

Senate Committee on Health
Informational Hearing
Improving Performance and Aligning Incentives in Commercial Health Insurance and Medi-Cal
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Chairperson Pan, members of the Health Committee, thank you for this invitation to discuss opportunities to improve performance in Medi-Cal.

With nearly one in three Californians receiving their health coverage through Medi-Cal, it is the single largest source of health coverage in our state. Over 80 percent of Medi-Cal's 13 million enrollees get their care through managed care plans. With 11 million enrollees, the Medi-Cal managed care program is larger than every other state's entire Medicaid program.

One of the many potential benefits of managed care to Medicaid enrollees and to states is that, unlike a fee-for-service system, there is an accountable organization responsible for meeting specific federal and state requirements in areas such as network adequacy, timely access to care, quality and cost. This accountability is a key reason the state transitioned seniors and persons with disabilities from fee-for-service into managed care starting in 2011 and that nearly all Medi-Cal enrollees with full scope coverage are now required to enroll in managed care.

Against this backdrop, I will address two questions:

- 1) What do we know about quality of care in Medi-Cal managed care?
- 2) What might California do differently to accelerate improvements in access and quality of care for Medi-Cal enrollees?

1) What do we know about quality of care in Medi-Cal managed care?

First, we know that quality of care is highly variable depending on where you live, what plan you're enrolled in, and your race and ethnicity. According to the Medi-Cal managed care dashboard, produced quarterly by the Department of Health Care Services, the aggregated quality scores of Medi-Cal managed care plans vary by a factor of 2.5 – meaning the top plan scores 2.5 times higher than the lowest scoring plan (Figure 1). These aggregate scores roll up several quality measures to provide a single snapshot of overall quality for each plan but mask the clinical significance and human toll of the variation. For example:

- 74% of women enrolled in San Francisco Health Plan received their recommended cervical cancer screen; among women enrolled in Health Net in San Diego, only 41% did.
- Among Medi-Cal beneficiaries with hypertension residing in the Inland Empire, 69% of those enrolled with Inland Empire Health Plan had their blood pressure adequately under control, whereas less than 40% of those enrolled with Molina Healthcare did.
- Among Medi-Cal beneficiaries with diabetes, those enrolled in the San Francisco Health Plan are 50% more likely to have their diabetes (HbA1c levels) under control than those enrolled in the Alameda Alliance Health Plan.

2) What might California do differently to catalyze significant improvements in access and quality of care for Medi-Cal enrollees?

Taking these factors into account, and after hearing from a diverse cross-section of Medi-Cal stakeholders that they support a vision of shared accountability to provide high quality, high value, whole person care, the California Health Care Foundation launched a project to design a financial incentive program that would address premium slide and promote more rapid quality improvement. We hired Cindy Mann, the former deputy administrator at the Centers for Medicare and Medicaid Services and director of the Center for Medicaid and CHIP Services in the Obama Administration, and engaged an advisory group of health plan leaders. Their effort produced recommendations for an approach similar to shared savings in which a managed care plan would receive a rate adjustment if it meets three criteria: (1) it generates cost savings greater than a threshold established by DHCS and its actuaries, (2) it meets quality targets based on providing excellent quality of care or demonstrating significant quality improvement, and (3) it demonstrates that it is investing at least a specified amount into health-related initiatives as defined by the state. One of the main benefits of this approach is that it would not require additional state spending.¹

This approach is just one of several approaches California could take, and today CHCF published a new report that describes five different types of financial incentive programs used by states for their Medicaid managed care programs. This report, “Making Quality Matter in Medi-Cal Managed Care” describes each approach and, for each, provides an example of how a state is putting it into practice. Some are simpler to administer than others; some would require additional state funding or a reallocation of existing Medi-Cal funds.

Of course, financial incentives are not a panacea and DHCS has and uses many tools in its tool chest to manage the managed care program: procurement; contract management and oversight, including performance measurement, audits and corrective action plans; public reporting; and non-financial incentives such as the performance-based auto-assignment process. Later this spring, we will publish a report that provides recommendations in each of these areas based on review of practices by DHCS, Covered CA, CalPERS, and five other state Medicaid programs.

Lastly, I want to acknowledge that DHCS and its plan partners are working hard to improve quality of care for their members, and the efforts of successful plans are reflected in improvements in their quality scores over time. You’ll hear today from extraordinary Medi-Cal managed care plan leaders, and several plans are making sizeable investments to improve care for their members. We have had the good fortune to partner with many of them to reduce unnecessary C-sections, to expand treatment options for those overusing opioids, to improve care at the end of life, and to expand access to care through telehealth. Moreover, what DHCS and its health plan partners have accomplished in just the last seven years is impressive – as the program has expanded to include millions of new enrollees – while tackling key priorities such as adding coverage for mild to moderate mental health conditions. With stronger incentives and appropriate flexibility, however, we can and should expect better outcomes from our Medicaid managed care program, as many states already do.

¹ The approach is described in greater detail in our report, *Intended Consequences: Modernizing Medi-Cal Rate Setting to Improve Health and Manage Costs*, available online at chcf.org.