

Medi-Cal Managed Care Models
Context Considerations
Sonoma Managed Care Planning Group, March 24, 2006
Prepared by Elinor Hall

1. The option to remain a Fee-for-Service County

- The State Medi-Cal Redesign Plan as approved by the Legislature calls for Sonoma County to join the PHC County Organized Health System Plan. DHS has said that it will work with the Counties regarding their preferred managed care models, but some model of managed care will be selected and implemented in the expansion counties.
- It is not possible to implement a COHS expansion without County Board support since the Board must adopt a local statute and appoint representatives to the Governing Board. PHC has said it will not expand into a County that is opposed.
- Similarly the Two-Plan Model requires the County Board of Supervisors to oversee the formation of the Local Initiative and appoint Initiative Board members.
- The State has legislative authority to implement Geographic Managed Care (covering CalWORKS beneficiaries only) in a county or region without support from County government. In order to implement GMC, the State would request proposals and select two or more competing commercial plans to serve the Medi-Cal population. The commercial plans would need an adequate provider network in order to meet State requirements.
- Bottom line: The State could attempt to implement the GMC model of Medi-Cal Managed Care without County Government support. GMC feasibility would depend upon the interest of commercial plans (including potentially, Blue Cross, Health Net, Kaiser, etc.) and the willingness of providers to contract with them.

2. Optimal Size for an At-Risk Health Plan

- Commercial Plans (in either GMC or Two-Plan counties) spread costs over multiple counties and over multiple lines of business (i.e. non-Medi-Cal enrollees). Commercial Plans are thus less impacted by the size of the beneficiary population in a particular county than are Local Initiatives and COHS Plans.
- A Two-Plan Local Initiative, or an independent COHS Plan, must have enough members to spread administrative costs efficiently and to have a viable “risk pool.” Smaller Plans spend a higher percent of their revenues on administration and have higher risks of financial instability.
- There is no regulation or hard and fast rule regarding the minimum sized Medi-Cal Plan. However a “rule of thumb” suggests that an independent Plan should be at least 25,000 members; 40-60,000 member plans are more likely to thrive.
- DHS does not believe that a new COHS or LI can be successful with fewer than 40,000 members. This is based on budgetary considerations including estimated start-up costs for a new Plan of \$3-5 million and on-going operational costs of \$5-\$10 million annually.

- The smallest Local Initiative is the San Francisco Health Plan with 29,000 members. The next smallest is the Contra Costa Health Plan with 41,000 members.
- San Mateo is the smallest COHS with 46,000 members; the next smallest is Santa Barbara with 51,000.

3. Size of Sonoma's Medi-Cal population

- Sonoma County has approximately 47,000 Medi-Cal beneficiaries during any given month.
- Statewide, an average of 53% of all Medi-Cal beneficiaries enroll in the GMC or Two-Plan plans in counties with those options. In COHS Counties, 87% of beneficiaries enroll in the COHS Plan.
- If Sonoma became a Two-Plan County, it could anticipate a total of 25,000 managed care enrollees (53% of the 47,000 Medi-Cal beneficiaries). The Local Initiative and a Commercial Plan would compete for enrollees. Based on proportionate enrollment rates in the other Two-Plan Counties, a Local Initiative could expect to enroll 60 to 80% of managed care participants. This would result in a Local Initiative with between 15,000 and 20,000 enrollees (60-80% of 25,000).
- Bottom Line on size for Two-Plan Model: Sonoma's population of beneficiaries is too small for the creation of a single county Two-Plan model. It might be possible to create a regional Two-Plan model that covered more than one county, though neighboring counties may not have the population or medical practice patterns to make this feasible.
- If Sonoma became an independent single county COHS, it would have approximately 41,000 members (based on 87% of 47,000 beneficiaries).
- Bottom Line on size for COHS: Sonoma's total Medi-Cal beneficiary population could potentially support a stand alone COHS Plan, though it would be the smallest of the existing COHS Plans. Sonoma could potentially seek to be a regional COHS to increase the size of its population.

(Data on size of existing Managed Care Plans and enrollment is from the Interim MANAGED CARE ANNUAL STATISTICAL REPORT, published by the CA DHS, August 2004)

4. Federal Restrictions on the number, size of COHS Plans

- California has a Federal Waiver allowing up to five COHS Plans covering up to 14% of Medi-Cal beneficiaries statewide. The five existing COHS Plans cover 8% of total Medi-Cal beneficiaries, or 560,000 enrollees.
- An additional 372,000 beneficiaries could be enrolled in existing COHS Plans before hitting the 14% cap (which is 928,000 of the total 6.7m Medi-Cal enrollees). Sonoma, Marin, Mendocino, San Benito, Merced and Ventura Counties could all join an existing COHS Plan without exceeding the cap.
- New COHS Plans can not be created without an amendment to the federal legislation that authorized the original CMS waiver. The State was hoping to secure such legislation as part of the Budget Reconciliation act in January 2006.

- The proposed language would have doubled the number of allowed COHS Plans to ten and would have permitted enrollment of up to 24% of Medi-Cal beneficiaries.
- The hoped-for legislation was never voted on. Merced and Ventura, which have asked to become COHS counties, plan to propose such legislation and anticipate State support. They and the State would like the support of other Counties and their Congressional representatives.
- Bottom Line for a new COHS: Federal legislation would be required before Sonoma County could become a new COHS, either as a stand-alone Plan or as a regional COHS Plan. The prospects for this legislation are uncertain.
- Bottom Line on an existing COHS: Sonoma could join Partnership Health Plan of California (or any other COHS) without additional federal Legislation. A routine amendment to the Medi-Cal waiver creating COHS Plans would be required to add new counties to an existing COHS.

Grid of Medi-Cal Managed Care Models
Sonoma Planning Group- March 24, 2006 Meeting
 Prepared by Elinor Hall

Traits	PLAN TYPES			
	Fee-for-Service	Geographic Managed Care GMC	Two-Plan Model	County Organized Health System COHS
General Description	Enrolled providers bill DHS for services, payment based on rate schedule and/or negotiated hospital per diems.	Commercial Plans meeting State criteria authorized to operate regionally. At-risk contract w State, plans contract w provider network or sub-contract w other Plans, IPAs	Co. Board creates a Local Initiative Plan; One commercial plan is selected by DHS via RFP. Plans compete for enrollees, providers. Contract w IPAs other plans	County forms a new governmental authority that manages all Medi-Cal services for all beneficiaries; no marketing, no competition, no choice. Use direct contracting more frequently.
Administration	Administered by DHS State staff do pre-authorizations, set rates, enroll providers.	Separate commercial plans administer managed care pursuant to their contracts with DHS Nationally CPs spent 9-10% for Medi-Cal Admin in 2001. In CA commercial plans spent 10-15% on admin.	Local Initiative administered by non-profit board appointed by B of S. Commercial Plan administered privately, see GMC info	Administered by a Board of providers, consumers and the public, appointed by the Board of Supervisors. In 2001 COHS Plans spent under 7% on administration
Risk	Risk held by State/feds Costs constrained by eligibility, rates and benefits	Risk held by commercial plans, may be shared with providers. Confidential rates negotiated by CMAC	Risk held by LI and CP, shared w providers. Much sub-contracting w other plans. Rates set by	At-risk contract, confidential rates negotiated by CMAC (except Santa Barbara). Risk shared with providers;

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			DHS (higher for LI)	minimal sub-contracting to other plans except for CalOptima
Enrollees	All Medi-Cal beneficiaries who are not enrolled in managed care are in FFS.	Families, Children, pregnant women must enroll in GMC Plans 53% of beneficiaries join Plans in GMC counties	Families, Children, pregnant women must enroll 53% of beneficiaries join Plans in Two-Plan counties	Families, Children, pregnant women, plus seniors, aged, blind disabled- 87% of beneficiaries join Plans in COHS counties
Benefits	Mental Health, Alcohol and drug, CCS, home and community based services are part of MC but managed separately by the State and the Counties	Mental Health, Alcohol and drug, CCS, optometry, dental home and community based services, CHDP, long-term care are carved out of GMC plans. Benefits are available FFS or through other County managed systems.	Same as GMC	Same as GMC except: <ul style="list-style-type: none"> • CCS is included in PHC, • MH included in PHC- Solano. L • long- term care included except San Mateo. • CHDP included only in PHC. Most plans cover chiropractic, acupuncture
Regulation	State DHS, contractors oversee FFS	Mandatory Knox- Keene certification by DMHC	Mandatory Knox- Keene certification by DMHC	Knox-Keene exempt, but all COHS Plans are now certified
Consumer Satisfaction	No routine measurement of satisfaction. Very limited to no assistance to individuals, no provider directory	Consumer Assessment of Health Plan Survey (CAHPS)performed every 2 years Every beneficiary has a medical home, receives	CAHPS survey performed every 2 yrs Every beneficiary has a medical home, receives benefit and provider materials and has access	CAHPS survey performed every 2 years Every beneficiary has a medical home, receives benefit and provider materials and has access to

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	Fee-for-Service	Geographic Managed Care GMC	Two-Plan Model	County Organized Health System COHS
		benefit and provider materials and has access to assistance and the grievance process	to assistance and the grievance process	assistance and the grievance process
Provider Participation	57% of physicians are enrolled in Medi-Cal FFS statewide. Provider enrollment back log is lengthy	Data on physician participation not available. Plans enroll providers using higher standards than M/C	Data on physician participation not available. Plans enroll providers using higher standards than M/C	COHS Plans report 90% of providers participating. Plans enroll providers using higher standards than M/C
Provider rates	Low rates: 35-60% of commercial PPO rates. Payments per unit of service. Hospitals paid contract rate or cost based (Sonoma)	Plans have flexibility to pay higher rates –detailed data not available Use of capitation and FFS	Plans have flexibility to pay higher rates – detailed data not available Use of capitation and FFS	Plans pay specialists 20-50% above M/C Use of capitation and FFS
Quality Measures	No routine, systematic measurement	HEDIS measurements and reporting	HEDIS measurements and reporting	HEDIS measurements and reporting
Governance	DHS oversees systems	Commercial Plans are private for- profit corporations (except non-profit Kaiser) Plans set policies, rates, etc. within State parameters	LI: non-profit governed by County- appointed Board, local committees. CP: Same as GMC - Plans set policies, rates within State parameters	COHS is a governmental entity, governed by a County-appointed Board with locally staffed committees Plans set policies, rates, within State parameters