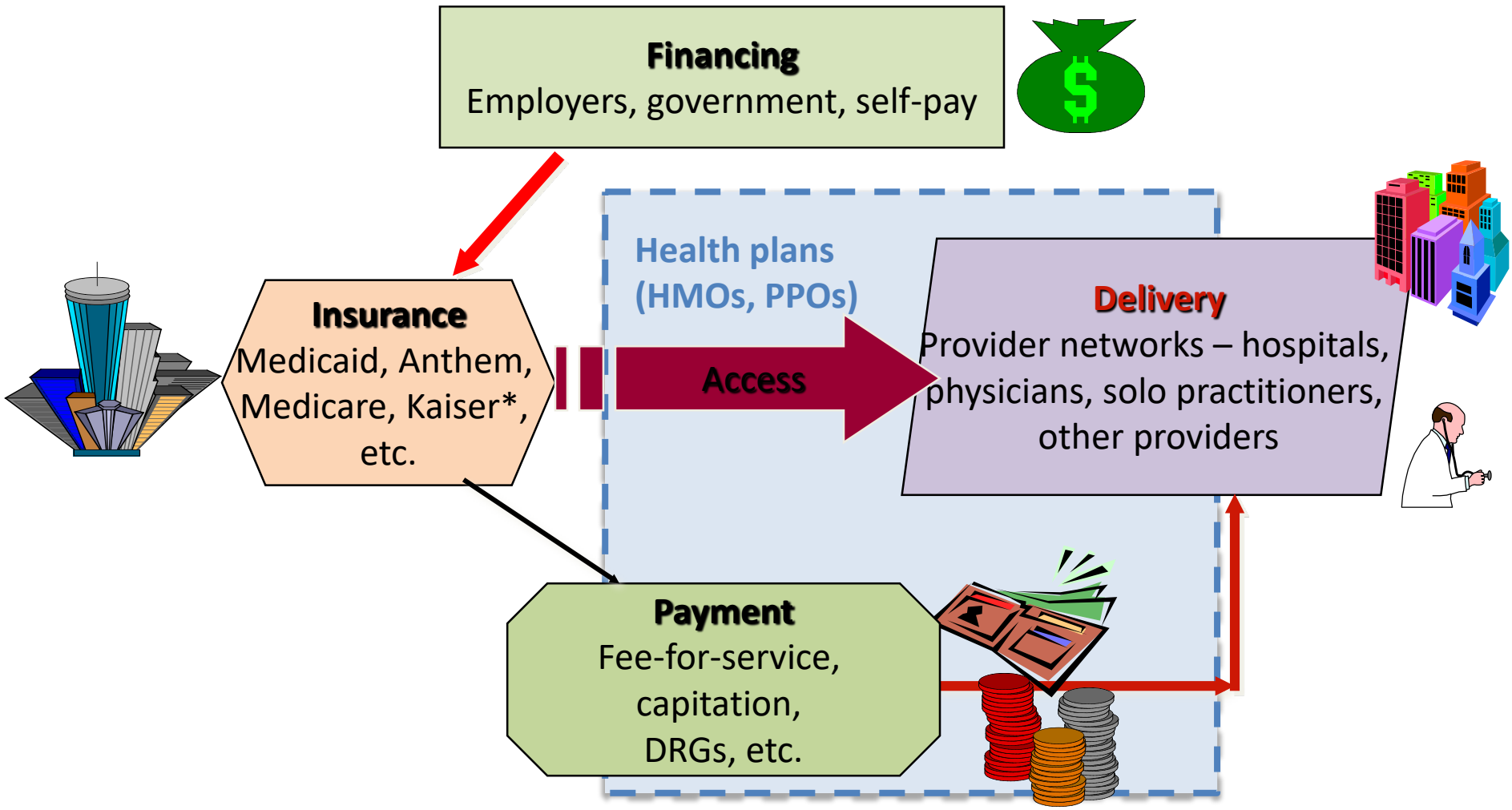
Alameda Alliance for Health
CalOptima
CalViva Health
CenCal Health
Central CA Alliance for Health
Community Health Group
Contra Costa Health Plan
Gold Coast Health Plan
Health Plan of San Joaquin
Health Plan of San Mateo
Inland Empire Health Plan
Kern Health Systems
L.A. Care Health Plan
Partnership HealthPlan of CA
San Francisco Health Plan
Santa Clara Family Health Plan

Medi-Cal Managed Care 101

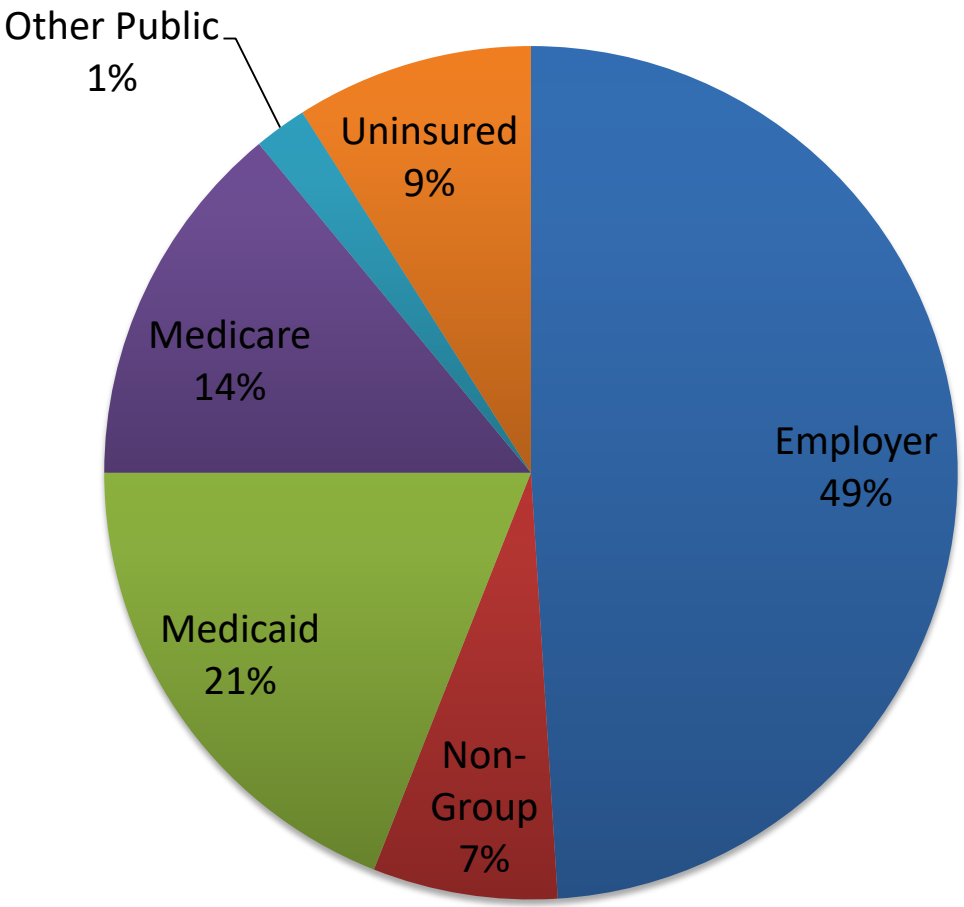
Len Finocchio

WHAT IS MEDI-CAL?

Health Care System Functions



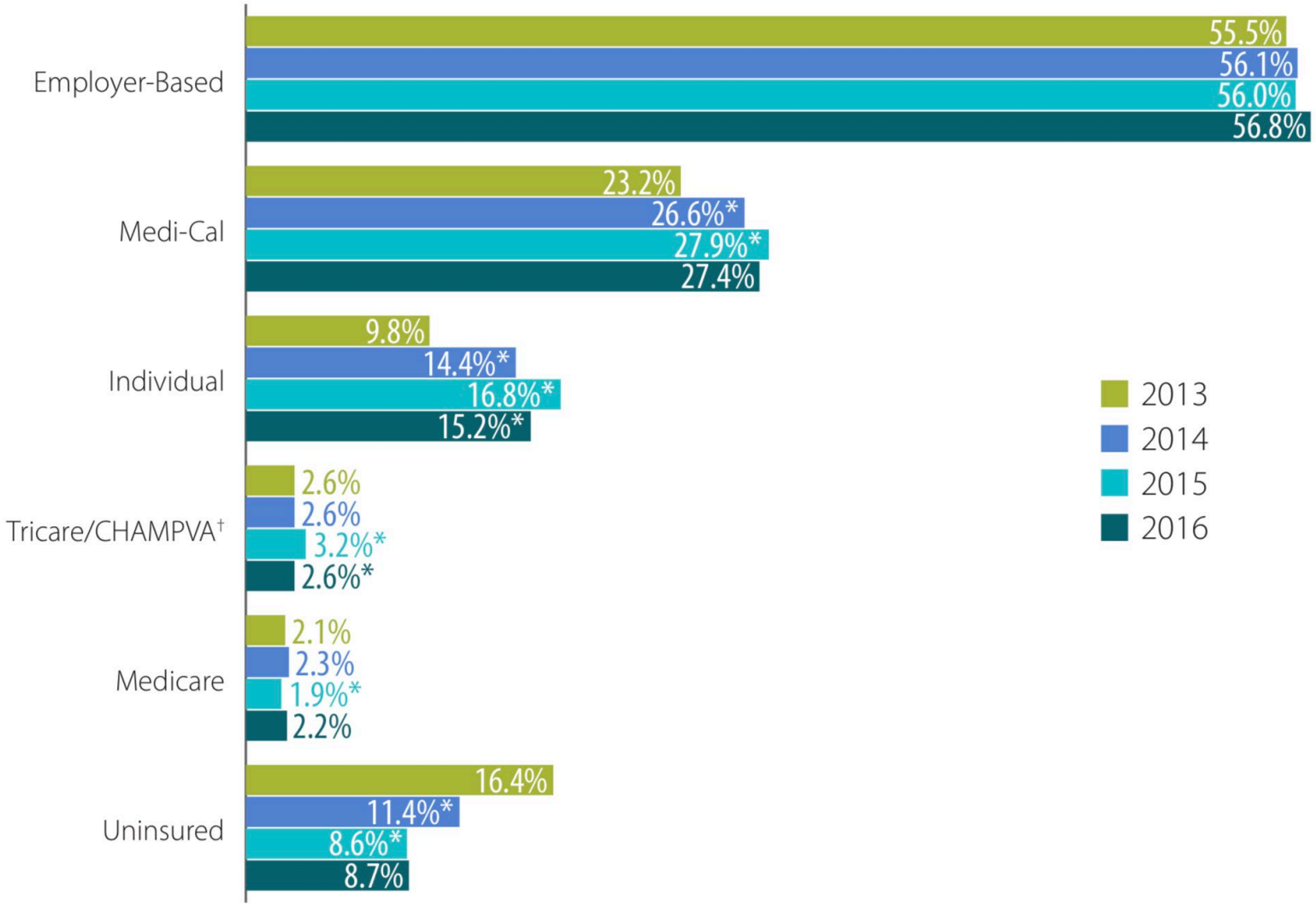
Insurance Coverage
United States, 2017



Source – Kaiser Family Foundation. Health Insurance Coverage of the Total Population. 2017

Health Insurance Coverage

California, 2013-16



Source: California HealthCare Foundation. *California's Uninsured: Progress Toward Universal Coverage.* August 2018.

What is Medicaid?

- Federal-state national public insurance program covering all entitled/eligible low-income persons
- States design/administer programs following federal rules
- Federal government finances 50% of spending, and more for expansion population and in poor states
- States have flexibility to determine benefits, care delivery models, payment methods and covered groups:
  - Infants & children
  - Pregnant women
  - Parents and non-elderly adults
  - Persons with disabilities
  - Very low-income seniors on Medicare

Source: Kaiser Family Foundation. Medicaid Pocket Primer. June 2017

Medicaid & Medicare

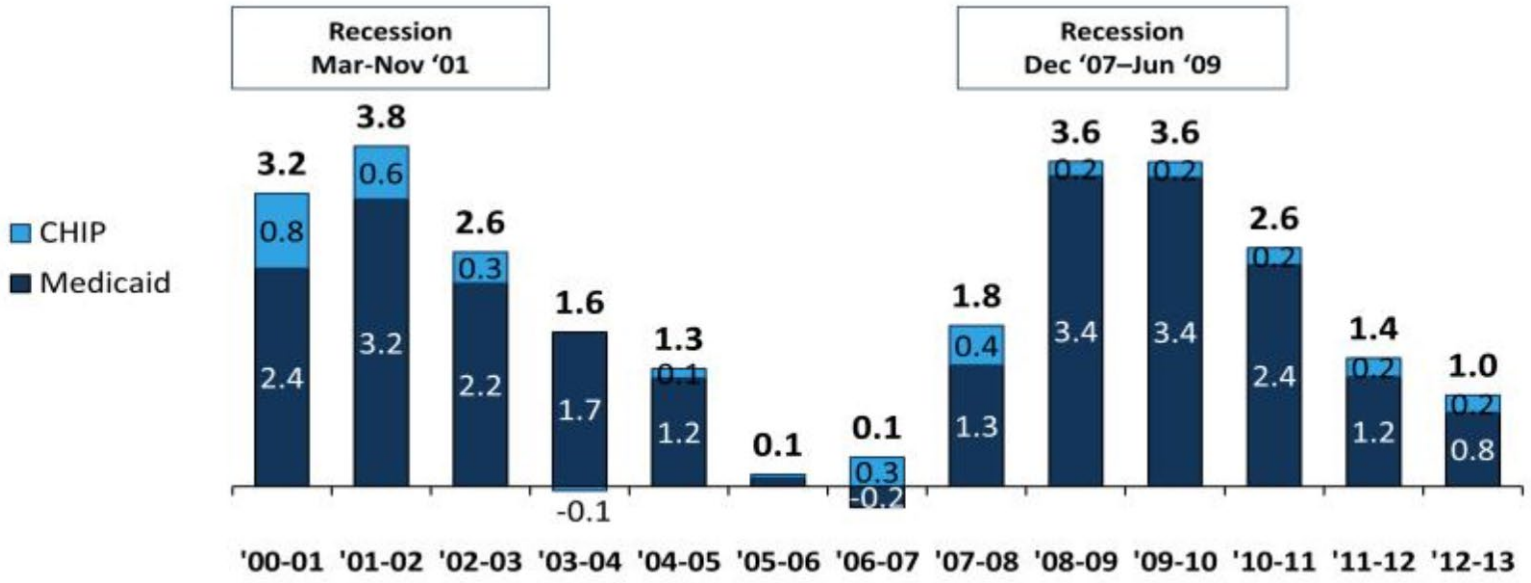
	Medicaid	Medicare
Population	• Low-income families, adults and children • People with disabilities • Pregnant women • Seniors (65+)	• Seniors (65+) • People with permanent disabilities
Enrollment	73 million nationally California – 13.1 million	60 million nationally California – 6.1 million
Services Covered	Primary care, specialty, acute, mental health, long-term care	Primary care, specialty, acute
Cost-sharing	No premiums or co-pays for lowest income beneficiaries	Beneficiaries pay premiums and deductibles
Financing	Federal and state governments	Federal government and beneficiaries
Administration	State government with federal oversight by CMS	Federal government with oversight by CMS

Medicaid Fast Facts

71.8 million	People in the United States with Medicaid coverage.
$476 billion	State and federal Medicaid spending for FY 2014.
1.8 million	Births in the United States covered by Medicaid yearly (about 40% of all U.S. births).
1 in 3	Children in the United States covered by Medicaid.
58%	Medicaid beneficiaries under 65 who are from diverse racial/ethnic groups.
5%	Medicaid beneficiaries, many with chronic illnesses and disabilities, accounting for 53% of total Medicaid spending.
49%	Medicaid beneficiaries with disabilities diagnosed with mental illness.
40%	Total long-term care costs in the United States financed by Medicaid.
34%	Percentage of Medicaid dollars spent on Medicare-Medicaid enrollees.
74%	Medicaid recipients who are enrolled in managed care.

Medicaid and the Economy

Annual Change in Medicaid and CHIP Enrollment, June 2000 – 2013 (in Millions)



Total Enrollment	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Medicaid	34.2	37.4	39.6	41.3	42.5	42.6	42.4	43.7	47.1	50.5	53.0	54.2	55.0
CHIP	3.1	3.6	4	3.9	4	4.1	4.4	4.8	5	5.2	5.3	5.5	5.7

SOURCE: *Medicaid Enrollment: June 2013 Data Snapshot*, Kaiser Commission on Medicaid and the Uninsured, January 2014. *CHIP Enrollment: June 2013 Data Snapshot*, Kaiser Commission on Medicaid and the Uninsured, January 2014.

THE HENRY J. KAISER FAMILY FOUNDATION

Medi-Cal Overview

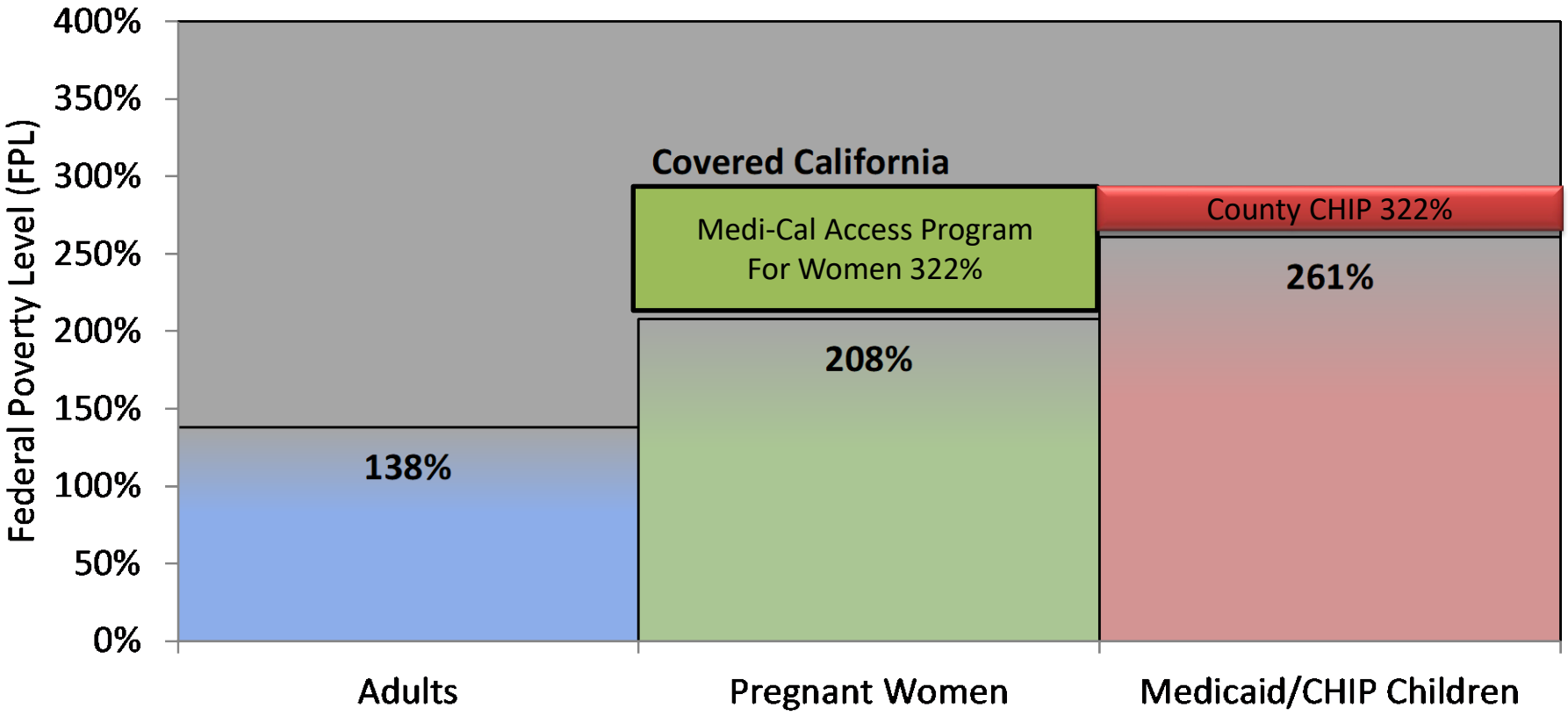
	Medi-Cal
Mission	Free or low-cost health coverage for adults and children with limited income and resources
Population	• Low-income families, adults and children • People with disabilities • Pregnant women • Seniors (65+)
Enrollment	13.1 million
Services Covered	Primary care, specialty, acute/hospital, mental health, substance use disorders, dental, vision, long-term care, pharmacy
Cost-Sharing	No premiums or co-pays for lowest income beneficiaries
Financing	Federal and California governments
Administration	State government with federal oversight by CMS State – California Health & Human Services Agency and Department of Health Care Services

Benefits and Populations Served

Low-Income Families	**Pregnant Women**: Prenatal care and delivery costs 280% FPL **Children:** Routine and specialized care for childhood development (immunizations, dental, vision, speech therapy) **Families:** Affordable coverage to prepare for the unexpected medical, emergency dental, hospitalizations, antibiotics)
Individuals with Disabilities	**Mental Illness:** Prescription drugs, physician services **Physical Disabilities:** Community-based and personal care; assistance to gain independence (personal care, case management and assistive technology) **HIV/AIDS:** Physician services, prescription drugs
Elderly Individuals	**Medicare Beneficiary:** Medicare premiums and cost sharing **Home and Community Waiver Participant:** Community based, alternative care and personal care **Nursing Home Resident:** Care paid by Medicaid since Medicare does not cover institutional care

Income Eligibility Limits

Medi-Cal & Covered California



Source: Manatt Health. Medi-Cal Landscape Assessment. California HealthCare Foundation. June 2016

Federal Poverty Levels, 2019

	Percent	100%	138%	213%	266%	322%	400%
Household size	**1**	$12,140	$16,754	$25,859	$32,293	$39,091	$48,560
	2	$16,460	$22.715	$35,060	$43,784	$53,002	$65,840
	3	$20,780	$28,677	$44,262	$55,275	$66,912	$83,120
	4	$25,100	$34,638	$53,463	$66,766	$80,822	$100,400

Source: Covered California. PROGRAM ELIGIBILITY BY FEDERAL POVERTY LEVEL. PLAN YEAR 2018.

Medi-Cal's Crucial Role

The number of Californians covered by Medi-Cal coverage has increased 63% under the Affordable Care Act.

Medi-Cal serves Californians at all stages of life — and with many types of health care needs, from those living with a disability to veterans to working adults without employer coverage.

Source: Department of Health Care Services, 2017.

What Share of California is Covered by Medi-Cal?

Medi-Cal Covers Nearly 13.5 Million Californians

Nearly **1 in 3**

Californians have Medi-Cal coverage

Source: Department of Health Care Services, 2017; California Health Interview Survey, 2015.

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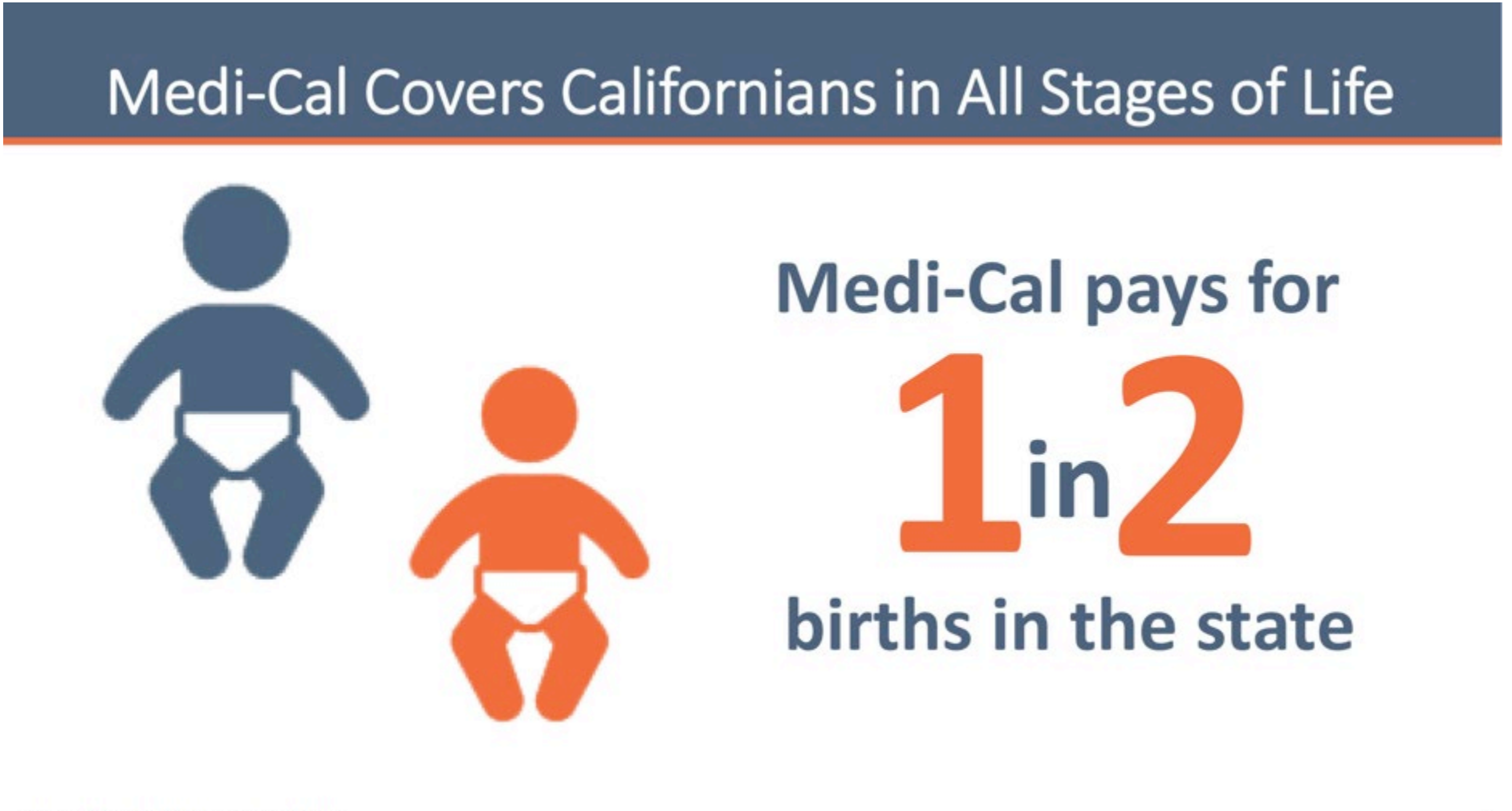
California HealthCare Foundation: Medi-Cal Matters. September 2017

How Many Births Covered by Medi-Cal?



Medi-Cal Coverage of Children?

Medi-Cal Covers Californians in All Stages of Life

Medi-Cal covers nearly 49% of kids age 0 to 11

Kids with Medicaid:*

Miss fewer school days because they're sick or injured

Are more likely to finish high school & graduate college

Are less likely to have high blood pressure, ER visits, or hospitalizations as adults

Earn more & pay more taxes as adults

Source: California Health Interview Survey, 2015. *Compared to children without health insurance. See source page for detailed citations.

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California HealthCare Foundation: Medi-Cal Matters. September 2017

Medi-Cal Coverage of the Elderly?

Medi-Cal Covers Californians in All Stages of Life

Medi-Cal covers more than 1 in 5 Californians age 65+

Source: California Health Interview Survey, 2015.

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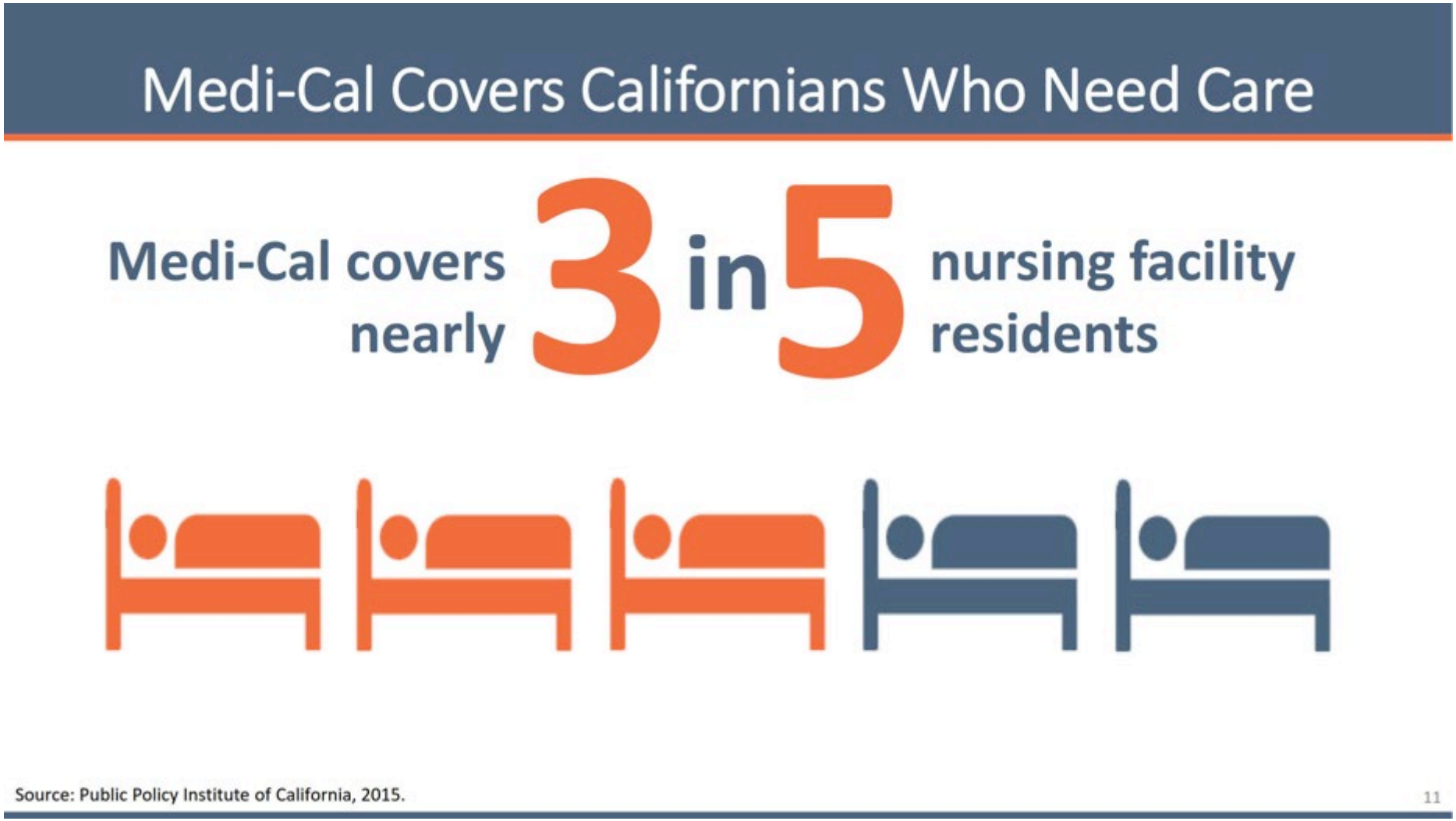
California HealthCare Foundation: Medi-Cal Matters. September 2017

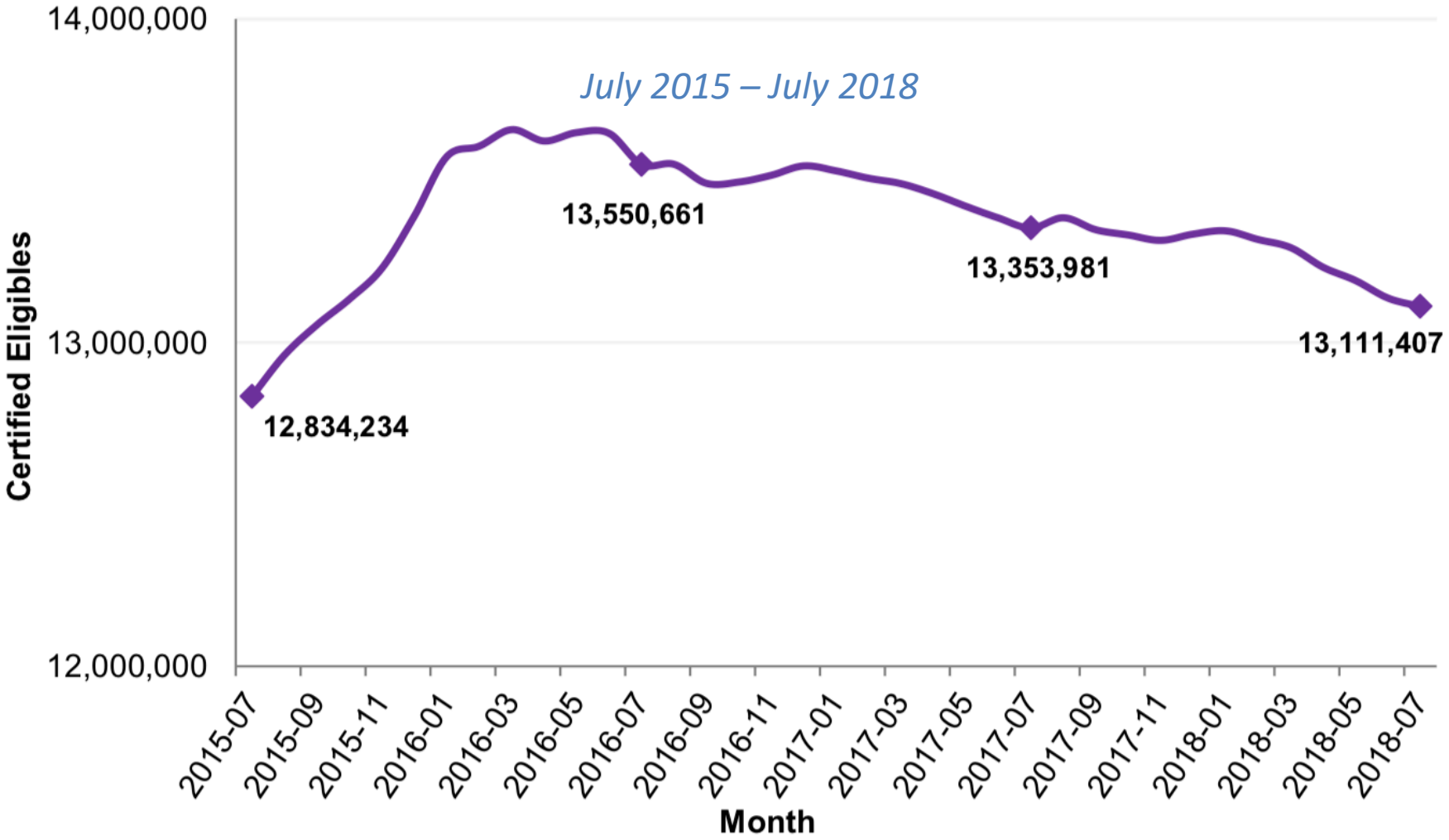
Medi-Cal Coverage of Persons with Disabilities?

Medi-Cal Coverage of Nursing Facility Residents?



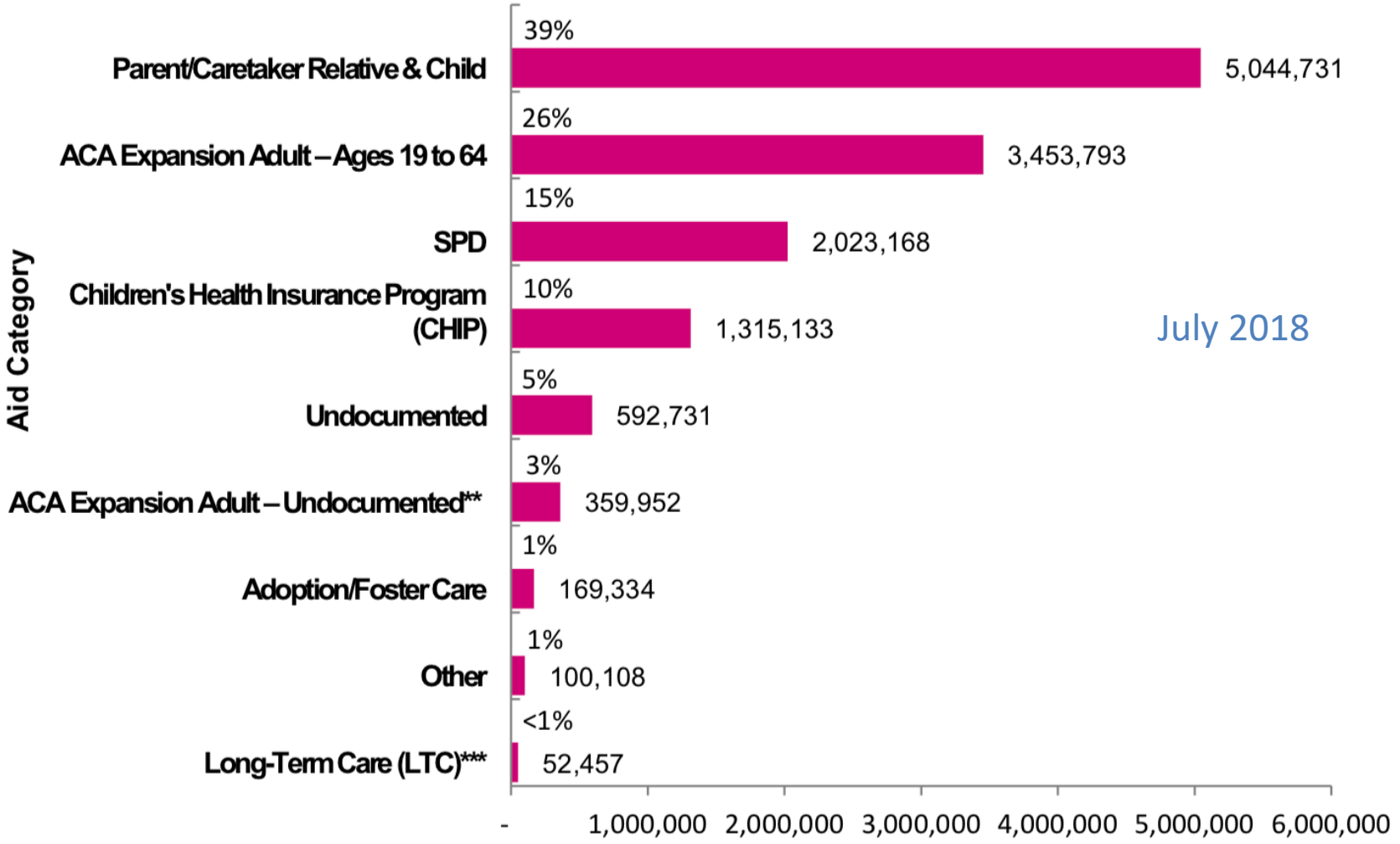
California HealthCare Foundation: Medi-Cal Matters. September 2017

Medi-Cal Enrollment



Source: Research and Analytic Studies Division. *Medi-Cal Monthly Enrollment Fast Facts, July 2018*. California Department of Health Care Services. July 2018.

Eligibles by Aid Category

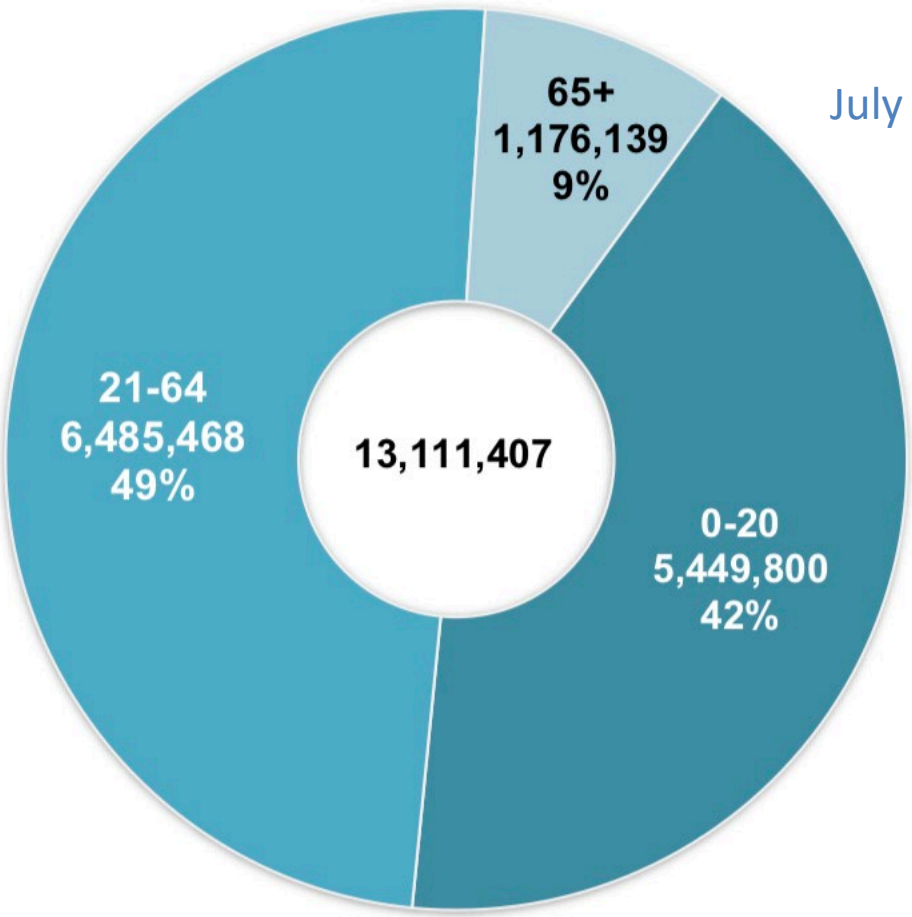


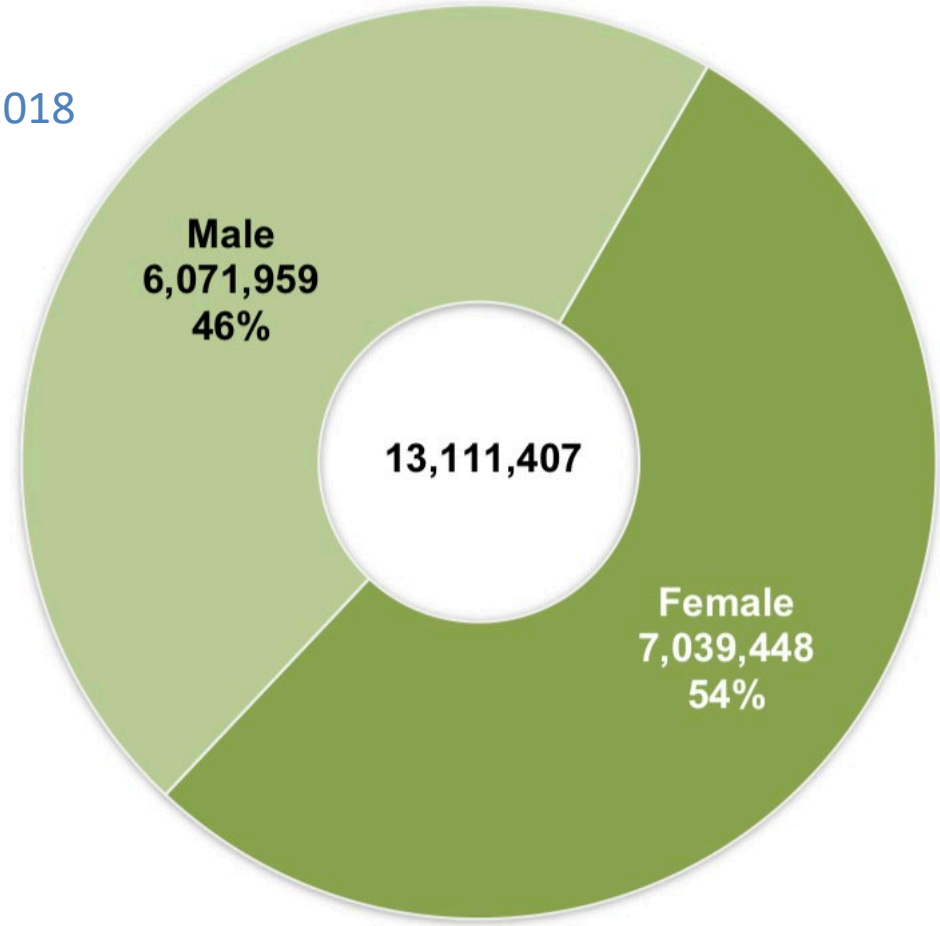
Source: Research and Analytic Studies Division. *Medi-Cal Monthly Enrollment Fast Facts, July 2018*. California Department of Health Care Services. July 2018.

Medi-Cal Beneficiaries

Gender and Age

July 2018



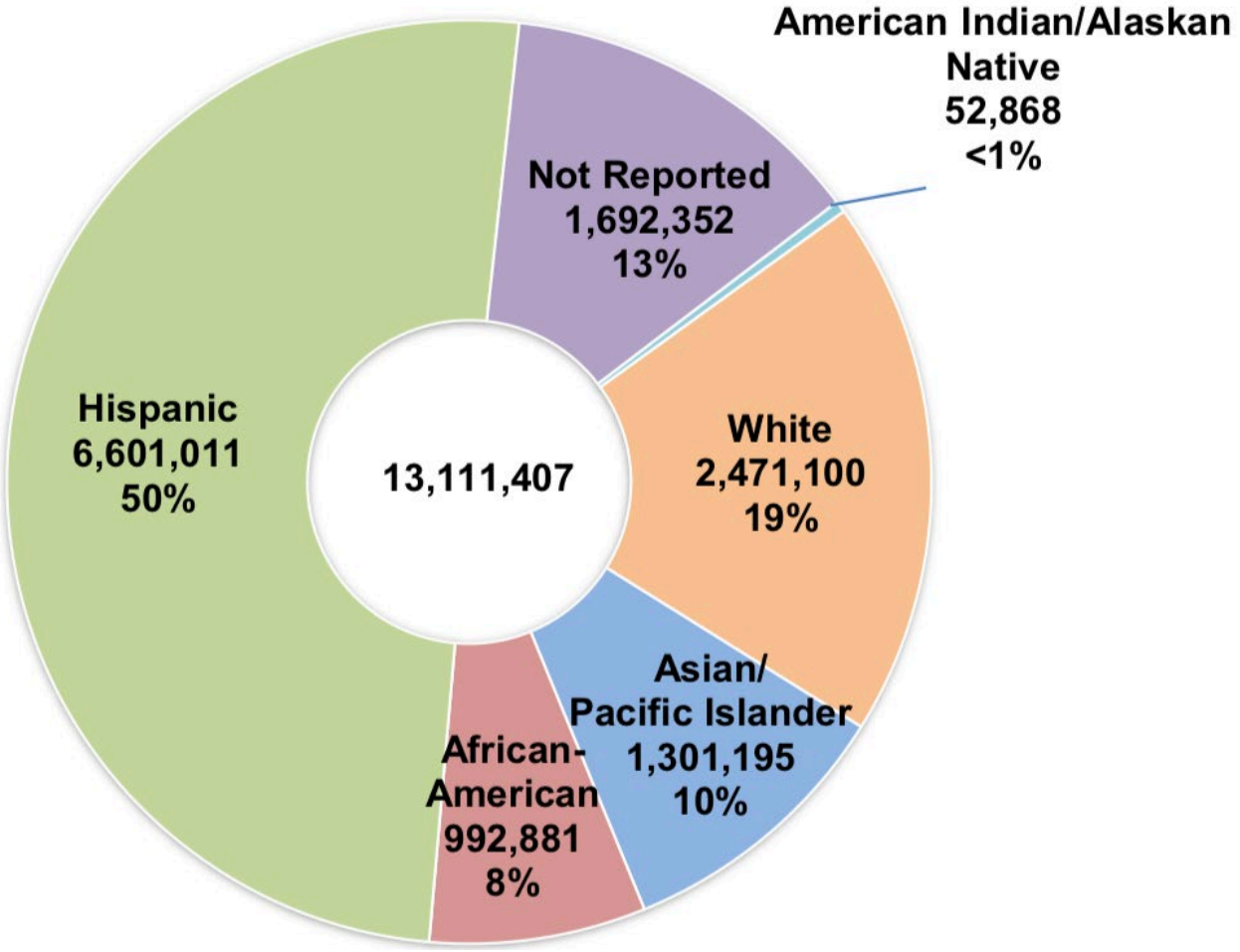


Source: Research and Analytic Studies Division. *Medi-Cal Monthly Enrollment Fast Facts, July 2018*. California Department of Health Care Services. July 2018.

Medi-Cal Beneficiaries

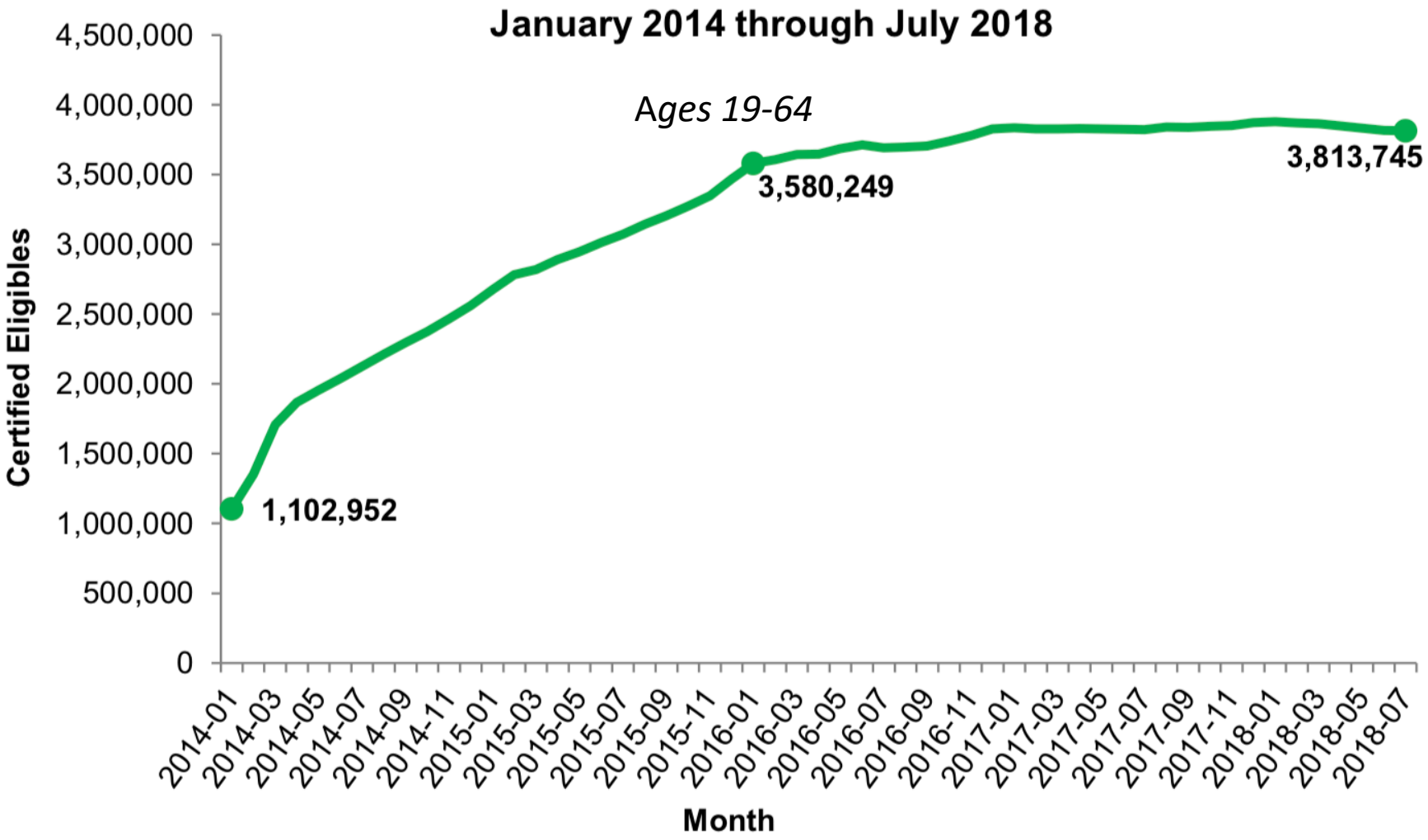
Race/Ethnicity

July 2018



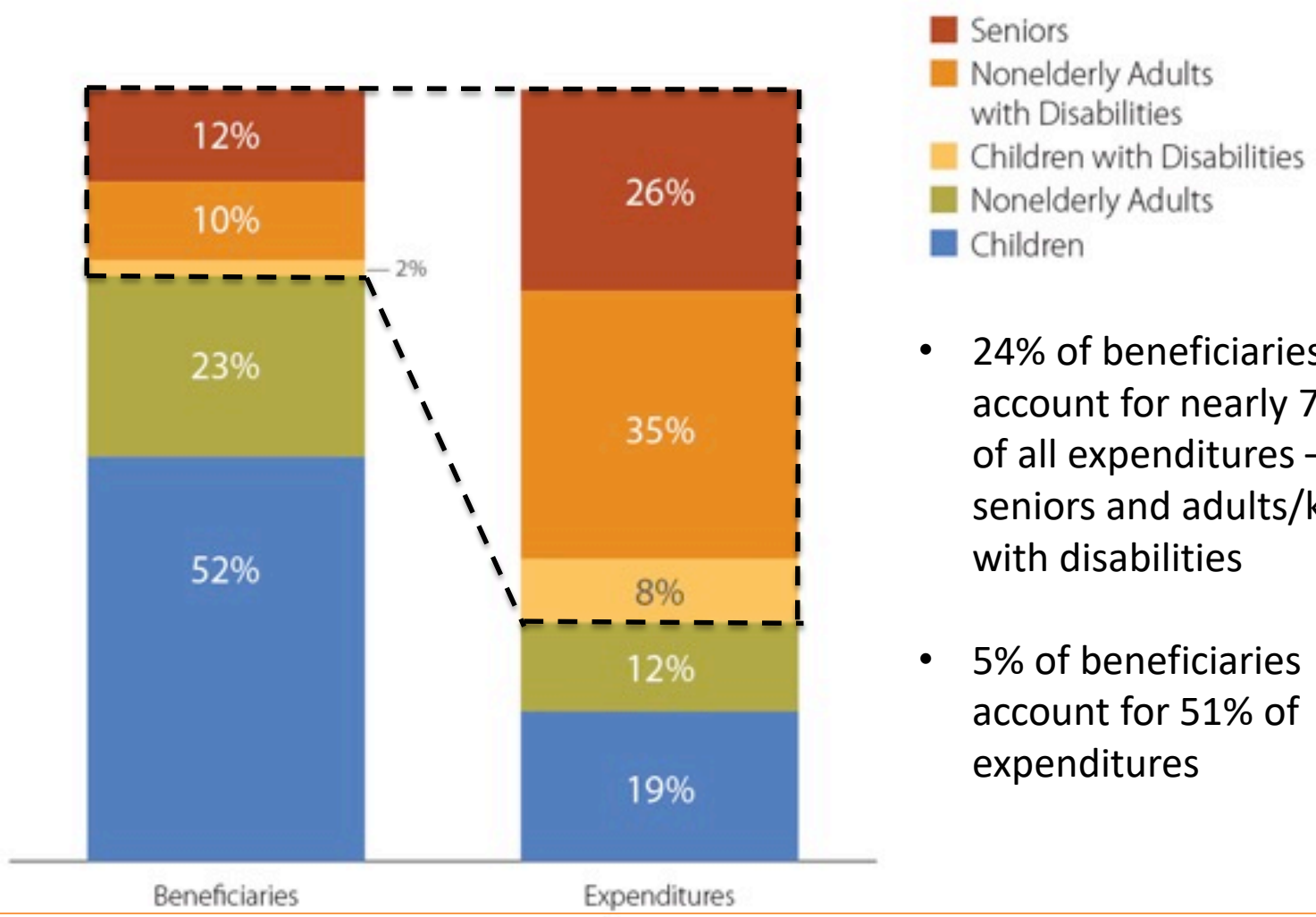
Source: Research and Analytic Studies Division. *Medi-Cal Monthly Enrollment Fast Facts, July 2018*. California Department of Health Care Services. July 2018.

ACA Medi-Cal Expansion Population



Source: Research and Analytic Studies Division. *Medi-Cal Monthly Enrollment Fast Facts, May 2017*. California Department of Health Care Services. May 2017

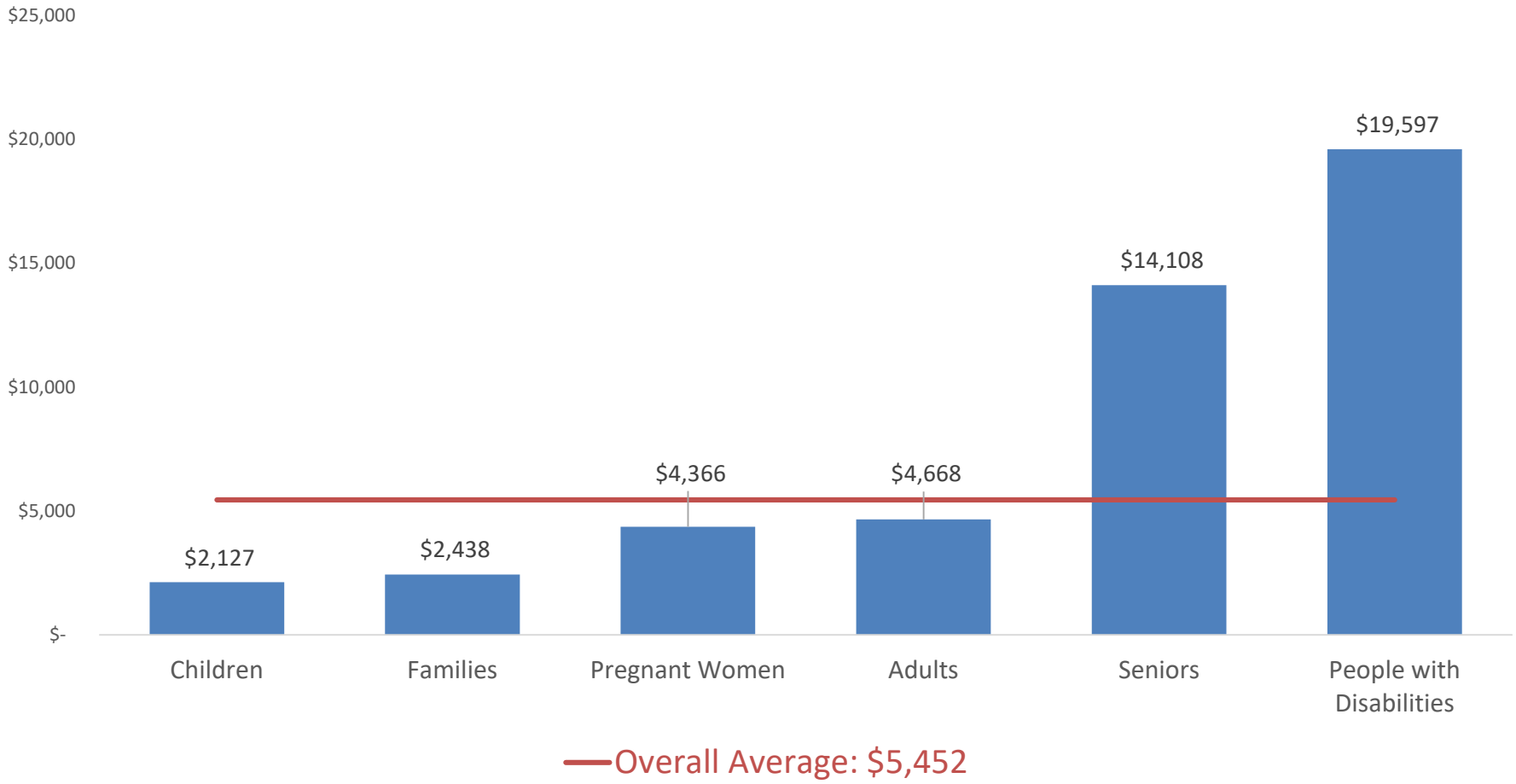
Spending by Enrollee Group, 2011



- 24% of beneficiaries account for nearly 70% of all expenditures – seniors and adults/kids with disabilities
- 5% of beneficiaries account for 51% of expenditures

Source: California HealthCare Foundation. Medi-Cal Facts & Figures: A Program Transitions. May 2013

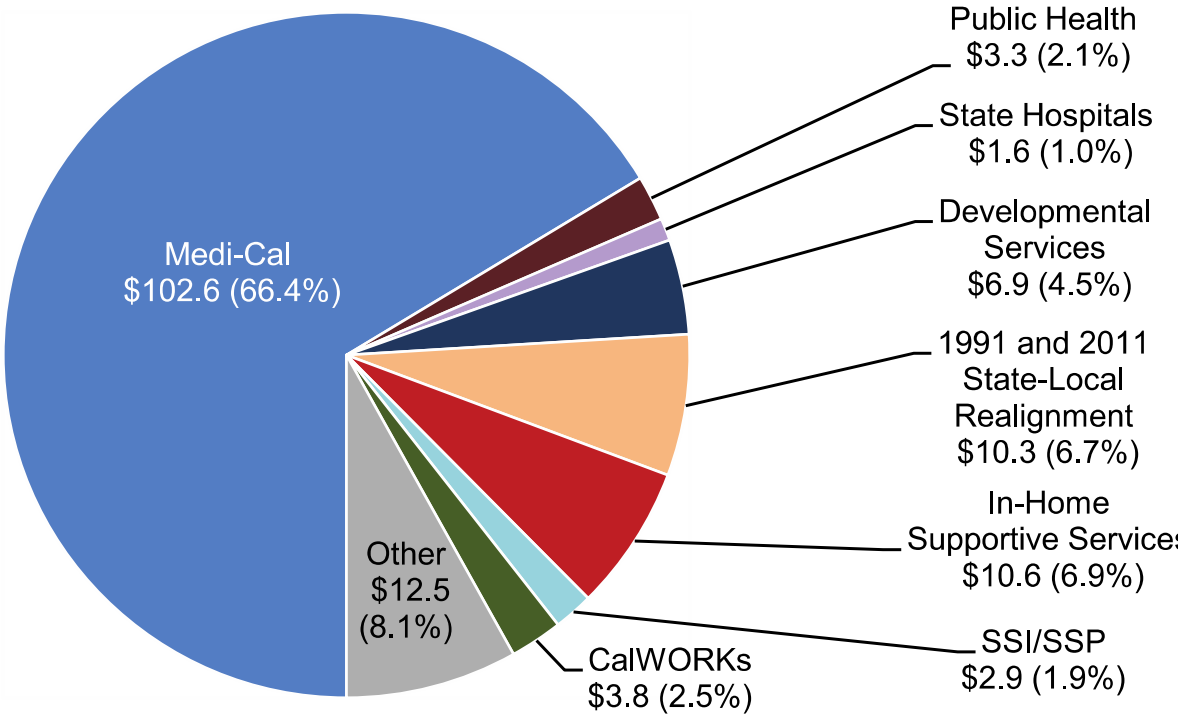
Spending by Enrollee Group, FY 2017-18

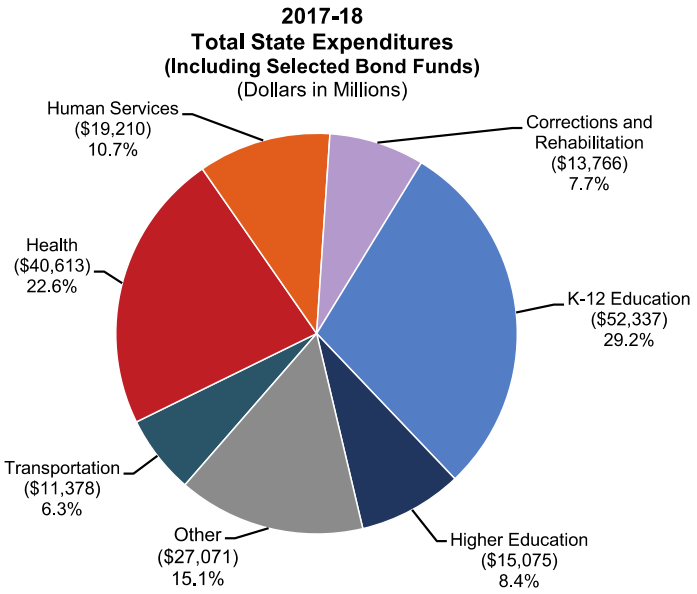


Source: Medi-Cal Estimate, Cost per Eligible, FY 2017-18

California Budget Expenditures

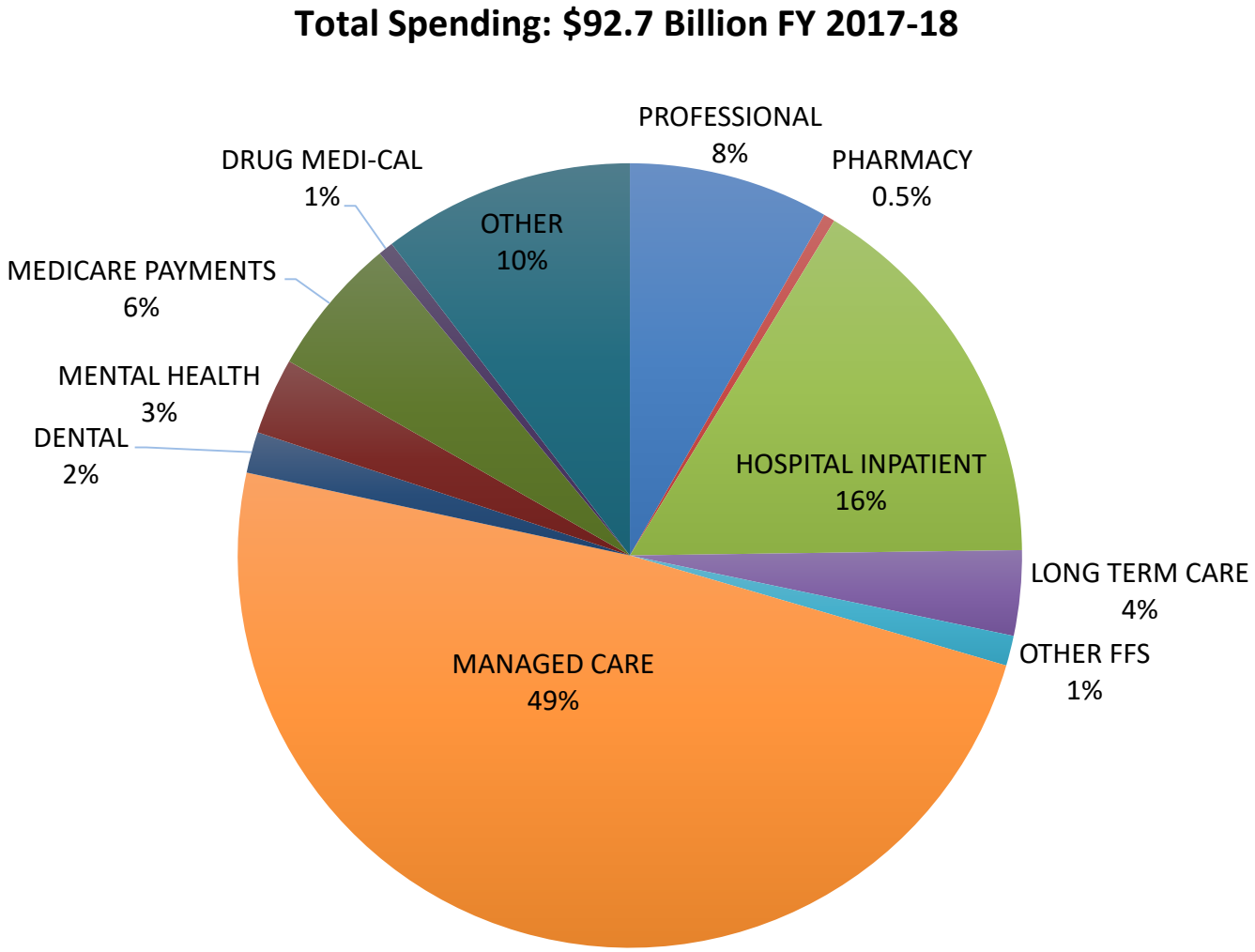
Health and Human Services Proposed 2017-18 Funding[1/]
All Funds
(Dollars in Billions)





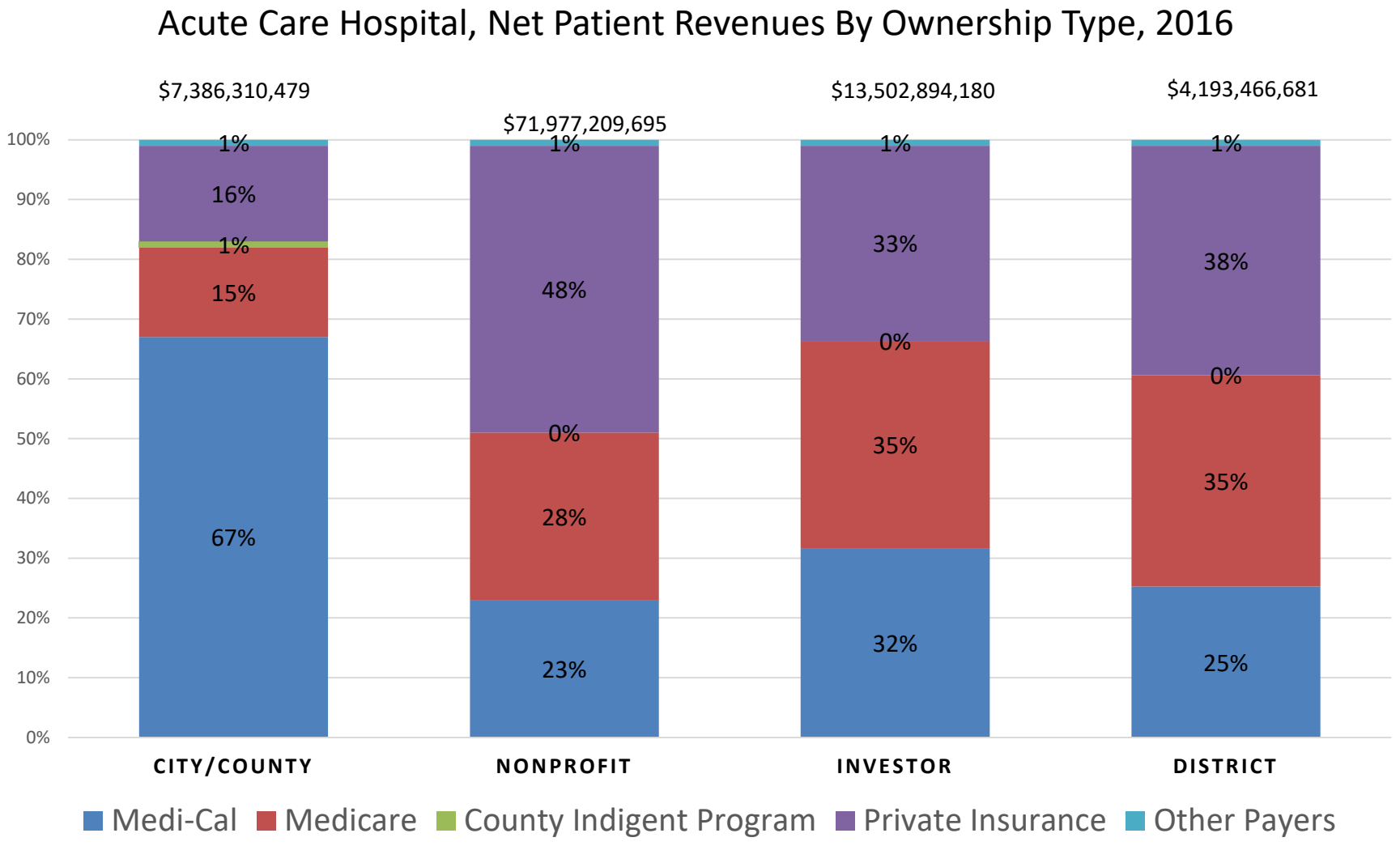
Source: California Governor's Budget Summary 2017 – 2018.

Expenditures by Service Category



Source: Medi-Cal Estimate, Expenditures by Service Category, FY 2017-18

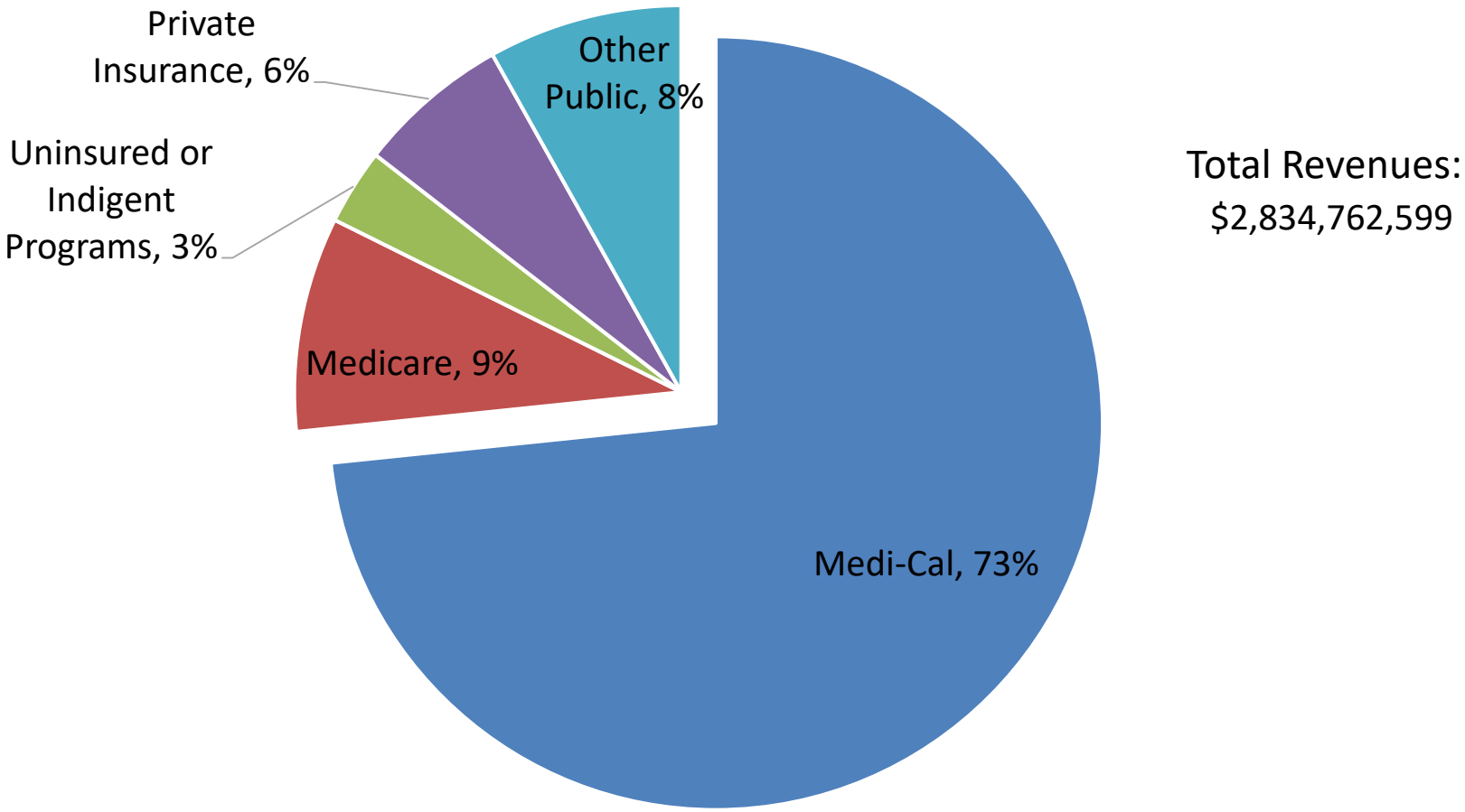
Safety Net Provider Revenues



Source: OSHPD, Hospital Financials Pivot Tables

Safety Net Provider Revenues

Primary Care Community Clinics, Net Patient Revenues By Payer, 2016



Source: OSHPD, Primary Care and Specialty Clinics Annual Utilization Data

Questions?

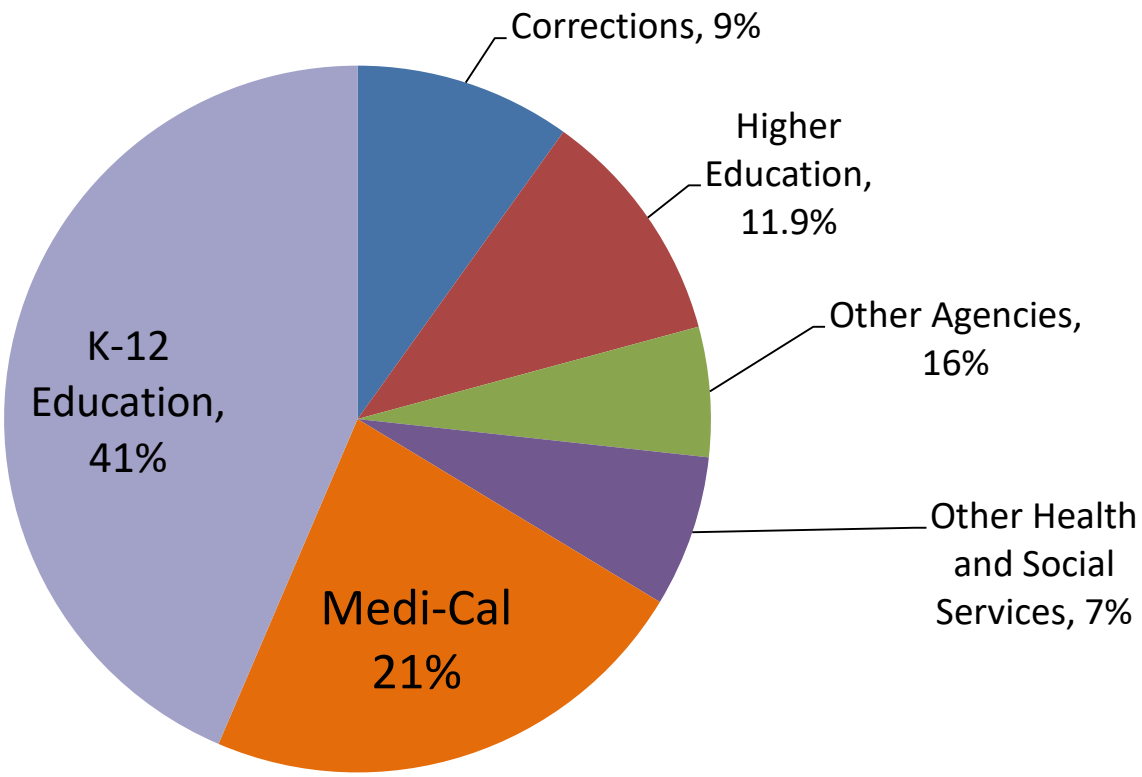
Jane Ogle

MEDI-CAL MANAGED CARE MODELS

Medi-Cal at a Glance

- California's Medicaid Program – Medi-Cal
- Key statistics:
  - Largest Medicaid program in the country by enrollees
  - 2nd largest Medicaid program in the country by expenditures
  - 2nd largest share of the state's general fund

Medi-Cal at a Glance — % of Budget



Medi-Cal at a Glance

Source of coverage for 13.5 million Californians

- Nearly 1 in 3 California residents
- 1 in 2 children

Source: California HealthCare Foundation, California Health Care Almanac, Medi-Cal Facts and Figures: A Program Transforms, May 2013. www.chcf.org; DHCS Research and Analytic Studies Branch, Medi-Cal Statistical Brief, August 2013

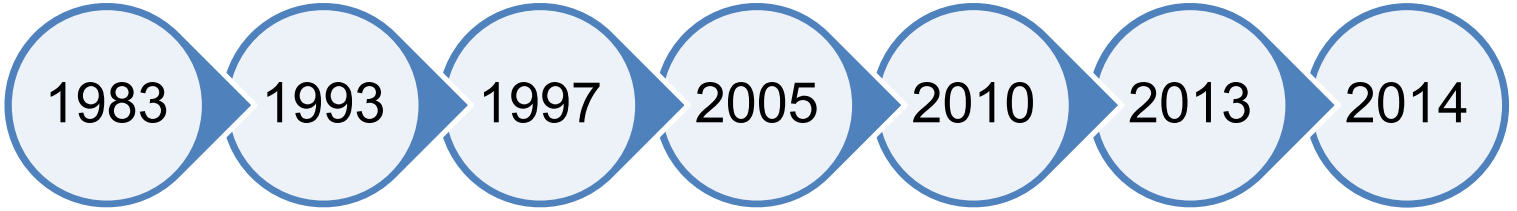
Medi-Cal's Delivery Systems

- Fee-for-Service
- Medi-Cal Managed Care
- Behavioral Health
- Substance Use Disorders
- Dental

A Very Little History

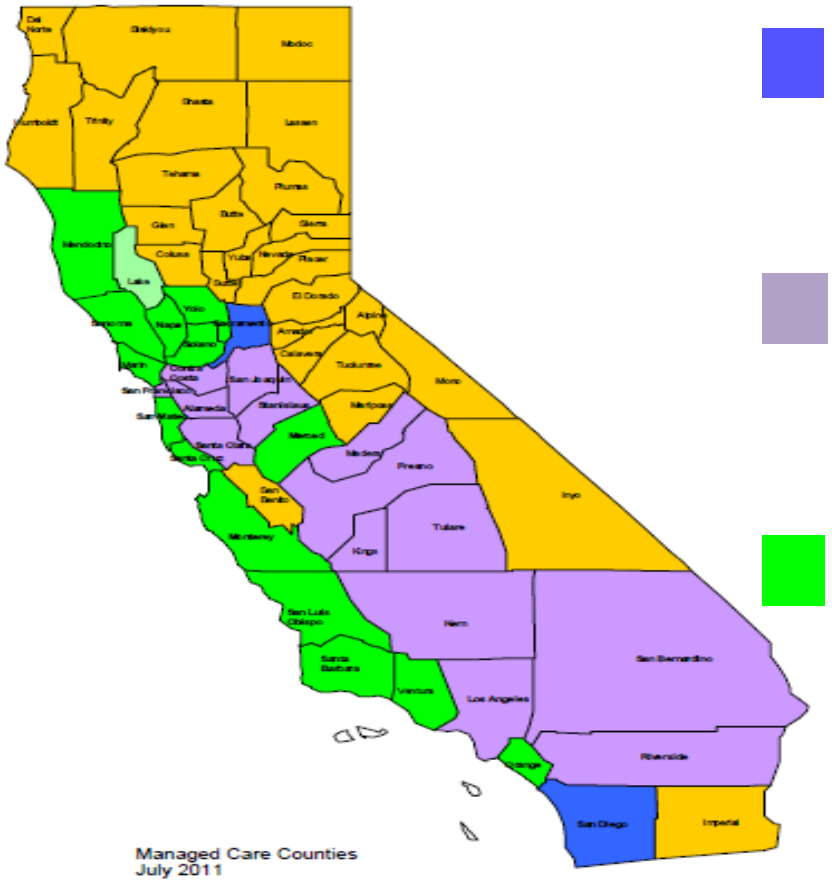
- Created in 1965 by President Johnson
  - The Great Society
  - Medicare
  - Medicaid an afterthought
    - Only for impoverished children and their caregivers
  - State option to join
    - Covered populations vary broadly
    - Arizona was last in 1982

Brief History of Medi-Cal Managed Care



- 1983 – Waivers (CenCal in Santa Barbara, Health Plan of San Mateo)
- 1993 – Clinton administration expands DHS authority to implement Two-Plan and COHS, California expands county-based Medi-Cal managed care programs
- 1997 – Balanced Budget Act encourages more expansion of managed care programs
- 2005 – Hospital waiver proposed to CMS to cover more SPDs in managed care
- 2010 – 1115 Waiver required transition of Seniors & Persons With Disabilities (SPDs) into managed care
- 2011-12 – SPD transition into managed care
- 2012 – Community-Based Adult Services (CBAS) transition into managed care
- 2013 – Healthy Families transition to Medi-Cal
- 2013 – Expansion of managed care to remaining FFS counties (28)
- 2014 – Low Income Health Program (LIHP) transition and Medi-Cal expansion; Coordinated Care Initiative (CCI)
- 2015 – Medi-Cal 2020 Waiver (PRIME, WPC, Global Payment); expansion to childless adults

Medi-Cal Managed Care Models (2012)



Geographic Managed Care (GMC)

- State contracts with various commercial plans in county

Two-Plan:

- State contracts with one local public plan and one commercial plan

County Organized Health System:

- State contracts with a local public plan

Of the 8.5 million Medi-Cal beneficiaries, 5.67 million are enrolled in a Medi-Cal managed care plan (2013)

Source: DHCS Medi-Cal Managed Care Enrollment Reports, July 2013

Medi-Cal Managed Care Statewide (2017)

- San Benito Model (Expansion)
- Imperial Model (Expansion)
- Regional Model (Expansion)
- COHS Model (Expansion)
- Two Plan Model
- GMC Model
- COHS Model

Medi-Cal Managed Care Models

- Six managed care models – 10.7M total enrollment*
  - County Organized Health Systems (COHS)
    - 2.2 million
  - Two-Plan Model
    - 6.9 million
  - Geographic Managed Care (GMC)
    - 1.1 million
  - Regional Model (RM)
    - 299,084
  - Imperial Model
    - 76,154
  - San Benito Model
    - 8,038

*As of January 2018

Key Distinctions Among Models

- Two-Plan Model
  - Regional Model
  - Imperial
- Geographic Managed Care
- County Organized Health System (COHS)
- San Benito

COHS

- Locally developed and operated managed care organization
  - Governing board approved by County Board of Supervisors
- Capitated arrangements and full-risk contracts
- Providers must be M/C certified
- Enrollment is mandatory for all aid codes
- No fee-for-service option in county
- No competing commercial plan options

California COHS — 2017

County	Plans	Total Members
Marin	Partnership HealthPlan of CA	39,339
Mendocino	Partnership HealthPlan of CA	38,289
Merced	Central California Alliance for Health	126,279
Monterey	Central California Alliance for Health	155,940
Napa	Partnership HealthPlan of CA	28,467
Orange	CalOptima	762,683
San Luis Obispo	CenCal	55,879
San Mateo	Health Plan of San Mateo	109,934
Santa Barbara	CenCal	124,937
Santa Cruz	Central California Alliance for Health	68,209
Solano	Partnership HealthPlan of CA	109,602
Sonoma	Partnership HealthPlan of CA	111,356
Ventura	Gold Coast HealthPlan	202,321
Yolo+ north	Partnership HealthPlan of CA	239,400
	Totals	**2,170,635**

Two-Plan Model

- Members choose between a commercial plan (CP) or Local Initiative (LI)
- The LI is a community organized not-for-profit HMO (quasi-governmental)
- The commercial plan is a for-profit or non-profit health plan (i.e., Anthem, Health Net, CA Health and Wellness, Blue Shield)

Two-Plan Model (cont.)

- Larger counties
- Capitated arrangements & full-risk contracts
- Enrollment mandatory for specific aid codes
- No fee-for-service option for mandatory beneficiaries
- In CCI counties, duals are mandatory

Los Angeles County

- Unique two-plan county
- L.A. Care is local initiative
  - Contracts with Anthem Blue Cross, CareFirst (Now Blue Shield), Kaiser
  - Also direct network – a more recent development
- Health Net is commercial plan
  - Contracts with Molina

California Two-Plan Model — 2017

County	Plans	Total Members
Alameda	Alameda Alliance for Health, Anthem Blue Cross	326,673
Contra Costa	Contra Costa Health Plan, Anthem Blue Cross	209,386
Fresno	CalViva Health, Anthem Blue Cross	251,972
Kern	Kern Family Health, Heath Net	322,322
Kings	CalViva Health, Anthem Blue Cross	47,216
Los Angeles	LA Care, Health Net	3,067526
Madera	CalViva Health, Anthem Blue Cross	55,518
Riverside	Inland Empire Health Plan, Molina Healthcare	690,155
San Bernardino	Inland Empire Health Plan, Molina Healthcare	701,413
San Francisco	San Francisco Health Plan, Anthem Blue Cross	153,288
San Joaquin	Heath Plan of San Joaquin, Anthem Blue Cross	241,303
Santa Clara	Santa Clara Family Health, Anthem Blue Cross	334761
Stanislaus	Health Plan of San Joaquin, Health Net	203,273
Tulare	Anthem Blue Cross, Health Net	207966
	Totals	**6,969,354**

GMC Model

- Sacramento and San Diego Counties
- A procurement was used in awarding of the contracts
- All participants are non-government health plans
- Capitated arrangements and full-risk contracts
- In San Diego, one community plan established by the clinics – Community Health Group

GMC Model (cont.)

- Mandatory enrollment mirrors two-plan enrollment
  - Duals mandatory in San Diego (a CCI county), not Sacramento (non-CCI)
    - Sacramento applied but did not have sufficient choice of plans to participate
- Members choose from several health plans
- No fee-for-service option for mandatory beneficiaries

California GMC Model — 2017

County	Plans	Total Members
Sacramento	Anthem Blue Cross, Health Net, Kaiser Foundation, Molina Healthcare	435,727
San Diego	Care 1st Health Plan, Community Health Group, Health Net, Kaiser, Molina Healthcare	720,138
	Totals	**1,155,865**

San Benito

- Anthem is sole plan
- Members have choice of fee-for-service or Anthem (managed care plan)
- Enrollment — 8,100

Imperial Model

- Two commercial plans — California Health & Wellness or Molina
- Capitated arrangements & full-risk contracts
- Enrollment mandatory for specific aid codes — mirrors two-plan model
- County intends to become a two-plan model
- Total enrollment — 76,142

Regional Model

- Members choose between two commercial plans — Anthem Blue Cross or California Health and Wellness
- A procurement was used to award the contracts
- Capitated arrangements & full-risk contracts
- Enrollment mandatory for specific aid codes
  - Mirrors two-plan enrollment
- Total enrollment — 295,000

Plan Benefits

- Medical and hospital care
  - Mild to moderate
  - Except soft organ transplants, SED/SMI, Dental and SUD, and CCS in some counties
- Pharmacy
  - Except psychotropics in most counties
- Long Term Services and Supports (LTSS) in CCI counties
- Dental anesthesia
- Optometry
- Podiatry
- Community-Based Adult Services (CBAS)
- Transportation

Plan Enrollment

- COHS Counties
  - All beneficiaries except emergency
- Two-Plan, GMC, Regional and Imperial Counties
  - CCI – All beneficiaries except emergency
  - Other counties
    - All except dual eligibles and emergency
- San Benito
  - Enrollment is voluntary

Plan Services

- Enrollment/eligibility verification
- Member services
  - Member materials
  - Nurse Advice
- Medical management/utilization review
  - Milliman
  - Apollo
  - Behavioral Health
- Case management/care coordination
- Pharmacy

Other Lines of Business

- Medicare
- Commercial
- Healthy Kids

Cal MediConnect

- Combines Medicare and Medi-Cal benefits into one plan
- Beneficiaries must enroll in a Medi-Cal plan
- BUT – always have choice in Medicare

Who is Eligible for Cal MediConnect?

- 456,000 full-benefit Medicare-Medicaid eligibles in the eight selected counties. (This includes a 200,000 cap in LA county)
- Ultimately, Alameda did not participate.
- Exclusions:
  - Younger than 21
  - Partial benefits or other health coverage
  - Home and Community-Based Services waiver enrollees (except Multipurpose Senior Services Program [MSSP])
  - Developmental disabilities clients
  - End-stage renal disease (ESRD) patients
  - Program of All-Inclusive Care for the Elderly (PACE) and AIDS Health Care Foundation enrollees

Coordinated Care Initiative (CCI)

- Mandatory dual enrollment in Medi-Cal managed care organizations (MCO)
  - LA, San Bernardino, Riverside, San Diego, Santa Clara, Orange, San Mateo
- Long-term services and supports in MCOs
  - In-home supportive services (IHSS)
  - CBAS
  - MSSP
  - Nursing Facility

CCI: One Person, One Plan, All Benefits

- Opportunity to coordinate:
  - Medical care
  - Integrated long-term services and supports (LTSS):
    - In-Home Supportive Services (IHSS)
    - Community-Based Adult Services (CBAS)
    - Multipurpose Senior Services Program (MSSP)
    - Nursing home care
  - Coordination county mental health and substance use programs
- CCI Goals:
  - Empower people to achieve their health goals
  - Help people stay in their homes
  - Improve care coordination across health care and social services
  - Bend the health care cost curve

Seven CCI Counties

- Los Angeles
  - Health Net and LA Care
    - Molina, Care First, CareMore
- Orange
  - CalOptima
- San Diego
  - Molina, Care 1st, CHG, Health Net
- San Mateo
  - Health Plan of San Mateo
- Santa Clara
  - Santa Clara Family Health Plan & Anthem Blue Cross
- San Bernardino
  - Inland Empire Health Plan & Molina
- Riverside
  - Inland Empire Health Plan & Molina

More Information

- Email for questions: MMCD.TPGMC@dhcs.ca.gov
- Department of Health Care Services (DHCS) website: http://www.dhcs.ca.gov
- Department of Managed Health Care (DMHC) website: http://www.dmhc.ca.gov
- Health Care Option (HCO): http://www.healthcareoptions.dhcs.ca.gov
- Cal MediConnect: www.CalDuals.org

Questions?

Jane Ogle

PROGRAM OVERSIGHT & REGULATION

State Regulators and Their Roles

The Regulators

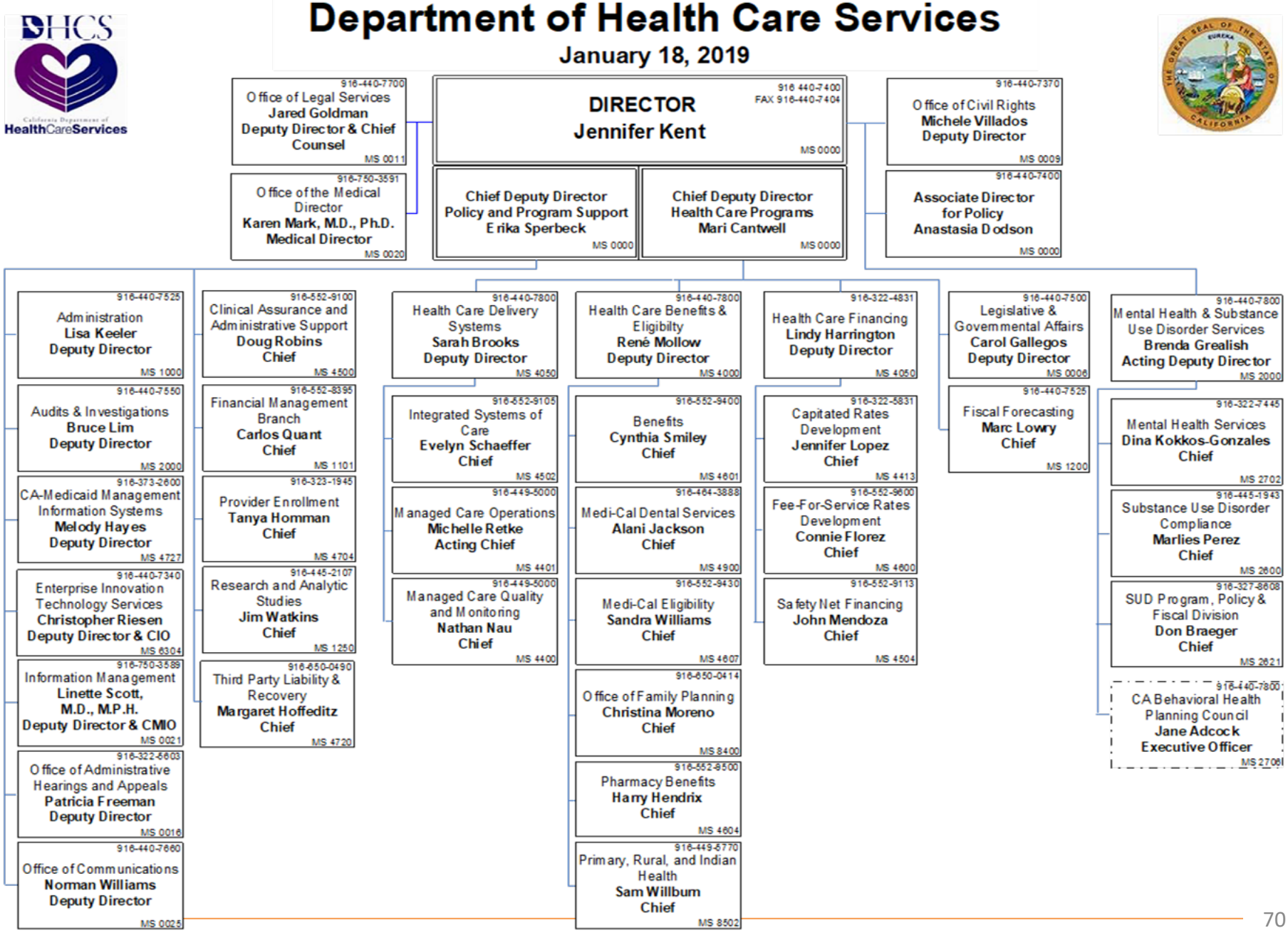
- Department of Health Care Services (DHCS)
- Department of Managed Health Care (DMHC)
- Bureau of State Audits
- Center for Medicare & Medicaid Services (CMS)

DHCS

- Single State Agency
  - Responsible for Federal Medical Assistance Percentages (FMAP)
  - 24% of state budget
  - $102 Billion
- Transitioning from fee-for-service to managed care
  - Evolving role of monitoring and oversight

Department of Health Care Services

January 18, 2019



DHCS Role

- As delivery system transitions to managed care and more fully integrated managed care, DHCS will adapt its processes

- Key departmental functions vis-à-vis plans:
  - Effective/efficient plan systems and operations
  - Plan oversight and monitoring
  - Integrating care across continuum
  - Collaboration across divisions

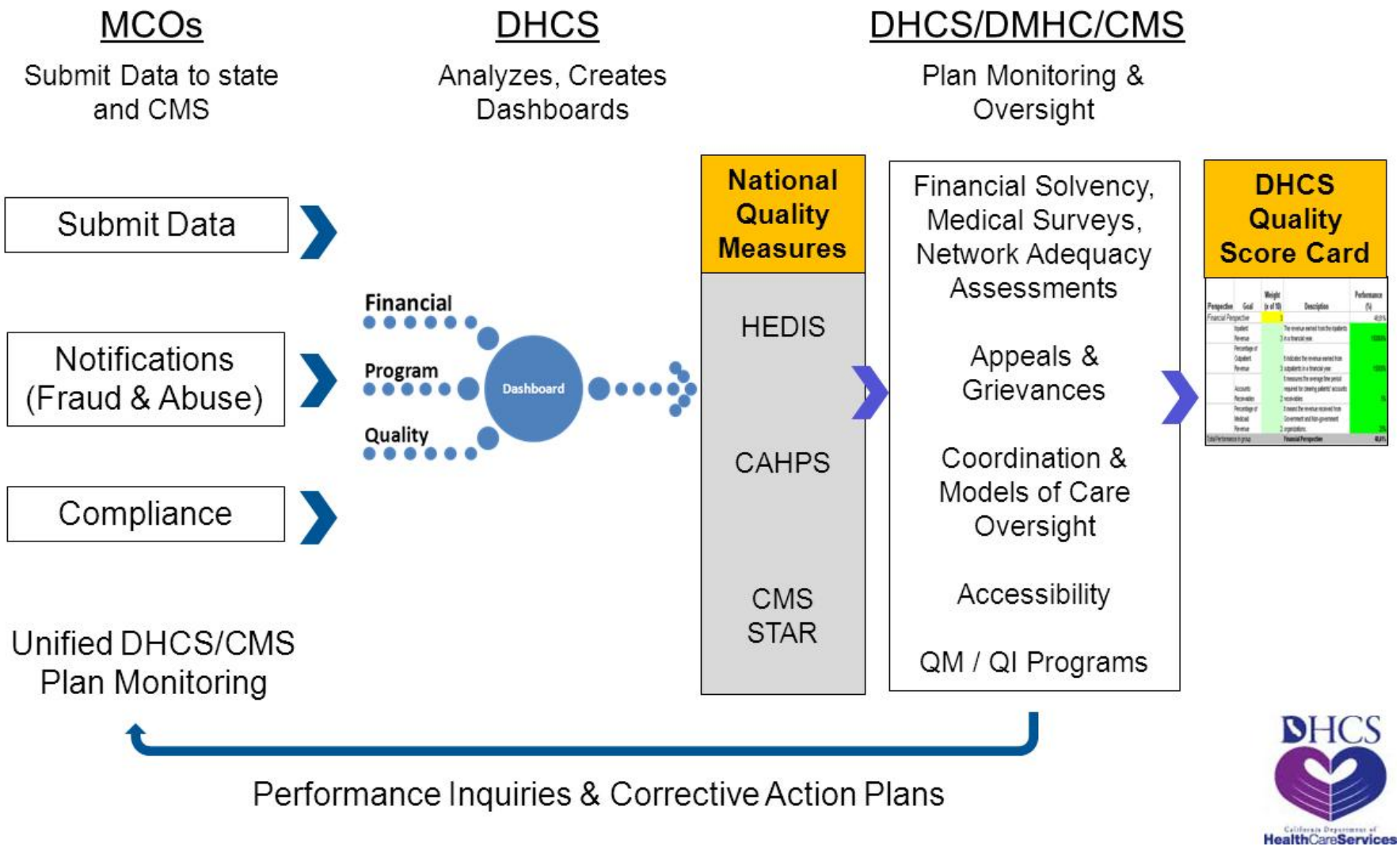
Plan Policy and Operations

- CMS Relationship – Waiver, approvals, reporting
- Contract development – Process and approvals
- System Readiness
- Choice Counseling/HCO/Maximus
- Health Plan Readiness
- Office of the Ombudsman
- State Fair Hearing
- Contract Liaisons with Health Plans
- Interface with California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)

The Oversight Role

- DHCS Audits and Investigations
- DHCS Quality and Monitoring
  - Also:
    - Capitated Rate Development
    - Integrated Systems of Care – for CCS
    - Eligibility
    - Pharmacy
    - Benefits
    - Provider Enrollment

Plan Monitoring — A Collaboration



The Quality Role

- DHCS Quality and Monitoring Division
  - Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS)
    - Corrective action plans
    - Sanctions
  - Complaints
  - State Fair Hearings
  - Dashboards

DMHC

- Authorized by the Knox-Keene Act of 1975
- Established in 2000
- Licenses HMOs and monitors other risk-bearing entities
  - More than 28 million in its health plans
    - Focus on commercial oversight
    - Risk-bearing entities, including medical groups
  - Local Initiatives and commercial Medi-Cal plans must be licensed
  - COHS are not required to be licensed
    - Healthy Families forced this requirement

DMHC Responsibilities

- HMO licensing
- Oversight of independent practice associations (IPAs) and medical groups financial viability
- Material modifications to licenses
- Oversight of most plan activities
  - Network adequacy and provider directories
  - Timely access
  - Grievances
  - Marketing and member communications — languages and formats
  - Marketing
  - Medical management
  - Quality
  - Finance, etc.

Overlap

- DHCS and DMHC both assess:
  - Network adequacy
  - Plan operations
  - Quality
  - Finances
  - Fraud and abuse
  - Utilization management

Mega Regs

- Medicaid standardizing across states
- Focus on finance, member satisfaction and quality
- Applied to MCOs, Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs)
  - County Behavioral Health Systems
  - SUD Organized Delivery Systems
  - AIDS Fdn. and Mosaic
- CMS wants to rate Medi-Cal health plans

New Managed Care Rule

- CMS released revised managed care regulations in April 2016, which strengthen existing Medicaid managed care rules.
- Highlights include:
  - Beneficiary support and information
  - Enrollment and disenrollment protections
  - Network adequacy and access to care
  - Short-term Institution for Mental Diseases (IMD) stays
  - Managed long-term services and supports (MLTSS)
  - Continued services during appeals
  - Medical loss ratio (MLR) standard
  - Delivery system and payment reform
  - Quality of care
  - Program integrity

Source: CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions. Kaiser Family Foundation. June 2016.

More Information

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Questions?

For more information, visit dhcs.ca.gov

Elizabeth Darrow

MANAGED CARE PRINCIPLES & PAYMENT

Objectives

- To explain concepts of risk and risk mitigation strategies used by managed care plans
- To provide examples of arrangements and relationships with providers
- To provide examples of incentive programs

The Concept

- The state agency that oversees Medi-Cal — DHCS — contracts with qualifying managed care plans to take “risk” for certain health care services.
- Risk — the potential of gaining or losing something of value.
- In this instance, the plans receive a certain amount of money every month for each enrolled member.
- With that money, the managed care plan must arrange and pay for that enrolled member’s health care.
- Health care includes: hospital, physician, home health, nursing home, medical equipment and supplies, and prescription drugs.

The Concept (cont.)

- Consider the following (loss) example:
  - The managed care plan receives $475 for a senior aide code member per month or $5,700 per year for health care services.
  - The plan must cover what the member is entitled to.
  - If the member has 3 hospital stays through the year with an average length of stay (LOS) of 4 days at $2,800 per day, the plan will spend $33,600 on hospital care alone for this member through the year.
  - This doesn't even address physician care, Rx or post-hospital care costs.

The Concept (cont.)

- Consider the following (gain) example:
  - The managed care plan receives $175 for a child aide code member per month or $2,100 per year for health care services
  - The member visits the doctor for one well visit for the year that costs the plan $45.
  - No other services are received or needed for this member.

The Concept (cont.)

- Keep in mind the managed care plan also needs to pay administrative costs, which include employees and infrastructure (IT, materials, building, lights, etc.).
- Managed care plans also must be able to pay providers in a timely fashion and must make working with the plan attractive for providers to continue to treat the plan's members.

How Do You Make This Work?

- Numbers matter!! The more membership a plan has, the more it can spread the risk.
- Keep in mind the 80/20 rule.
- There is a natural incentive built in this model for the plan to manage care both internally (at the plan level) and externally (at the provider level).
  - Case management, disease management, care navigation, network management, provider incentives, risk sharing/capitation
  - Data, data and more data (data integrity)

The Strategies

- Build membership
- Understand 80/20 rule (know the population, understand cost drivers)
- Interventions:
  - Case management (acute versus chronic): a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.
  - Disease management: a set of activities aimed at improving the health and clinical outcomes of a population of patients, defined by a chronic medical illness. Activities are usually facilitated by the use of electronic health record, identification of outliers and high utilizers or disease registry programs. It is proactive and providers appropriate support for enhanced self-management.

The Strategies (cont.)

- Care navigation/Patient navigation: This can take many different forms both at the health plan and provider level. The key is patient/member engagement, assisting the patient/member navigating the health care system, reminders for follow-up appointments, networking and identifying resources. Nurses, community health workers or social workers can fill this role. Customer service staff at the plan also provides this support function.

- Network management: Contracting strategies, partnerships, service and balance (not too large, not too narrow) and monitoring provider patterns and outcomes.

- Provider incentives: pay for quality and enhanced service, must be clearly defined and managed via benchmarking and frequent reporting of data (quality measures/goals).

The Strategies (cont.)

- Capitation: payment to a physician or group of physicians (or other provider types) of a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.
- The amount varies based on services expected, health status or aide code
- Essentially shares risk with the plan for care of membership
  - Individual PCP
  - IPA
  - HMO

Data

- Data is the key to success.
- Plans must demonstrate to the State the actual costs of health care via encounter data.
- Plans must monitor providers (especially capitated) to ensure members are receiving the care they need and that the providers are submitting the data needed to characterize that care.
- Plans must report data to providers so that improvement opportunities can be acted upon and any other relevant interventions taken.
- If there are additional incentives built into the capitated arrangement, plans must demonstrate via the data that goals have been missed or met .

Questions?

Elizabeth Darrow

KEY FUNCTIONS OF MANAGED CARE PLANS

Objectives

- To provide an overview of the key functional areas of the managed care plan
- To describe how these functions are interrelated
- To emphasize strategies for success

The Point

- Medi-Cal managed care plans serve different customers with different needs and expectations:
  - DHCS and CMS
  - Members
  - Providers

Operational Areas and Functions

- Marketing
  - No direct sales
  - Focus is branding or brand awareness
  - Community awareness, visibility and networking

Operational Areas and Functions

- Customer Service (Member)
  - Availability to answer questions, deal with complaints, navigate and communicate plan rules, network and benefits
  - Workforce must be as diverse as the population served, language- and hearing-impaired compliant, must record calls, trend issues and report to relevant committees (service and quality and/or access and availability)
  - Must distinguish calls from basic issues to appeals or grievances and quality of care concerns and forward to applicable departments
  - High degree of training and knowledge required

Operational Areas and Functions

- Customer Service (Providers)
  - Sometimes embedded in the “Call Center” for members
  - Address claims, billing and auth inquiries
  - Address concerns about member issues
  - Address questions regarding rules, changes in rules or benefits, etc.

Operational Areas and Functions

- Enrollment
  - Manage the data that comes in for current members, new members and dis-enrolling members
  - This data must be available for multiple system functions, must be accurate
  - Must manage special status data and take appropriate actions

Operational Areas and Functions

- Medical Management
  - Must be overseen by MD, functions include utilization management, case management, medical committees, disease management, pharmacy and health education
  - This is managed (health) care!
  - Analytics, predictive modeling, health care trends, new technologies, and treatment protocols/ must stay on top of community practice patterns, cost effective care and outcomes
  - Highly regulated and high visibility

Operational Areas and Functions

- Quality Management (Quality Improvement)
  - Overseen by MD
  - Must develop a yearly QM/QI plan, work plan and evaluation, usually coordinates HEDIS and takes actions for improvement opportunities
  - Operates the QI Committee
  - Develops QI projects both at the State and plan level
  - Investigates quality of care concerns, physician office site and medical records review
  - QI staff are usually the change agents!

Operational Areas and Functions

- Provider Contracting and Provider Relations
  - Negotiates and oversees the contracting process
  - Credentialing and Credentialing Committee
  - Orientation and provider education
  - Manages network and monitors network (access and availability)
  - Addresses problems, diplomacy between the plan and the providers

Operational Areas and Functions

- Compliance
  - Stays on top of new regulations and reporting requirements, acts as liaison with regulators
  - Develops Compliance Plan and educates staff and providers, ensures policies, procedures and practices comply with regulations, ensures Standards of Conduct are well publicized and available
  - Investigates compliance issues, monitors and audits and issues and oversees corrective actions
  - Reports to CEO with dotted line to Board
  - Monitors and responds to compliance hotline calls, lead efforts on fraud, waste and abuse (FWA)

Operational Areas and Functions

- Claims
  - Pays the bills!
  - Claims are complicated and systems to process claims are challenging
  - Must manage frequently changing rules, updated fee schedules, monitor FWA, “cap leak,” etc.
  - Must audit for timelines and financial accuracy
  - Works on timely resolution of provider disputes

Operational Areas and Functions

- Finance
  - Medi-Cal financing is not for the faint of heart!
  - Complicated payment methodology with many moving parts and constant changes
  - Frequent audits by governing agencies
  - Must manage and monitor budgets, admin costs and MLR, reserves, etc.
  - High visibility

Operational Areas and Functions

- Information Technology (IT)
  - Very expensive and ever-evolving
  - All departments are dependent on high-functioning IT
  - Analytics, database, data warehouse, security, HEDIS, encounter data, ad hoc reporting, etc.
  - Difficult decisions like “build or buy” or “in-source versus outsource”

The Point (Again)

- All departments depend on each other and no department is an island.
- Errors have ripple effects throughout the organization.
- Technology, data and data integrity are essential to success.
- Must have solid risk strategies and members must be medically managed.
- Members and providers must be satisfied and retained.
- Compliance is non-negotiable.

Questions?

Len Finocchio, Elizabeth Darrow, Jane Ogle

CURRENT & FUTURE ISSUES IN MEDI-CAL MANAGED CARE

Questions for the Faculty

- Financing — What major issues could affect Medi-Cal managed care financing now or in the next year or two?

- Quality — What are the challenges for improving quality for Medi-Cal managed care plans? What are the opportunities? What can plans expect in terms of new state requirements?

- Behavioral Health Integration — What are the current challenges? Where have we succeeded to date in doing this? Where do we need to do more?

Questions for the Faculty

- Policy Changes from DC — What are some Medicaid policy changes the federal government might promote (e.g., work requirements) and how might they affect Medi-Cal managed care plans?

- New Administration — Of the Medi-Cal related proposals from the new Governor, which can we expect to stick?

Governor Newsom's Proposals

- Drug pricing
- Medi-Cal expansion to undocumented young adults
- Waiver?
- Universal coverage
  - Expansion of Covered CA subsidies
  - Mandatory

Questions *from* the Faculty

- What kinds of issues are you hearing from your members?
- What areas of plan operations are particularly challenging for your plan?
- What types of issues do you need to know more about to perform your job effectively?
- Is your plan preparing for any of the federal or state policy changes discussed today or others not discussed?
- What did you learn today that you didn't know before or that surprised you about Medicaid or Medi-Cal managed care?

Thank You!