ISSUE AND OPTION PAPER

Improving the Medi-Cal Managed Care System of Sacramento County

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BACKGROUND:

On March 11, 2019, the California Department of Health Care Services (DHCS) gave notice that the next Medi-Cal Geographic Managed Care (GMC) program plan procurement process will occur in 2020. This announcement, coupled with a growing sense among local stakeholders of urgently needed changes in the Medi-Cal managed care program, presents a great opportunity to examine options that would dramatically improve the system for the more than 425,000 Sacramento County residents enrolled in Medi-Cal.

The Sacramento County GMC program began as a pilot program in the 1990's to afford Medi-Cal eligibles the opportunity to obtain health care services through a choice of "two or more" managed care health plans.[1] Since that time, there has been little review of this pilot program by the state Medi-Cal program, nor significant changes to the program, apart from the passage of legislation in 2010 (Senate Bill 208)[2] that authorized the creation of a local stakeholder advisory committee to provide input to the California Department of Health Care Services (DHCS); and a 2015 Request for Application process that resulted in the addition of two more plan choices (United Healthcare and Aetna Better Health) to the existing crowded set of four health plan choices already in the market (Anthem Blue Cross, Health Net, Kaiser, and Molina Healthcare.)

Yet, despite the competition, the non-Kaiser Sacramento GMC plans have been among the lowest quality health plans in the entire statewide Medi-Cal managed care program.[3] The addition of two new plans into the GMC model, which occurred with no input from Sacramento County to DHCS, did little to address existing community concerns over inadequate access to care, poor quality, and the challenges for enrollees and providers in navigating among multiple plan authorization processes and networks, and nonexistent linkages with county services.

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1 https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14089.&lawCode=WIC

2 https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14089.07.&lawCode=WIC

3 https://www.chcf.org/wp-content/uploads/2017/12/PDF-AlmanacRegMktBriefSacramento16.pdf

CURRENT STATE OF SACRAMENTO COUNTY GMC:

The Sacramento GMC model currently has five managed care plans that directly contract with DHCS. The latest enrollment (as of April 30, 2019) by plan in the Sacramento GMC was as follows:

Anthem Blue Cross	177,258
Health Net	106,587
Kaiser	86,956
Molina	50,922
Aetna	6,386

The top four plans have been participating in the Sacramento GMC model for over a decade and have been active participants in the Sacramento County Medi-Cal Managed Care Stakeholder Advisory Committee since its inception in 2010. This collaboration extends to the Committee's Care Coordination Work Group, which was formed several years ago to seek common approaches towards care coordination among the GMC plans. Yet even with these efforts, the Stakeholder Advisory Committee functions with no teeth and therefore has little to no ability to influence the provision of care for Sacramento County residents enrolled in the Medi-Cal system.

Beginning early in 2019, Chet Hewitt, President of the Sierra Health Foundation, Dr. Peter Beilenson, Director of the Sacramento County Department of Health Services, and State Senator Dr. Richard Pan have collaborated to convene a series of three meetings with a broad range of stakeholders on Sacramento County Medi-Cal System concerns. This group consists of physicians, nurses, social workers and other providers, advocates, community-based organizations, students, health plans, health systems, public health practitioners, FQHCs, IPAs, funders and community members. The first stakeholder meeting on February 15 laid a foundation of understanding about the state of the program in the County. The second stakeholder meeting, held April 12, allowed participants to discuss the challenges, and opportunities with the existing system. The third meeting, scheduled for June 17, will allow for a discussion of potential questions about the desires of the group for improving the system in Sacramento County.

CHALLENGES FACING THE CURRENT SACRAMENTO COUNTY GMC SYSTEM:

During this stakeholder process, participants discussed several challenges that have contributed to an underperforming GMC model. These challenges are rooted in the GMC model and in the local marketplace. In some cases, they are tied together. The following describes these challenges.

Model Based Challenges

Multiple Plans Create Confusion for Providers and Enrollees

Until recently, the Geographic Managed Care (GMC) program had five non-Kaiser health plans operating in Sacramento County, which meant providers and beneficiaries had to contend with five different programs and policies to access care and services. Even with the departure of United Healthcare from the market in 2018, four different non-Kaiser plans (Anthem Blue Cross, Health Net, Molina Healthcare, and Aetna Better Health) are operating in the GMC program. They do so either through direct contracts with providers, or through 3-4 contracted delegated medical groups (Independent Physician/Practice Associations) that have assigned enrollment and their own networks and referral systems.

For hospitals and their emergency departments, in a market absent a common data sharing platform or health information exchange program, it is a daunting challenge to identify and link presenting patients to one of five different potential health plans and referral gateways. Likewise, community providers and social service organizations must navigate four different plans and their delegates to coordinate care for non-Kaiser GMC enrollees.

For their part, enrollees themselves and the navigators that serve enrollees can be confused with too many choices and not enough education and assistance towards finding the care they need from multiple different plans. Although the Care Coordination Work Group has been exploring ways to provide plan and group contact information to front-line providers, simply asking Medi-Cal plans to adopt common authorization practices and documentation (without any mechanism for accountability) is problematic.

Potential Solutions:

- Regardless of which system model is adopted, work must begin to address the complexity of sharing data to better serve the Medi-Cal enrollees in the County. An important step would be the development of a robust health information exchange (HIE) in the County. This would allow emergency departments, mental health providers, hospitals, primary care providers and specialists to share information on patients, resulting in better coordination of care.

- Creation of a central call center would also be very beneficial to participants in the system, by answering questions from enrollees, ER providers, and community navigators to assist in the identification of enrollee plan assignments, help obtain access to plan-authorized services and transportation, and secure linkages to community services, including County Mental Health and substance use services.

Fragmented Responsibilities

Although not a problem unique to Sacramento County or the GMC model, Medi-Cal managed care plans are responsible for medical care, case management, and mild-to-

moderate behavioral health services, but not responsible for severe mental health treatment services and substance use treatment services, which remain the responsibility of the County behavioral health system.

Given the split responsibility for behavioral health and substance use disorder (SUD) services between managed care plans and county programs, it's critical for GMC plans to work with the county's mental health and SUD programs and networks to facilitate needed care for GMC enrollees. Data sharing and clinician access between plan and county programs is essential, but are often impeded by multiple plans and systems, and a lack of a common data-sharing platform.

Potential Solutions:

- Require effective gateways between the GMC plans and the county's mental health and substance use programs to build a clinically integrated program between the GMC plans and the County programs.

Lack of Local Control

Unlike the state's other GMC program in San Diego County, Sacramento County has no actual control over how the local GMC program operates. Although legislation enabled the implementation of a Stakeholder Advisory Committee in 2010, this body has absolutely no authority to oversee or administer the Medi-Cal program operating within its borders.

Through Welfare and Institutions Code Section 14089.05[4], San Diego County has a direct role in the operation of their GMC model through advisory committees that report to the County, and in the "designation" of health plans that can contract with the State. In this structure, the County has the ability to hold the local plans accountable for meeting various quality and outcome criteria.

Market Based Challenges

Major Health Systems' Limited Participation in Medi-Cal Managed Care

Even though the Sacramento region benefits from the significant presence of four major health systems (Common Spirit (Dignity) Health, Sutter Health, UC Davis Health, and Kaiser Permanente), only Kaiser commits their medical panels to any significant participation in the GMC program. For financial (funding and rates) as well as workforce limitation (insufficient staffing) issues, none of the three remaining systems allow their medical groups to contract with the GMC plans for significant assigned primary care enrollment or specialist care.[5] And until recently, the GMC plans were unable to contract with all three non-Kaiser hospital networks due to a reluctance by Sutter Health and UCD

[4] https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14089.05.&lawCode=WIC

[5] https://www.sierrahealth.org/assets/HCP/SHF_HCP_Market_Analysis_2017_web.pdf

Health to increase their Medi-Cal managed care business. However, with Medi-Cal's introduction of new funding through directed payment programs to plan-contracted providers, local health systems are expanding their participation in GMC networks.

Inadequate Access to Primary Care

Although the region's FQHCs and local practices carry a large load of the primary care enrollee assignments from the GMC plans, access to primary care providers has been problematic in Sacramento County for years. Part of this is a result of health systems competing for, and absorbing available practitioners; part of this is a limited geographic supply of practitioners to begin with; and part of this is tied to inadequate Medi-Cal reimbursement levels that drive health systems away from fully participating in the program for fear of taking on a disproportionate load of the GMC program against their bottom lines.

Access to behavioral health and substance use providers is also inadequate, especially since the coverage expansion contained in the Affordable Care Act. Again, supply and rates are reasons behind these challenges, but there has been only limited local coordinated effort among the provider community, county programs, or the Medi-Cal plans to address these challenges.

Limited Access to Specialist Services

Related to the system participation issues above, there is also inadequate access to specialist services in the region for Medi-Cal patients. As the health systems heretofore have limited their involvement at the specialist level in the GMC program, the Medi-Cal health plans are forced to rely upon the same group of community providers, whether they be FQHCs or specialists who operate outside of the system, sometimes even volunteering their services. This overloads those providers and between that over-utilization and the health systems' periodic acquisition of those specialists to bolster their own needs, the pool of available specialists to serve the GMC enrollment outside of Kaiser is inadequate.

Uneven Quality and Accessibility of Primary Care Services

Although Sacramento County is home to almost three dozen FQHCs and community practices that participate in Medi-Cal managed care, the lack of health system participation puts the full burden of the GMC enrollment onto those clinics and practices, which are of varying degrees of effectiveness in addressing enrollee needs, preventing avoidable emergency room utilization, and are subject to geographic clustering rather than locating in truly underserved areas. And in a multi-plan model, one practice or clinic site can attest to having adequate enrollment capacity (member to PCP ratios) *for several plans*, creating a situation where one clinic has taken on more enrollment that perhaps it should handle.

The ability of a clinic or practice site to effectively handle thousands of enrollees rests upon its internal systems, outreach efforts, use but not over-use of midlevel practitioners (Physician Assistants, Nurse Practitioners), and referral and linkage to available specialists, social supports, and nonmedical services (behavioral health and substance use

treatment). But with multiple plans assigning enrollment directly or through delegated IPA groups to the same group of FQHCs and community practices located in many of the same areas, underperforming and/or overloaded clinics and practices can easily result in poor health outcomes and overtaxed area emergency rooms acting as a proxy for primary care sites.

Safety Net Infrastructure is Lacking

Sacramento County has no county hospital or system of county clinics to support the safety net, and historically has not supported a robust county health system. There is no local Health Information Exchange to support data sharing that can lead to effective care coordination programs.

Potential Solutions to Capacity Problems:

- Load Sharing: Get hospital/health systems to commit their medical group PCP's and internists to FQHC sites through office hours to serve complex enrollees. Get the three non-Kaiser systems to commit to sharing the load for provision of a limited number of specialty office hours at participating FQHCs. Specialties can be divided up among the systems and their availability or interest in participating.

- Medical Resident placements: Incentivize participation in this effort by providing a pipeline of medical school residents from UC Davis and California Northstate University (CNSU) to participating clinics.

- Specialty Hubs: Plans and IPA's could pool their resources to locate and staff Specialty hubs/outpatient clinics across the County that would support enrollment at community practices in direct or group networks. IPA's could also arrange for Southern California specialists to come into town 1-2 days a month to provide office hours at these specialty hubs if the plans support the establishment of hosting office sites.

- Telemedicine: UCD and Dignity Health can divide up specialty services by type based on existing programs and availability of receiving sites.

- Medical School Support: Medi-Cal plans can support the recruitment of new specialty faculty or foundation hires in exchange for a commitment to Medi-Cal access by those hires.

- Missed Appointments: Plans need to consider paying for missed appointments to deal with provider aversion to the Medi-Cal population. Plans can minimize these missed appointments through the expanded transportation benefit.

- Emergency Room (ER)/Post Discharge Challenges: As a trade-off to the health systems for their increased commitment to the GMC program, health plans, IPA's, and primary care providers must make a renewed

commitment to reducing avoidable ER visits, lengthy GMC inpatient stays, and readmissions through the development of diversion/navigation programs, system-inclusive inpatient management programs, post-discharge programs, and SNF/post-acute placement programs.

Having laid out the challenges and concerns with the current Sacramento County GMC model, the Stakeholder Group will meet again on June 17, 2019, to discuss several questions that will set the stage for a discussion with the California Department of Health Care Services about the Stakeholder Group's wishes. After emissaries of the stakeholder group meet with the DHCS leadership, the Stakeholder Group will reconvene to discuss a set of Medi-Cal model options that Sacramento County could adopt that best address the desires of the group and the willingness of DHCS to accommodate them.

QUESTIONS FOR THE STAKEHOLDER GROUP TO DISCUSS ON JUNE 17:

a) Should Sacramento County pursue legislation that will give the county authority to, among other actions, choose participating plans.
b) Should Sacramento County pursue legislation that will give the county authority to hold plans and IPAs accountable for access, outcome and satisfaction metrics?
c) Should Sacramento County form a regional Medi-Cal delivery system, with surrounding counties (e.g. Yolo, Placer, El Dorado and/or others)?
d) Should Sacramento County strive to form a robust, comprehensive countywide Health Information Exchange to address the massive coordination issues in the county; and are all participant willing to contribute funds?
e) Should Sacramento County remain a GMC (>2 plans) system, and if so, do we want to limit the number of participating plans?
f) Should Sacramento County consider becoming a Two-Plan system?
For this potential option to be successful, Kaiser will have to take on more enrollees, and the other three health systems (Dignity, UC Davis and Sutter) will have to be willing to participate fully in the Medi-Cal system in Sacramento County.