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Thoughts on the §1115 Waiver's Expansion of Managed Care
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The §1115 waiver proposes to expand Medi-Cal managed care in the following ways:

- Expansion for the seniors and persons with disabilities (also known as the SPD's)
    - Mandatory enrollment in managed care for 380,000 individuals, accounting for an estimated $7.5 billion in spending
    - County alternative option (managed care for outpatient services, fee for service for inpatient care – in other words a PCCM or Primary Care Case Management Program)
- Four pilot programs for the Medi-Medis (those with dual Medicare/Medicaid eligibility)
    - Medi-Medis (also known as dual eligibles) comprise 46% of national Medicaid spending and 1/4th of Medicare spending
    - There are 1.1 million dual eligibles in California – $7.6 billion in Medi-Cal spending, $21 billion in combined Medicare and Medicaid spending
    - The waiver proposes 4 pilots – two in County Organized Health Systems, one by a Local Initiative and one other
    - Beneficiaries may opt out of managed care.

We think in general expansion of managed care would improve patient health, slow the rise in health spending, reduce state budgetary pressure and better position California for implementation of federal reforms.

Medi-Cal managed care to date has provided superior care[1] to Medi-Cal fee for service for several reasons: first there is an organized and coordinated network; second there is a primary care doctor for every patient; third network providers must meet specific quality standards, and fourth, there is an accountable entity to assure access to services and two state regulators, the Department of Managed Health Care and the Department of Health Care Services to enforce compliance.

Medi-Cal managed care has been working well for the populations enrolled for more than a decade and has been steadily improving its performance. Most enrollment is in local public health plans like LA Care, CalOptima, Alameda Alliance or Santa Clara Family Health Plan (local MCOs). Substantial enrollment is in commercial plans as well, such as Health Net, Anthem Blue Cross and Molina Health Plan. Seniors and the

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[1] See UCSF Primary Care Research Center, Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee for Service with Managed Care (February 2004) at www.chcf.org and California HealthCare Foundation, Medi-Cal Beneficiaries, Comparing Managed Care with Fee for Service Systems (August 2005) at www.chcf.org

disabled are faring well in the managed care plans in the 9 COHS (County Organized Health System) counties. Over half of Medi-Cal beneficiaries but less than 20% of program spending are in managed care. Virtually all Healthy Families children are in managed care plans, primarily HMO's; many local MCO's are quite competitive in this market in their counties as well.[2] Roughly three in ten of California's Medicare beneficiaries enroll voluntarily in managed care plans; some local MCOs participate in this market, but do not have a large market share. Half of those Californians insured through their employers are enrolled in HMOs; only a very small percentage enroll in local MCOs that typically do not participate in this market. In general, patients report greater satisfaction with HMOs than the fee for service alternatives over issues like prevention, out of pocket, claims processing, customer services and less satisfaction on access to care, particularly for specialists.[3]

On the other hand, California has had past negative experiences with managed care during the Medi-Cal managed care expansions of the '70s and the for profit commercial managed care expansion of the '90s. In each case the legislature enacted major reforms, starting with the Waxman-Duffy Act, then the Knox-Keene Act and subsequent amendments. In California, HMO's are reasonably well regulated by state statutes. Although state regulatory oversight has not been without failings, regulators have been reasonably vigilant and forceful enforcers.

In general, both advocates and providers have opposed Medi-Cal managed care expansions. Advocates' concerns emanate from the bad actions of some plans (e.g. some particularly unscrupulous plans took the state's premiums and did not pay the patients' providers) in the '70s and from irresponsible actions from a different set of health plans (excessive gate-keeping and run-arounds when patients sought care or plan reimbursements) in the '90s and the subsequent battles to establish regulatory oversight as well as the advocates desire to assure patient freedom of choice of plans and providers. Hospitals are typically concerned that managed care will reduce their revenues as hospital utilization falls in the context of managed care. Doctors are often concerned about the financial risks associated with the receipt of capitated payments and the oversight and control that plans exercise. And all are

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[2] See Tuttle and Wulsin, California's Safety Nets and the Need to Improve Local Collaboration in Care for the Uninsured (Insure the Uninsured Project, October 2008) at www.itup.org/reports

[3] See Duke Helfand, HMO Members More Satisfied in 2009, Approval Ratings Rise for Six of California's Nine Largest Providers in Annual Survey, Los Angeles Times, February 10, 2010) and Office of the Patient Advocate, California Health Care Quality Scorecard, 2009 at www.opa.ca.gov/report_card See also Bruce Landon et al, Comparison of Traditional Medicare vs. Medicare Managed Care, Journal of the American Medical Assn. vol. 291 no. 14 (April 2004) and "Quality of Care in Medicaid Managed Care and Commercial Plans", JAMA 2007: 298 1674-81; Public Opinion about Health Care – Satisfaction with Health Insurance Plans (2004) at www.libraryindex.com/pages/1872/Public-Opinion-About-Health-Care-Satisfaction-With-Health-Plans.html**.** Consumer Reports, Best Health Insurance, 37,481 Readers Show You How to Make the Right Choice (September 2009) at www.consumerreports.org/healthinsurance

concerned about the excessive administrative costs of some commercial plans[4] and the possibility that a for-profit health plan could put its profit motives before a patient's well being.[5]

In the next month, the state legislature will decide whether to expand Medi-Cal managed care as described in the first two paragraphs. We would hope it does so; it is time to stop re-fighting the battles of the past and look to the future. The expansion is tied up with other issues: a) $10 billion request over the next 5 years for increased federal financial participation in California's care to the uninsured and low income populations, b) resolution of aspects of the state budget impasse and c) creation of important building blocks with coverage expansion initiatives available to all 58 counties. Most importantly we will never slow the rise in health spending unless we correct the financial mis-incentives of fee for service medicine. This needs to be done in a compatible way for all the program's beneficiaries. Failure to move forward on this package does not assure the status quo; in fact due to the dire budgetary situation facing the state of California and its local governments, it moves us in reverse.

There are admittedly problems with the managed care component of the §1115 waiver, however in our view these are problems of under-reach, not over-reach. The "alternative county organizations" proposed in the waiver are a very big step back from comprehensive managed care, and in our view a poor idea 1) because the savings in hospitalizations generated by well-run managed care are returned to the federal government rather than reinvested in the delivery system and 2) because the "alternative county organizations" are not regulated under Knox-Keene. We would hope that counties do not devote the extensive resources needed to develop and embrace this new temporary option. Moreover, the federal government in the federal health reform package has indicated strong interest in consolidating Medicare and Medicaid coverage while California waiver is proposing only 4 county pilots; we should be asking for more. Moreover, we need to re-integrate, coordinate and end the special carve out arrangements that prevent a better organized system of care for persons with mental illness and children with special health needs.

What do you think?

Prepared by Lucien Wulsin August 6, 2010

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[4] See California HealthCare Foundation, California Health Care Almanac: California Health Plans and Insurers (January 2009) at www.chcf.org

[5] Some health plans report far higher administrative costs and lower percentages of premiums devoted to medical care (medical loss ratios) than others and some for profit plans report high percentage of their premium revenues remitted to their shareholders as dividends. Ibid.