

Baseline: 1997

A Survey of Medi-Cal Managed Care Plans in County Organized Health System and Two-Plan Counties

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Conducted for the Medi-Cal Policy Institute by

Helen Schauffler, Ph.D.

Sara McMnamin, M.P.H.

University of California, Berkeley School of Public Health

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Medi-Cal Policy Institute
476 Ninth Street
Oakland, CA 94607
tel: (510) 286-8976
fax: (510) 238-1382
www.medi-cal.org

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I. Executive Summary

Introduction

California has two models of Medicaid managed care that are unique: the County Organized Health System and the Two-Plan model. The Medi-Cal Policy Institute is interested in tracking the operations, viability, and care delivery of these and other models over time to assist policymakers in understanding the impact of managed care on Medi-Cal.

The shift of Medi-Cal recipients into managed care, initiated in 1993 by the California Department of Health Services' Managed Care Strategic Plan, sparked a powerful and continuing debate about the efficacy and effectiveness of managed care for the Medi-Cal population. Some advocates and representatives of beneficiaries raised concerns about the program's complexities and inclusiveness. Clinics and public hospitals voiced doubts about the effects of managed care on traditional and safety net providers. And the State stressed that the program had the potential to widen access and improve quality in addition to containing costs.

An important stakeholder of the managed care system is not always invited to weigh in on the progress and challenges of managed care implementation: the health plans responsible for organizing and providing health services. While health plans certainly participate actively in the managed care debate, they seldom have an opportunity to evaluate their aggregate successes and challenges from a noncompetitive and educational perspective. The Department of Health Services in its regulatory capacity monitors contractual compliance of the plans. Advocates report on health plan responsiveness to consumer needs. Yet the plans are rarely asked to describe implementation issues within a framework that permits identification of opportunities for broad systemic and policy improvements.

The Medi-Cal Policy Institute contracted with Dr. Helen Schauffler of the University of California at Berkeley to conduct a survey of Medi-Cal managed care plans to create a baseline of information about the plans relatively early in their development. This is not a scientific audit of plans nor is it intended as a report card or ranking of scores. The charts and graphs should be read with that in mind. Instead, this report gives a glimpse of first steps health plans have taken to develop systems that meet the myriad, complex needs of Medi-Cal beneficiaries and areas where improvement is still needed.

By the end of 1997, nearly 1.5 million Medi-Cal recipients in California were enrolled in a managed care plan. A relatively small proportion of recipients had been in managed care for many years prior. The majority of recipients—voluntarily or by assignment—were enrolled in managed care in 1996 or 1997. Many of the managed care organizations responsible for Medi-Cal recipients' health care were new entities themselves, established within the past few years for the purpose of serving Medi-Cal populations.

The primary managed care models for Medi-Cal are (1) Geographic Managed Care, (2) County Organized Health Systems (COHS), and (3) the Two-Plan Model developed by the State, in which Local Initiatives and commercial plans compete. With the exception of Medi-Cal recipients in Sacramento's Geographic Managed Care model, the vast majority of Medi-Cal recipients in managed care were members of one of sixteen plans operating within County Organized Health Systems or the Two-Plan Model during 1997. For four plans, 1997 was the first year of operations as a Local Initiative (Contra Costa, Los Angeles, San Francisco, and Santa Clara Counties).

Survey and Key Findings

To better understand the challenges encountered by plans in 1997, the Medi-Cal Policy Institute commissioned the Center for Health and Public Policy Studies at the School of Public Health of the University of California, Berkeley, to survey Medi-Cal managed care plans. Specifically the purpose of the survey was to:

1. Establish a baseline to track implementation of Medi-Cal managed care and monitor changes in the system over time;
2. Systematically capture the perspective of health plans to identify challenges and best practices; and
3. Identify common areas for improvement across the Medi-Cal managed care system.

The survey was conducted via mail in June 1998 among sixteen health plans operating as a County Organized Health System (five), Local Initiative (eight) or the designated commercial plan under the Two-Plan model (three). The response rate was 100%. Please see Appendix A

for the list of plans surveyed. Other forms of Medi-Cal managed care were not included in the survey such as geographic managed care plans, primary care case management and special projects due to limited enrollment as of 1997 and the wide variation in model types.

An advisory group of stakeholders participated in the design of the survey and in the interpretation of the findings; the group was comprised of representatives of County Organized Health Systems (two), Local Initiatives (three), commercial plans (two), consumer and advocacy groups (three), and the Department of Health Services (four). Please see Appendix B for a full list of group members.

As the intent of this survey is to examine characteristics of the system—rather than compare performance by plans—the survey data were analyzed on an aggregate level. Plans were not identified by name in the analysis or to the Institute.

This report presents baseline findings on the status of Medi-Cal managed care plan operations as of December 31, 1997. Presented in this report are findings in the areas of: Data; Quality; Audits; Provider Payments; Communicating with Providers; Communicating with Consumers; Health Promotion and Public Health; and Problems and Barriers to Improving Health Outcomes.¹

Overall, the survey results suggest a few broad findings. Data suggest that in 1997:

- Plans viewed instability in member enrollment as a significant problem in program implementation;
- Plans reported the biggest barriers to improving health outcomes over time to be low Medi-Cal reimbursement rates as well as instability in member enrollment;
- Public plans (Local Initiatives and COHSs) were more likely to offer public health promotion programs and collaborate with local health departments;
- The majority of plans (eleven of fifteen) involved members in identifying and solving problems within their plan;
- Plans were more likely to calculate a bonus or withhold amount based on individual provider performance than on group performance;
- Commercial plans were much less likely to capitate individual primary care providers than the Local Initiative or COHS;

¹ Additional findings from this survey are also discussed in the publication *The State of Health Insurance in California 1998*, issued in January 1999, for the Health Insurance Policy Program by Helen Schaffler and Richard Brown and funded by the California Wellness Foundation.

- State audits were not coordinated nor were they effective in stimulating plan improvements; and
- Plans had limited capacity to collect and report required utilization and enrollment data.

The stakeholder group reviewed the survey findings and the participating plans received the findings. Most of the findings were not of particular surprise to respondents; rather the findings represent the issues and concerns already identified by many of those involved with implementing Medi-Cal managed care.

The findings point to specific areas for increased focus, including:

- Identifying barriers to effective member involvement in plan activities and policymaking;
- Identifying better ways of communicating with providers aside from resource intensive face-to-face trainings;
- Understanding the impact of different provider payment methods on access to and quality of care;
- Improving data collected by the state from plans and by plans from providers;
- Assessing infrastructure of plans and their capacity to track individual member-level information (e.g. receipt of health assessment, length of time enrolled in plan); and
- Adapting auditing processes to ensure that findings are useful and have an impact on plan activities and performance.

The Medi-Cal Policy Institute is committed to working with policymakers, plans, providers and consumer representatives to make improvements in areas identified in this survey. Clearly, many of the issues require additional attention and resources from a range of stakeholders.

II. Findings

Methodology

The survey instrument was designed by U.C. Berkeley with input on issues of relevance and priority from a team of stakeholders including representatives from health plans, consumer groups and the California Department of Health Services. A complete list of participants on the design team is in Appendix B. The U.C. Berkeley team prepared a list of survey questions, and the design team met to discuss related issues and suggest additional questions. A draft questionnaire was circulated to the design team for their review and comment. The final survey instrument was 31 pages in length.

The survey was mailed, in June 1998, to all COHSs, Local Initiatives and commercial plans operating in Two-Plan counties. Plans were instructed to complete the survey using data as of December 31, 1997. Plans had two months to complete the survey. The response rate was 100%.

Problems and Barriers to Improving Health Outcomes

Respondents were asked to reflect on the most significant issues that either impeded implementation of plan policies and operations or are expected to pose barriers to improving future health outcomes.

Factors Contributing to Implementation Problems

A majority of the Medi-Cal managed care plans pointed to three factors as contributing or greatly contributing to the problems faced by their plan in 1997:

1. Lack of continuous eligibility of enrollees;
2. Enrollment transitions from traditional Medi-Cal to managed care; and
3. Lack of lock-in provisions (open enrollment every 30 days).

In fact, six of the seven Local Initiatives responding to this question identified these three factors as their most significant barriers. These problems were less of an issue for the commercial or COHS plans. In addition, three of the Local Initiative plans reported that the managed care model under which they were structured also contributed to the problems they faced in 1997.

Factors that Contribute to Plan Problems by Medi-Cal Managed Care Model Type, 1997

Factors Contributing to Plan Problems	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Lack of continuous eligibility	6	1	2	69%
Enrollment transition	6	1	1	62%
Open enrollment	6	1	0 ¹	58%
Medi-Cal structure	3	0	1	31%
Increases in SSI in plan	0 ²	1	0	10%
n = number of plans	(n = 7)	(n = 1)	(n = 5)	(n = 13)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

1: Only 4 plans responded

2: Only 5 plans responded

Barriers to Improving Health Outcomes in the Future

In response to an open-ended question about barriers to improving health outcomes in the next year and next three years, three or more plans identified low Medi-Cal reimbursement rates and lack of continuous eligibility as barriers. Other short- and long-term barriers identified by two plans included lack of Medi-Cal beneficiary understanding of how to use managed care, difficulty in collecting data from providers, and multiple audits.

Barriers to Improving Health Outcomes in Medi-Cal Managed Care Plans in the Next Year and Next Three Years, 1997

Barriers to Improving Health Outcomes	Barriers in Next Year	Barriers in Next 3 Years
Low Medi-Cal reimbursement rates	4	3
No continuous eligibility	5	3
CCS and mental health carve outs	4	1
Lack of lock-in/open enrollment every 30 days	3	1
HCFA-DHS-DOC incompatibilities	1	2
Lack of Medi-Cal beneficiary understanding of how to use managed care	2	2
Data collection from providers	2	2
Multiple audits	2	2
Unfunded mandates such as HEDIS and other quality/data requirements	1	2
DHS policies and delayed responses	1	1
Language and cultural diversity	1	1
n = number of plans	(n = 12)	(n = 12)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Additional barriers to improving health outcomes in the *next year* that were identified by three or more plans include mental health and California Children Services being “carved-out”—or provided outside the plan—and open enrollment every 30 days (lack of lock-in). Additional barriers anticipated by two plans in the *next three years* include incompatibilities in requirements and activities among the Department of Health Services (DHS), the Department of Corporations (DOC), and the Health Care Financing Administration (HCFA), and the growing number of unfunded mandates, such as HEDIS and other quality/data reporting requirements.

Health Promotion and Public Health Issues

Programs Open to Non-Plan Members

Local Initiatives and COHS plans were more likely to offer a wider range of health promotion programs to the general public than the commercial plans in Two-Plan counties. All of the Local Initiatives and a majority of the COHSs open some health promotion programs to non-plan members in the community.

Types of Health Promotion Programs Open to Non-Plan Members in Community by Medi-Cal Managed Care Model Type, 1997

Types of Programs Open to Community	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Offer any program	8	1	4	87%
Health fairs	8	1	4	87%
Free materials	7	1	3	73%
Community events	5	1	1	47%
Health education classes	3	0	3	40%
Preventive screenings	5	0	0	33%
Immunizations	4	0	0	27%
Media campaigns	4	0	0	27%
Health risk appraisals	4	0	0	27%
Public Service Announcements (PSAs)	3	0	0	20%
n = number of plans	(n = 8)	(n = 2)	(n = 5)	(n = 15)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Collaboration with Local Health Departments

While most plans are required by DHS to contract via a Memorandum of Understanding with the county health department for certain health services such as HIV testing and immunizations, formal relationships related to health promotion were not required in 1997. Even in the absence of a formal requirement, plans reported collaborating with local health departments on a range of issues. Whereas fourteen of fifteen plans collaborated with local health departments on promotion activities related to childhood immunizations, only three plans collaborated in the area of breast and cervical cancer programs.

**Areas of Collaboration with Local Health Departments for
Health Promotion by Medi-Cal Managed Care Model Type, 1997**

Areas of Collaboration with Local Health Departments	Two-Plan Model		COHS	Total
	Local Initiative	Commercial Plan		
Childhood immunization	8	1	5	93%
Prenatal care	6	1	3	67%
Smoking cessation	5	1	4	67%
Asthma	5	1	3	60%
Nutrition	5	1	3	60%
TB	6	1	2	60%
Injury prevention	6	0	2	53%
Family planning	5	1	2	53%
Adult immunizations	3	1	3	47%
Tobacco use prevention	4	0	3	47%
Diabetes	3	1	3	47%
STD control	4	1	1	40%
Drug or alcohol use	3	1	2	40%
HIV/AIDS	3	0	3	40%
Violence in the community	4	0	0	27%
Breast and cervical cancer	2	0	1	20%
Dental health	2	0	1	20%
Quality measurement	2	0	1	20%
Exercise	1	0	1	13%
Hypertension	0	0	1	7%
n = number of plans	(n = 8)	(n = 2)	(n = 5)	(n = 15)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Communicating with Consumers

The Institute was interested in the various methods that health plans use to communicate with their members and the degree to which plans perceived the methods to be effective. The following descriptive information may assist plans, providers, and other organizations seeking to better communicate with Medi-Cal managed care consumers.

Educational Approaches

For example, of the five plans that reported contracting with community-based organizations (CBOs) to educate members in 1997, all five of the plans found it to be at least somewhat effective. Overall, home visits were reported as the most effective method of educating members relative to the other approaches. All sixteen plans reported using letters or newsletters but the majority found them to be only somewhat effective in educating members.

Use and Effectiveness of Approaches to Educate Members about Medi-Cal Managed Care, 1997

Approach to Educating Members in Medi-Cal	Number of Plans Using Approach	Very Effective or Effective	Somewhat Effective	Not Very or Not at All Effective
Letters	16 ¹	29%	64%	7%
Newsletters	16 ¹	21%	71%	7%
Pamphlets	14 ²	23%	69%	8%
Orientations	13 ³	50%	33%	17%
During home visits	6 ⁴	80%	0%	20%
During ER visits	3	33%	33%	33%
Contract with CBOs	5	40%	60%	0%
n = number of plans	(n = 16)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

1: 14 plans reported on effectiveness

3: 12 plans reported on effectiveness

2: 13 plans reported on effectiveness

4: 5 plans reported on effectiveness

Transitional Medi-Cal Information

Efforts are underway in many communities to communicate to Medi-Cal recipients—specifically recipients in the CalWORKs program—that they may be eligible for Transitional Medi-Cal (TMC) if they leave welfare due to work or increased earnings. At the time of the survey few plans reported notifying members about Transitional Medi-Cal. However, anecdotal evidence suggests that many plans have begun to notify members about TMC or are preparing to do so. From this survey we know that of the plans using one of the approaches listed below in 1997, most found each approach to be an effective or very effective method of notifying members about TMC.

Method of Notification for Eligibility for Transitional Medi-Cal, 1997

Approaches Used to Notify Members About Eligibility for Transitional Medi-Cal	Number of Plans Using Approach	Very Effective or Effective	Somewhat Effective	Not Very Effective
Letters	3	3	0	0
Newsletters	2	1	1	0
Phone calls to members	3	3	0	0
Coordinate with county welfare department	4	3	1	0
Linkage with other agencies	2	1	1	0
n = number of plans	(n = 4)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Areas of Direct Member Involvement

The majority of Medi-Cal managed care plans reported directly involving members in areas of problem identification and solutions development. Of the eleven plans with consumers involved in problem identification, nine rated consumers as being extensively to moderately involved in these activities. Fewer plans involved consumers in efforts related to cultural competency. In addition to problem identification, consumers appear to have been involved more in grievance procedures and the plans' focused studies than in other areas. Focused studies are one method of quality measurement required by DHS in 1997.

Direct Consumer Involvement in Medi-Cal Managed Care Plans, 1997

Consumer Involvement in:	Number of Plans Using Approach	Extensively or Moderately Involved	Somewhat Involved	Minimally or Not at All Involved
Problem identification	11	82%	18%	0%
Problem solutions	11	55%	27%	18%
Cultural competencies	7	57%	14%	29%
Grievance procedure ¹	6	80%	0%	20%
PCP selection procedure ¹	6	60%	20%	20%
Linguistic competencies ¹	6	40%	20%	40%
Quality improvement	5	20%	60%	20%
Focus studies	5	80%	0%	20%
New member orientation	5	60%	0%	40%
Ombuds program	3	33%	33%	33%
Enrollment procedures	2	100%	0%	0%
n = number of plans	(n = 15)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

1: Only five of the six plans rated the level of consumer involvement

Member Involvement in Plan Operations and Policy

DHS requires plans to ensure that members are represented and participate in establishing the plans' Medi-Cal program policies. All plans involved Medi-Cal managed care members in advisory committees to increase involvement in plan operations and policy development; however, this was rated as very effective or effective by fewer than half of the plans. Only five plans involved members in the development of member surveys, but all rated this as an effective or very effective approach. Other approaches used by at least half the plans include involvement on the board of directors, involvement in improving grievance procedures, and participation in focus group studies. A majority of plans rated these strategies as effective.

Approaches Used to Involve Members in Plan Operations and Policy Development in Medi-Cal Managed Care Plans, 1997

Approaches Used to Involve Members in Plan Operations	Number of Plans Using Approach	Very Effective or Effective	Somewhat Effective	Not Very or Not at All Effective
Advisory committees ¹	15	36%	57%	7%
Grievance procedures ²	11	60%	40%	0%
Board of directors ³	10	67%	11%	22%
Participation in focus studies ⁴	7	83%	17%	0%
Development of member surveys ⁵	5	100%	0%	0%
Ombuds program ⁶	3	100%	0%	0%
n = number of plans	(n = 15)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

1: 14 plans rated effectiveness

2: 10 plans rated effectiveness

3: 9 plans rated effectiveness

4: 6 plans rated effectiveness

5: 4 plans rated effectiveness

6: 2 plans rated effectiveness

Communicating with Providers

DHS requires that health plans give providers training related to services, policies, procedures, and regulations of the plan and the Medi-Cal program. Plans are specifically required to issue provider manuals and bulletins to all providers in their network. The Institute was interested in the plans' assessments of the efficacy of these and other forms of communicating with providers. As part of this survey, plans were asked to rate the effectiveness of different methods of communication.

Educating Medi-Cal Providers About DHS Regulations

The approach rated as the most effective method to educate Medi-Cal providers about DHS regulations was seminars and conferences. Twelve plans reported using this method of communication. Newsletters and provider manuals were also used by nearly all the plans, with only half of the plans rating them as effective methods of educating providers.

**Utilization and Effectiveness of Methods to Educate Providers
about DHS Regulations in Medi-Cal Managed Care Plans, 1997**

Approach to Educate Providers	Number of Plans Using Approach	Very Effective or Effective	Somewhat Effective	Not Very Effective
Provider manuals	13	54%	38%	8%
Seminars/conferences	12	83%	17%	0%
Newsletters	14	57%	43%	0%
n = number of plans	(n = 16)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Educating Providers About Medi-Cal Enrollees' Special Needs

All but one of the Medi-Cal managed care plans offered seminars or conferences to educate providers about Medi-Cal patients' special needs, and all rated these as effective or very effective approaches to educating providers. All but one plan used newsletters to educate providers and just over half rated this as an effective method. Four plans shared data with providers on Medi-Cal enrollees as a way to educate them and a majority rated this as an effective or very effective approach. The approach that was rated as least effective was the provider manuals developed by all but one of the Medi-Cal managed care plans.

**Utilization and Effectiveness of Methods to Educate Providers
about Medi-Cal Patients' Special Needs, 1997**

Approach to Educate Providers	Number of Plans Using Approach	Very Effective or Effective	Somewhat Effective	Not Very Effective
Seminars/conferences	15	100%	0%	0%
Newsletters	15	60%	40%	0%
Provider manual	15	47%	47%	7%
Share data with providers	4	75%	25%	0%
n = number of plans	(n = 16)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Provider Payments

The Institute was interested in the variation in method of paying or reimbursing contracted providers across plans. While the State pays Medi-Cal managed care plans a capitated amount—a set fee per member per month—the plans have the authority to pay providers in a number of ways.

Primary Care Provider Payments

The majority of Medi-Cal managed care plans capitate medical groups and IPAs (Independent Practice Association), as well as individual providers, for primary care services. Four plans paid salaries to primary care providers (PCPs) and only two made fee-for-service payments to medical groups and IPAs for primary care services. More than half of the plans that capitate medical groups and IPAs subject their capitation payments to bonuses or withholds. All of the plans that capitate and salary individual physicians subjected their capitation payments and salaries to bonuses or withholds. In general, commercial plans were much less likely to capitate individual PCPs than the Local Initiative or COHS plans. Use of capitation payments to medical groups and PCPs may affect the plans' ability to report member-level utilization data.

Methods of Paying PCPs by Medi-Cal Managed Care Model Type, 1997

PCP Payment Methods	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Capitation to medical group/IPA	5	2	3	63%
Capitation to individual PCP	5	0	5	63%
Fee-for-service to individual PCP	2	2	2	38%
Salaried employees	3	0	1	25%
Fee-for-service to medical group/IPA	1	1	0	13%
n = number of plans	(n = 8)	(n = 3)	(n = 5)	(n = 16)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Specialist Payments

Eleven of thirteen Medi-Cal managed care plans paid individual specialists on a fee-for-service basis, with 70% also capitating specialists at the level of the medical group or IPA. Three plans capitate individual specialists. Less than one-third of plans subjected specialist payments to withholds or bonuses.

Methods of Paying Specialist Physicians by Medi-Cal Managed Care Model Type, 1997

Specialist Payment Methods	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Fee-for-service to individual specialist	6	2	5	81%
Capitation to medical group/IPA	5	3	3	69%
Fee-for-service to medical group/IPA	2	1	3	38%
Salaried employees	4	0	1	31%
Capitation to individual specialist	1	0	2	19%
n = number of plans	(n = 8)	(n = 3)	(n = 5)	(n = 16)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Bonuses and Withholds

HCFA regulations limit to 20% the amount of Medi-Cal managed care payments that may be withheld or used as bonuses. The factors most commonly used by Medi-Cal managed care plans to calculate physician bonuses or withholds include use of inpatient hospital services, prescription drugs, specialty referrals, and laboratory or other ancillary services. Plans were more likely to calculate a bonus or withhold based on individual provider performance than group performance.

Two plans used quality of care measures, patient satisfaction ratings, or productivity measures to calculate physician bonuses or withholds. Five of the twelve plans using bonuses or withholds as part of their physician payment strategy used total costs as a factor.

Factors Used to Calculate Bonuses/Withholds in Medi-Cal Managed Care Plans, 1997

Factors Used to Calculate Bonuses/Withholds	Used by Plans	Bonus or Withhold Calculation Based on:		
		Individual Provider's Performance	Provider Group's Performance	Both Individual and Group Performance
Use of inpatient hospital services	9	22%	11%	67%
Patients' use of prescription drugs	7 ¹	14%	0%	86%
Patients' use of referral, laboratory or other ancillary service	6	17%	0%	83%
Total costs	5 ²	25%	0%	75%
Quality of care	2	50%	50%	0%
Patients' satisfaction rating	1	100%	0%	0%
Productivity	1	100%	0%	0%
n = number of plans	(n = 12)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

1: Only 7 plans stated how bonuses/withholds are calculated

2: Only 4 plans stated how bonuses/withholds are calculated

Financial Incentives for Preventive Care

Fewer than half of the Medi-Cal managed care plans offered any type of incentive to network physicians in 1997 to increase provision of preventive services to enrollees, despite low rates of utilization for recommended preventive care. Only six plans offered preventive care incentives to individual physicians, with most structuring incentives as bonus payments to reward performance, and five plans offering incentive payments to medical groups as bonuses. Half of the Local Initiatives used provider incentives to reward provision of preventive care.

Hospital Payments

The method of paying hospitals used by more than half of the plans was per diem payments. Nearly one-third of the plans capitated only hospital services. Three plans paid hospitals using discounted charges and one used diagnostic-related groups (DRGs). Local Initiatives were most likely to use per diem payments and global capitation. Commercial plans in Two-Plan counties were most likely to use capitation for hospital services only. COHS plans were most likely to use per diem payments to hospitals.

In-Network Hospital Payments by Medi-Cal Managed Care Model Type, 1997

Hospital Payment Method	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Discounted charges	2	1	0	19%
Diagnostic-related group	1	0	0	6%
Per diem	5	1	3	56%
Capitation – hospital services only	2	2	1	31%
Global/full capitation	3	1	0	25%
n = number of plans	(n = 8)	(n = 3)	(n = 5)	(n = 16)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Audits

Regulatory audits are designed partly to monitor and guide compliance with contractual requirements. The Department of Corporations (DOC) is responsible for auditing all plans with a Knox-Keene license, including most Medi-Cal plans. The Audits and Investigations Branch of the Department of Health Services (DHS A&I) is responsible for financial and medical audits, often referred to as “compliance” audits.

Timely Feedback

Plans cited a lack of timeliness in receiving audit results and feedback as a significant problem. When asked about the barriers to improving health outcomes, plans cited multiple audits and lack of coordination between DHS, DOC, and HCFA as a barrier.

Based upon plans' responses, the results of audits, particularly by DHS Audit and Investigations Branch, are not received prior to the implementation of the next audit or “in time” to implement any changes identified by the previous audit.

Feedback from Audit/Review in Time to Implement Changes in Medi-Cal Managed Care Plans, 1997

Audit/Review	Number of Plans	Always or Usually in Time	Sometimes in Time	Not Often or Never in Time
DOC – Financial	7	43%	29%	29%
DOC – Medical	4	50%	25%	25%
DHS A&I – Financial	12	17%	0%	83%
DHS A&I - Medical	12	8%	8%	83%
n = number of plans	(n = 16)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Usefulness of Audits

In addition to timing issues, plans felt that the audit findings were not very useful in identifying areas for improvement within a plan. Audits by DOC were more likely to be useful for plans than DHS Audits and Investigations Reviews.

Usefulness of Audit/Review of Medi-Cal Managed Care Plans, 1997

Audit/Review	Were Reviewed /Audited	Extremely or Very Useful	Somewhat Useful	Not Very/ Not at All Useful
DOC – Financial	7	14%	71%	14%
DOC – Medical	4	25%	50%	25%
DHS A&I – Financial	12	0%	50%	50%
DHS A&I – Medical	12	8%	67%	25%
n = number of plans	(n = 16)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Impact of Audits

Not only were audit findings not useful but the majority of plans reported that these audits had little impact on operations and practices. This may or may not be strictly an issue of timing as findings above indicate, audits are not necessarily produced in time for plans to take corrective action prior to the next audit.

Audits are also performed on a voluntary basis by the National Committee for Quality Assurance (NCQA) as part of its accreditation process. At the time of the survey NCQA had audited and accredited only one plan (a commercial plan). This plan found the NCQA audit to be very useful, timely, and effective in making changes in plan operations.

Impact of Audit or Review on Quality of Care in Medi-Cal Managed Care Plans, 1997

Audit/Review	Number of Plans	Great or High Impact	Some Impact	Little or No Impact
DOC – Financial	7	0%	14%	86%
DOC – Medical	4	0%	0%	100%
DHS A&I – Financial	12	0%	0%	100%
DHS A&I – Medical	12	0%	42%	58%
NCQA	1	100%	0%	0%
n = number of plans	(n = 16)			

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

NCQA Accreditation

One plan was NCQA accredited at the time of the survey and one additional plan was preparing for an NCQA accreditation audit. Ten other plans were planning to seek NCQA accreditation. Those plans not planning to seek accreditation indicated that they have not precluded accreditation.

NCQA Accreditation Status by Medi-Cal Managed Care Model Type, 1997

Accreditation Status	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Accredited by NCQA	0	1	0	6%
Preparing for NCQA accreditation audit	1	1	1	19%
Planning to seek NCQA accreditation	7	1	2	63%
Not planning to seek NCQA accreditation	0	0	2	13%
n = number of plans	(n = 8)	(n = 3)	(n = 5)	(n = 16)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Quality Issues

In 1997, Medi-Cal managed care plans were required by DHS to conduct certain quality of care studies. Eleven “focused studies” were required for each plan. Plans selected or were assigned study topics from a list included in each plan contract.

120-Day Health Assessment Rates

DHS requires all COHS and Two-Plan model plans to perform an initial health assessment within 120 days of new member enrollment. The purpose of this requirement is to ensure that

members receive access to care and that outstanding health needs are identified as early as possible. Not all COHS plans, however, were required to report 120-day health assessment rates in 1997.

The majority of plans (eleven of sixteen) were unable to report rates for 120-day health assessments in 1997. Half of the Local Initiatives were able to report. Lack of length of enrollment data may be a significant contributor to the inability to track these rates.

**Ability to Report Rates for 120-Day Health Assessment
by Medi-Cal Managed Care Type, 1997**

	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Able to report	4	0	1	31%
Unable to report	4	3	4	69%
n = number of plans	(n = 8)	(n = 3)	(n = 5)	(n = 16)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

HEDIS Measures

Nine of the plans reported they were able to collect data required for HEDIS indicators in 1997. That year, the state's External Quality Review Organization collected independent data via medical chart reviews for HEDIS-related data for quality measurement.

Data Collection for HEDIS Indicators by Medi-Cal Managed Care Model Type, 1997

Medicaid HEDIS Measures	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Do collect data	4	2	3	56%
Do not collect data	4	1	2	44%
n = number of plans	(n = 8)	(n = 3)	(n = 5)	(n = 16)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Data Issues

The Medi-Cal Policy Institute is particularly interested in the potential for data to provide valuable information on the operations and quality of care delivered in Medi-Cal managed care. The term data often suggests several different types of information; in managed care it most often refers to enrollment and member data, utilization or encounter data, or financial and claims data.

In 1997, COHS and Two-Plan managed care organizations were required to submit encounter data to DHS on a monthly basis. The survey findings suggest that health plans, regardless of model type, did not collect and report contractually required data in 1997. Among the Local Initiatives, differences in capacity for data collection and reporting were not related to a plan's start date.

Length of Member Enrollment Data

The length of time an individual is enrolled in a health plan is important data to collect for several reasons, including targeting programs and services to meet members' needs as well as measuring quality of care. The majority (eleven of fourteen) of plans reported they were not collecting or able to report the data on members' length of enrollment in their plans in 1997. None of the Local Initiative plans, two of the commercial plans, and only one of the COHS plans collected data on length of enrollment of their members in 1997. There are fewer incentives for COHSs to track length of enrollment or reasons for disenrollment because recipients are disenrolled only when Medi-Cal eligibility is discontinued.

For all plans, however, the lack of data on length of enrollment by plans is problematic for assessing quality measures. Without denominators for the enrolled population, assessment of most quality indicators, including HEDIS measures, is limited. In addition, absence of this data would be problematic for tracking members over time for utilization of preventive services as well as meeting 120-day health assessment requirements. Observed differences were not a function of plan start-up date.

Post-survey discussions with some plans suggested that the lack of enrollment data might be a function of the methods used to relay data from the state systems to plans. Some plans also indicated they have developed historical data files of members since the survey was conducted.

Data Collection on Length of Enrollment by Medi-Cal Managed Care Model Type, 1997

Length of Enrollment Data	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Do collect data	0	2	1	21%
Do not collect data	6	1	4	79%
n = number of plans	(n = 6)*	(n = 3)	(n = 5)	(n = 14)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

*Two plans did not answer this question.

Utilization Data

Collection of utilization data varies across model type and type of service. The collection of utilization or encounter data is a significant issue under Medi-Cal managed care. Traditionally, under the fee-for-service system, providers submitted reimbursement forms in order to be

paid. These claims forms served as proof of service provided. Thus, providers had an explicit financial incentive to submit a detailed record of services provided to a centralized location or database, typically the state's processor of claims, Electronic Data Systems (EDS). Under managed care, many providers and institutions are paid using capitated arrangements. Capitation severs the link between payment and reporting of services provided. There are also additional administrative entities through which data must often flow. For example, Medi-Cal managed care plans that contract with IPAs or medical groups often depend upon the IPA to collect, process and report utilization data from individual providers.

These shifts in payment methods and organizational structure have resulted in significant challenges in collecting and reporting utilization data required by federal and state regulators and private purchasers. In 1997 many plans reported that they did not collect utilization data in particular areas. Twelve of sixteen plans reported that they did not collect data on STD rates.

Utilization Data Collected by Medi-Cal Managed Care Model Type, 1997

Utilization Data Collected	Two-Plan Model		COHS	% Total
	Local Initiative	Commercial Plan		
Inpatient utilization rates	5	2	5	75%
ER utilization rates	5	2	4	69%
Childhood immunization rates	7	2	2	69%
Pap smear rates	4	2	3	56%
STD treatment rates	2	1	1	25%
n = number of plans	(n = 8)	(n = 3)	(n = 5)	(n = 16)

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

Barriers to Data Collection

When asked about the barriers to collection of utilization data, the majority of plans not able to report patient level data in 1997 cited lack of infrastructure/information systems as the main reason. It is unclear to what degree respondents were referring to lack of infrastructure within the plans' own administrative capacity or at the level of the IPA, medical group, or individual provider.

Not captured in this question was the extent to which delegation of care or subcontracts influenced a plan's ability to collect data. Some plans have five or seven subcontracts with other health plans. All of these plans are dependent upon the ability of their sub-contractors—hospitals, IPAs, and other medical groups—to have access to and transmit needed data.

Provider reporting is typically less problematic when provider payments are fee-for-service versus capitation because claims data serves a dual purpose and providers have a built-in

financial incentive to accurately and thoroughly record encounters. Most provider information systems were designed for a claims-based data collection. To the degree that “unresponsive providers” was a barrier (14% of plans), this appears to be the case only for ambulatory visits for specialty care. Given that most plans reimburse specialty providers on a fee-for-service basis, method of payment may not be the only explanation for lack of provider responsiveness.

Not Able to Report Patient Level Data in Medi-Cal Managed Care Plans, 1997

Patient Level Data	Not Able to Report	Reasons Why Plans Are Not Able to Report Data			
		Lack Infrastructure/ Information Systems	Lack Financial Resources	Unresponsive Providers	Info Not Requested of Providers
Hospital re-admissions	7	86%	14%	0%	0%
Lab utilization	7	86%	14%	0%	0%
Ambulatory visits for specialty care	7	71%	14%	14%	0%
Inpatient diagnosis	6	100%	0%	0%	0%
Ambulatory visits for primary care	6	83%	17%	0%	0%
Ambulatory diagnosis	6	83%	17%	0%	0%
Hospital discharges	5	100%	0%	0%	0%
Inpatient LOS	4	75%	25%	0%	0%
Pharmacy utilization	4	75%	0%	0%	0%
n = number of plans	(n = 15)				

Source: UC Berkeley Survey of Medi-Cal Managed Care Plans, 1998

III. Conclusion and Next Steps

The Medi-Cal Policy Institute hopes the findings presented in the report motivate health plans and policymakers to examine the successes and structural challenges of Medi-Cal managed care in order to continue to implement system improvements. Many changes have already been made since 1997 when these results were collected. However, more are needed.

The Institute will use three primary methods of addressing the broad policy issues that are raised in these findings. These methods will include continued research, policy analysis, and the convening of stakeholders.

The Institute will focus on the following managed care related activities:

- Survey health plans over time to track improvements in these and other areas;
- Survey Medi-Cal consumers to capture their perspectives on areas for improvement;
- Analyze and monitor the viability of Medi-Cal managed care plans, including the impact of payment rates on the delivery and quality of care;
- Publish and distribute information on Medi-Cal managed care issues to inform related policy decisions;
- Track similar issues in other states to identify opportunities and best practices for California;
- Identify barriers to data collection and reporting at the provider, plan and state level;

- Stimulate the demand for quality information by Medi-Cal consumers;
- Assist in the development of standard audits and reporting requirements that are effective and non-duplicative; and
- Promote the adoption and use of standardized and validated quality measures to improve health outcomes.

It is our hope that the activities above, as well as the efforts of many other stakeholders throughout the state, will assist in improving the integration of health care delivery systems and ultimately lead to better health care for recipients of Medi-Cal.

Appendix A

Health Plans Surveyed

Plan	Model Type	First Year of Medi-Cal Managed Care Operations	Medi-Cal Membership December 1997 ¹
Alameda Alliance for Health	Local Initiative	1996	68,652
Blue Cross / CaliforniaCare	Commercial Plan	1996	212,967
CalOPTIMA	County Organized Health System	1995	226,184
Contra Costa Health Plan	Local Initiative	1997	39,280
Health Net	Commercial Plan	1997	258,295
Health Plan of San Joaquin	Local Initiative	1996	55,667
Health Plan of San Mateo	County Organized Health System	1987	45,785
Inland Empire Health Plan	Local Initiative	1996	131,587
Kern Family Health Care	Local Initiative	1996	52,324
L.A. Care Health Plan	Local Initiative	1997	181,742
Molina Medical Centers ²	Commercial Plan	1998	N/A
Omni Healthcare	Commercial Plan	1997	37,936
San Francisco Health Plan	Local Initiative	1997	20,659
Santa Barbara Health Authority	County Organized Health System	1983	39,877
Santa Clara Family Health Plan	Local Initiative	1997	37,323
Santa Cruz County Health Options	County Organized Health System	1996	23,691
Solano Partnership Health Plan	County Organized Health System	1994	45,130

¹ Medi-Cal Managed Care Division, California Department of Health Services. *Monthly Enrollment Report*, December 1997.

² Molina was originally surveyed, however, their responses were not included in our analysis because their contract to operate as the commercial plan under the Two-Plan Model in Riverside and San Bernardino Counties was not implemented until March 1998.

Appendix B

Survey Stakeholder Group

Milt Camhi
Chief Executive Officer
Contra Costa Health Plan

Larry Dickey
Chief, Office of Clinical Preventive Medicine
California Department of Health Services

Mary Fermazin
Chief, Policy & Quality Improvement Branch
California Department of Health Services

Celia Gaytan
Health Policy Analyst
Latino Issues Forum

Liz Gibboney
Government Relations Director
Partnership Health Plan

David Grant
Director, MedCAP
Health Access

Kim Jacobs
Director of Provider Development
Health Net

Lynn Kersey
Executive Director
Maternal & Child Health Access

Ann Kuhns
Chief, Medi-Cal Managed Care Division
California Department of Health Services

Barbara Masters
Vice President
Local Health Plans of California

John Monahan
General Manager
Blue Cross of California/CaliforniaCare

J. Douglas Porter
Deputy Director, Medical Care Services
California Department of Health Services

John Richardson
Associate Director of Financial Planning
CalOPTIMA

Anthony Rodgers
Chief Executive Officer
L.A. Care Health Plan