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Mainstreaming Medi-Cal

Investing in Patient Access, Improving Economic Productivity

BAYAREA COUNCIL ECONOMIC INSTITUTE

Acknowledgments

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About the Institute

Since 1990, the Bay Area Council Economic Institute has been the leading think tank focused on the economic and policy issues facing the San Francisco/Silicon Valley Bay Area, one of the most dynamic regions in the United States and the world's leading center for technology and innovation. A valued forum for stakeholder engagement and a respected source of information and fact-based analysis, the Institute is a trusted partner and adviser to both business leaders and government officials. Through its economic and policy research and its many partnerships, the Institute addresses major factors impacting the competitiveness, economic development and quality of life of the region and the state, including infrastructure, globalization, science and technology, and health policy. It is guided by a Board of Trustees drawn from influential leaders in the corporate, academic, non-profit, and government sectors. The Institute is housed at and supported by the Bay Area Council, a public policy organization that includes hundreds of the region's largest employers and is committed to keeping the Bay Area the world's most competitive economy and best place to live. The Institute also supports and manages the Bay Area Science and Innovation Consortium (BASIC), a partnership of Northern California's leading scientific research laboratories and thinkers.

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Executive Summary

Medi-Cal is massive. It covers over 13 million people,[1] more than the entire population of every state except Texas, New York, and Florida. As California's state Medicaid program, it finances healthcare access for low-income children and adults as well as pays for a great deal of care for seniors and the disabled.

Over 50 years, Medi-Cal has grown from a niche safety net program to an essential foundation of the state's healthcare delivery system and economy. It is the largest Medicaid program in the nation, with an annual budget comprising state and federal funds of more than $90 billion.[2]

Because Medi-Cal is the provider of healthcare coverage for such a large percentage of the state's population and the second-largest item in the state budget, it is critical to understand the growth of Medi-Cal over time, its economic and social benefits, and its strengths and weaknesses.

It is particularly important to recognize that this is now a program that covers millions of working Californians—and hence enhances their health and economic productivity—in addition to paying for the care of millions of children, the disabled, and elderly residents.

In spite of the large absolute size of state spending on Medi-Cal, the program compensates healthcare providers significantly less than private payers and Medicaid programs in other states. Increasing access—and reducing the burden on the privately insured to fund California's Medi-Cal delivery system—may require significant additional investments in this program.

However, improving the Medi-Cal program is not simply about raising reimbursement levels. There are important reforms that will get the state better value for its spending on Medi-Cal, many of which are being advanced through a landmark agreement that California has just negotiated with the federal government.

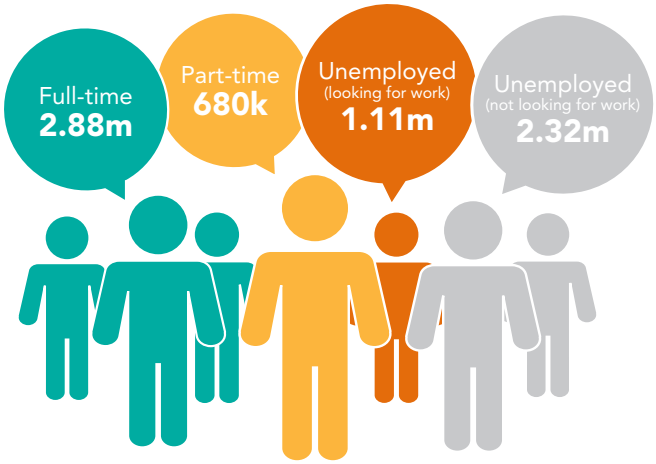
Medi-Cal's Importance At a Glance

13.3 million
Californians covered by the program, over 33% of the state's population

6.4 million
Working Californians and their family members covered by the program

1.7 billion
Increased yearly personal income in the state as a result of Medi-Cal coverage

47th
National rank for California's Medi-Cal provider reimbursement rates



Over Two Thirds of Adult Medi-Cal Enrollees are Working or Actively Seeking Work

Mainstreaming Medi-Cal

A History of Expanding Coverage

Medi-Cal enrollment has expanded significantly since its inception. Originally intended to provide health insurance to pregnant women, children in lower-income households, and the elderly and disabled with low incomes, the program covered fewer than 6% of the state's population when it began in 1966. Over the years, the share of the enrolled population has ebbed and flowed as a result of economic cycles and policy changes. Medi-Cal Managed Care was introduced in 1973, and the Healthy Families Program began in 1998, expanding coverage to children in families with incomes above the traditional Medicaid threshold. As the program evolved, enrollment remained at under 15% of California's population during the 1990s and under 20% through the 2000s.[3]

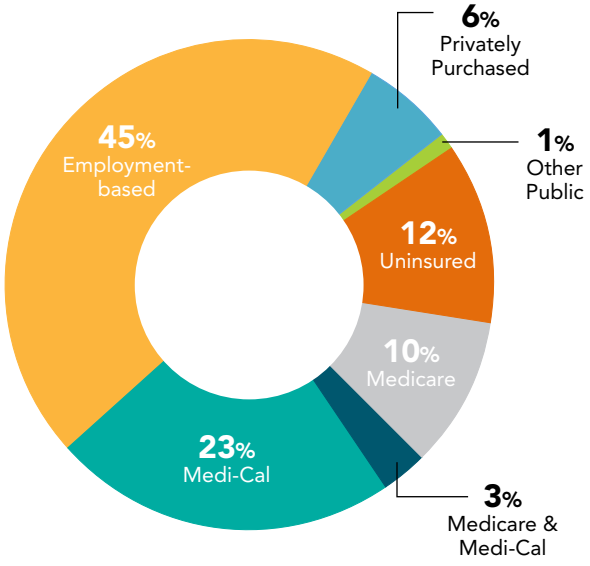
A watershed moment for the program came in 2010 as a result of the passage of the Patient Protection and Affordable Care Act (ACA). Most significantly, Medicaid became accessible to any individual with a qualifying income, when it had previously been unavailable to "childless adults" (nondisabled, nonpregnant adults without dependent children). A Supreme Court ruling allowed states to reject the ACA's Medicaid expansion and the billions of federal dollars associated with it, and some states have done so. However, California's implementation effort has been the most robust in the nation. From 2012 to 2015, Medi-Cal enrollment increased from 7.9 to 13.3 million, and the program now covers over one-third of the state's population.[4]

One key goal of the ACA was to reduce the number of uninsured Americans. Though the subsidized private insurance marketplaces or "exchanges" get much of the attention, the primary way this goal has been accomplished is through the expansion of Medicaid. California has added 5.4 million new individuals to the Medi-Cal rolls since the passage of the ACA, whereas the total enrollment in Covered California has been hovering below 1.5 million, many of whom were previously insured in nonsubsidized plans. The addition of millions of individuals to Medi-Cal means that the program is serving an increasingly large and diverse population. Medi-Cal now covers the young and the old, the employed and the unemployed, many of whom we had previously allowed to fall through gaping holes in our state safety net.

Employment-based health insurance still remains the way that the largest number of individuals in California receive coverage. Some 16.8 million individuals were covered under an employer-sponsored health plan in 2014, the most recent year for which we have comprehensive numbers for all sources of coverage. This was followed by Medi-Cal, which has grown significantly since this estimate; Californians who remain uninsured; and Californians covered by Medicare, the federal healthcare program for individuals over 65.

Source of Health Insurance Coverage Among Californians, 2014

Source: California Health Interview Survey
Analysis: Bay Area Council Economic Institute



Medi-Cal: A Major Source of Coverage for Working Californians

However, many working Californians are not covered by their employers. By 2014, 10% of the state's full-time workforce and 20% of its part-time workforce were covered by Medi-Cal. Millions more working Californians purchased healthcare coverage on their own or remained uninsured, or were covered by Medicare or another public program. Focusing simply on the percentage of employed Californians covered by the Medi-Cal program therefore masks the fact that the absolute number of working people covered is very high, particularly in comparison to the total population of many other states.

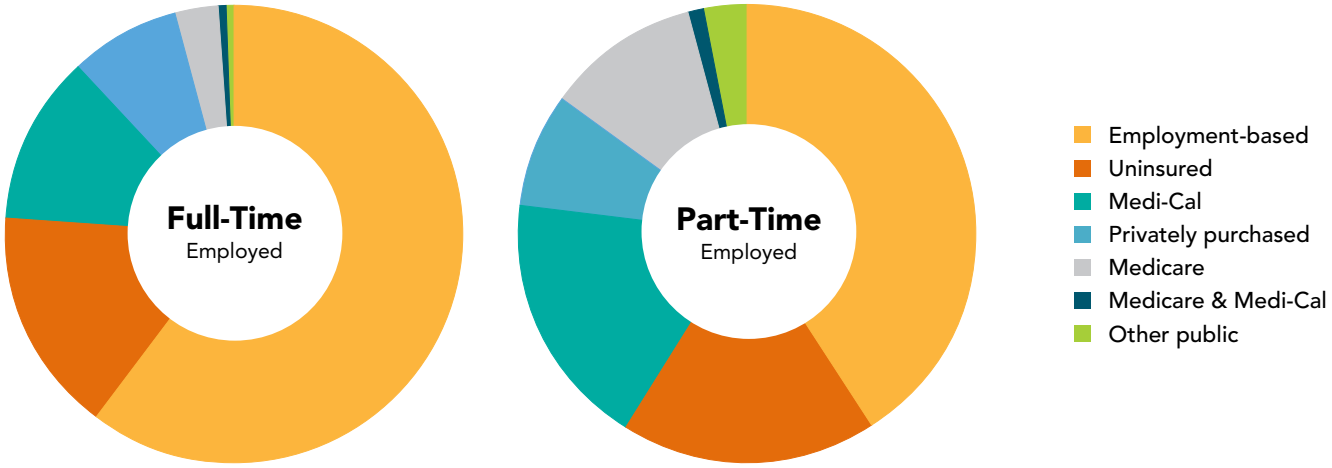
We estimate that 4.67 million labor force participants—over two-thirds of the adults enrolled in Medi-Cal—rely on the program for healthcare coverage.

We estimate that 4.67 million labor force participants, over two-thirds of the adults enrolled in Medi-Cal, rely on the program for healthcare coverage. This figure includes 2.88 million full-time employed California residents, 680,000 part-time employed residents, and 1.11 million unemployed individuals actively looking for work. In addition, there are over 700,000 uninsured and fully employed Californians eligible for Medi-Cal but who are not enrolled, and over 280,000 part-time employed individuals eligible but not enrolled.[5] Medi-Cal is an even more essential program for the state's teens and children. The program covers nearly half of all children in California, many of them the children of working Californians. Overall, 2.8 million teens and children covered by Medi-Cal reside in a household where at least one parent is employed either full- or part-time.

It is especially important to understand that this increase in Medi-Cal coverage is almost exclusively going to those who were previously uninsured rather than replacing or "crowding out" private coverage, which has remained stable in the state while rates of uninsurance have dropped precipitously from 22% before healthcare reform to under 11% in 2015.[6]

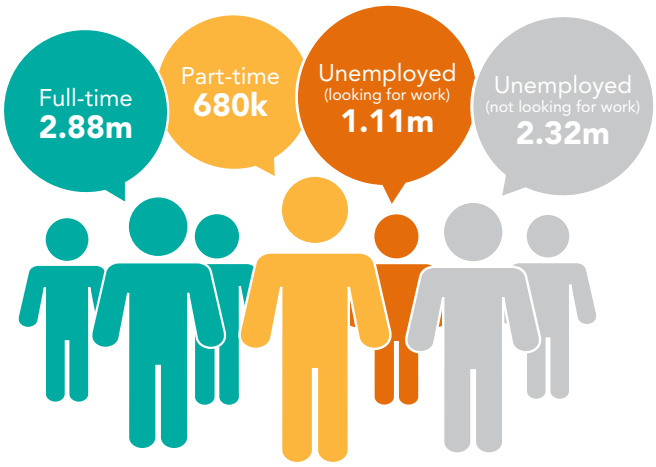
Share of Employed Californians by Coverage Type, 2014

Source: California Health Interview Survey
Analysis: Bay Area Council Economic Institute



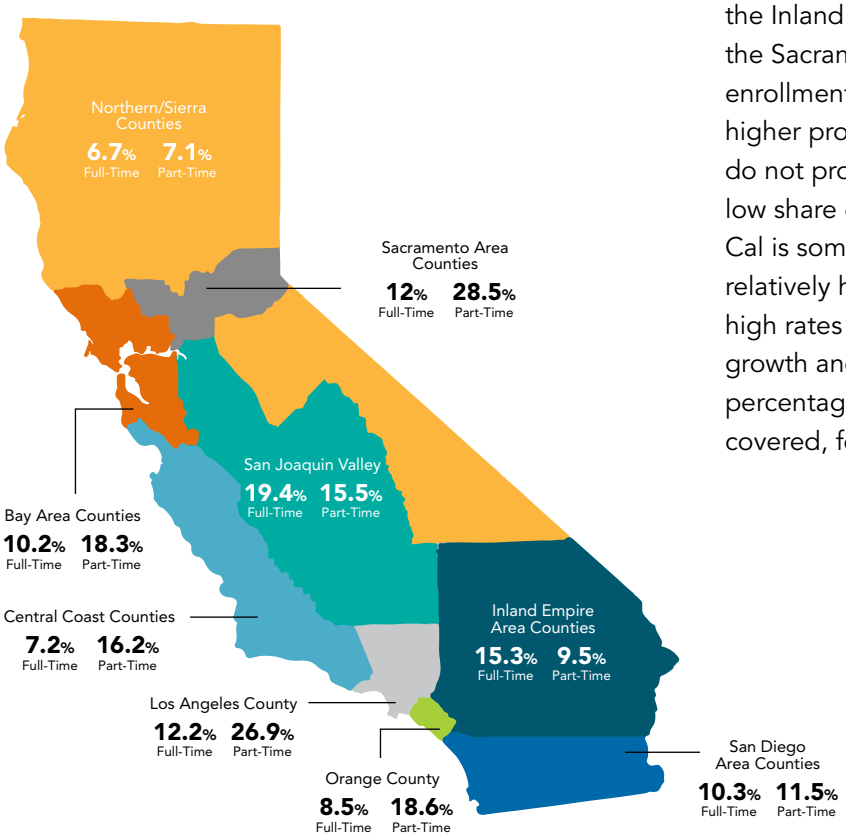
Over Two Thirds of Adult Medi-Cal Enrollees Participate in the Labor Force

Source: California Health Interview Survey
Analysis: Bay Area Council Economic Institute



Share of the Workforce Covered by Medi-Cal, 2014

Source: California Health Interview Survey
Analysis: Bay Area Council Economic Institute



Medi-Cal Coverage of Working Californians Varies by Region

California is a large state made up of several distinct regions. Following the Great Recession, the economic recovery in the state has been uneven. Coastal regions such as the Bay Area, San Diego, and Orange County have seen impressive growth, while inland regions such as the San Joaquin Valley and North State have lagged behind.[7] Average earnings in these regions are also very different; hence higher shares of employed individuals are eligible for Medi-Cal in some regions than in others. Rates of Medi-Cal enrollment among the employed therefore vary significantly across the state.

The North State, Central Coast, Orange County, San Diego and Bay Area regions have the lowest shares of full-time employed individuals enrolled in Medi-Cal. With the exception of the North State, these regions have done very well coming out of the Great Recession, recording low unemployment and a high number of well-paying jobs. By contrast, the San Joaquin Valley, the Inland Empire Area, Los Angeles County, and the Sacramento Area have higher rates of Medi-Cal enrollment among the employed. This is due to their higher proportions of lower- to middle-income jobs that do not provide health benefits. In the North State, the low share of working Californians covered by Medi-Cal is somewhat surprising. These rates are a result of relatively higher percentages of unemployment and high rates of uninsurance, though, rather than robust growth and higher wages. Of the relatively smaller percentages in this region who are employed and covered, fewer are enrolled in Medi-Cal.

Medi-Cal Coverage Leads to a Healthier Economy

With a budget of over $90 billion, Medi-Cal is important to the state economy in a multitude of ways. As one of the largest payers in the state, Medi-Cal is essential to clinics, hospitals, and other providers administering services to enrollees. As a source of health insurance coverage to millions of working Californians and their families, Medi-Cal plays a critical role in ensuring the health of the economy's labor force. In turn, these healthier employees live longer, remain in the workforce longer, and are more productive at work—all benefits that accrue to the state's economy and to the state as a whole.

The primary intention of Medicaid expansion is to provide more universal health coverage within the United States. However, Medicaid expansion has and will continue to have a significant positive impact on state economies. The program now pays for medical care and long-term healthcare services for just over 70 million Americans.[8] Of the estimated $1 trillion cost for expanding the program through 2022, the federal government will assume 93%, or $931 billion.[9] This massive influx of spending will have a direct positive effect on jobs and incomes in states that move forward with Medicaid expansion. A review of state-based economic impact analyses showed sustained job and economic activity growth in every state that conducted such a study.[10]

These positive impacts were anticipated in a 2012 Bay Area Council Economic Institute report that examined the expected impact of ACA implementation on California. The study provided an assessment of how the California economy might have been different in 2010 if the ACA had been fully implemented at that point. It found that full implementation in 2010 would have added 98,861 jobs and $4.4 billion in additional gross state output. Since the healthcare sector alone has added hundreds of thousands of jobs in the state since the passage of the ACA, these estimates now seem quite conservative.

The Institute did not conduct an analysis specifically for the expansion of Medi-Cal, but Medicaid spending is a major contributor to that positive economic impact. Though some continue to make nonempirical claims that the ACA has had a negative impact on jobs, such claims are increasingly difficult to sustain in the face of more than 60 straight months of private sector job growth since the passage of the law. An economic slowdown will happen eventually in any case, but linking such a slowdown to the expansion of insurance coverage will be challenging, if not impossible, to do empirically.

Anticipated Economic Impacts of the ACA

Source: Bay Area Council Economic Institute, 2012

Measuring the "Medi-Cal Productivity Bump" in California

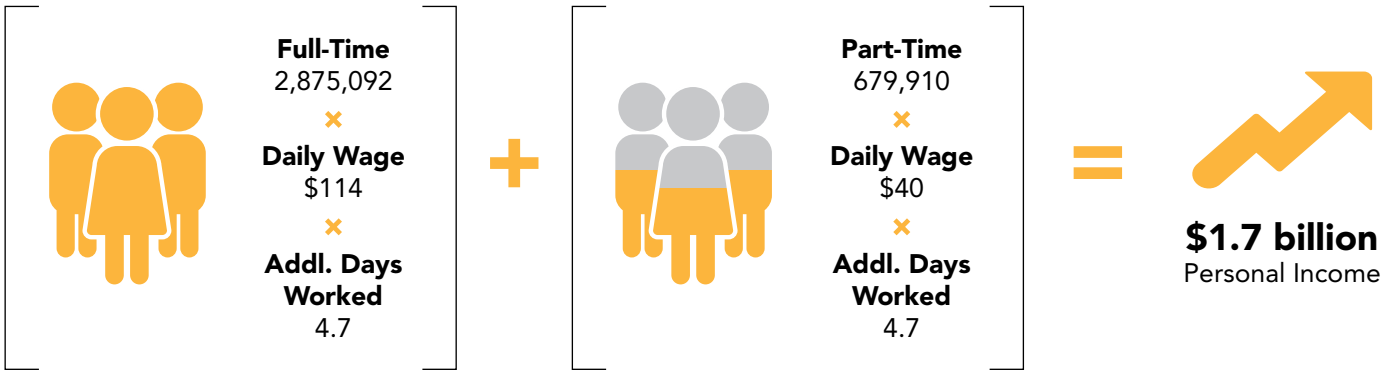
Increased access to health insurance coverage also leads to an improvement in health status and reduced mortality and morbidity.[11] Prior to the expansion of coverage under the ACA, millions of working Californians were uninsured, a factor that reduced their economic productivity. Medi-Cal coverage matters. Data from the National Health Interview Survey shows that uninsured individuals are over four times more likely to have no usual source of care than those with Medicaid coverage, and they are nearly three times more likely to go without care due to cost.[12]

Poor health leads to a reduction in productivity through missing work due to illness, attending work while ill, and reduced work output, whereas good health improves economic outcomes. Individuals with a lower self-reported health status are significantly more likely to drop out of the labor force, while improving an individual's health status increases annual earnings by 10% to 30%.[13] Looking at this correlation at an economy-wide level, the Institute of Medicine took an approach to valuing the health of the uninsured community similar to the methods used by the US Environmental Protection Agency in setting emissions standards and the Department of Transportation in setting seat belt and air bag requirements. The report sought to quantify the additional value added through insuring those currently uninsured. It found that the annual economic value of insuring every uninsured American was between $65 billion and $130 billion and concluded that the benefits of providing insurance outweigh the costs.[14]

One of the most concrete pieces of evidence we have on the direct connection between insurance coverage and productivity is the fact that, according to a major survey, employees with health insurance on average missed 4.7 fewer days than those without coverage.[15] It also found that investments in preventive care had a positive impact on the number of healthy employees. To develop an estimate of the increased productivity that accrues to the California economy as a result of Medi-Cal, we used coverage and employment data from the California Health Interview Survey and wage data from the Consumer Population Survey. Assuming a gain of 4.7 working days per year as a result of being covered by Medi-Cal, the state of California experiences a gain of $1.7 billion in personal income per year as a result of the program.

Productivity Increase Among California Employees Covered by Medi-Cal

Source: California Health Interview Survey; Current Population Survey; *Health Insurance as a Productive Factor*
Analysis: Bay Area Council Economic Institute



Does the Medi-Cal Program Provide Good Access to Care?

Coverage through Medi-Cal or private insurance is just the first part of the equation. A key metric of Medi-Cal's success must be a determination of whether Medi-Cal enrollees have access to high-quality care. Over the years, access issues within the Medi-Cal program have been well documented, as have potential explanations for these issues, including low physician reimbursement rates, physician-to-population ratios well below state and federal averages, and self-reported difficulty among enrollees in finding a physician.[16] These factors may be exacerbated by the increase in the enrolled population under the ACA. Focusing on quality of care and barriers to access is, therefore, an even more critical issue for the state as the program grows rapidly.

Access Versus Medicaid Programs in Other States

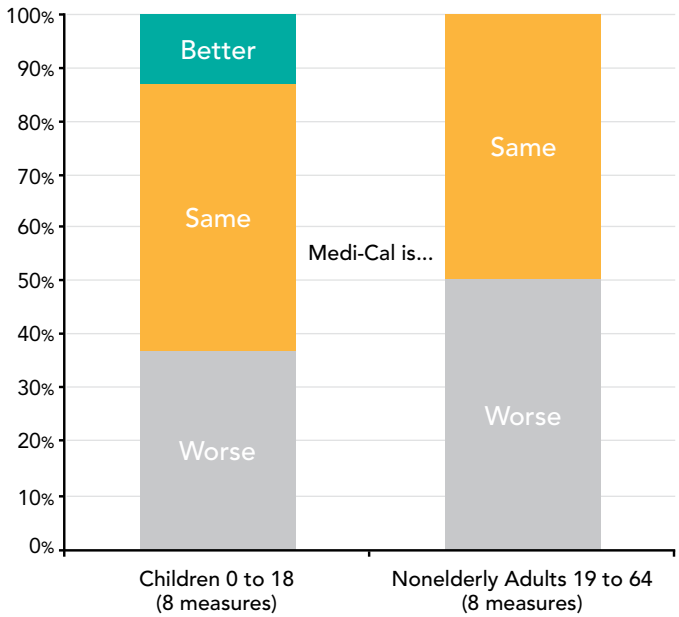
Policymakers and consumer advocates have long been concerned that Medi-Cal enrollees have inadequate access to care compared with those in other Medicaid programs and with other insured populations. Two recent reports by the California HealthCare Foundation (CHCF) give us the best, most recent snapshot of the relative quality of access within the Medi-Cal program.

The first, *Medi-Cal Versus Medicaid in Other States: Comparing Access to Care*, examines access to care in Medi-Cal versus access in Medicaid programs across the nation. Using the National Health Interview Survey (NHIS), the report examines three measures of access: gaps in potential access to care, gaps in realized access to care, and health outcomes and behaviors. The report makes comparisons through descriptive statistics of the Medi-Cal program and Medicaid programs across the nation as well as through regression-adjusted comparisons intended to account for differences in health needs and socioeconomic circumstances.

The CHCF report found that Medi-Cal falls behind its peers in realized—rather than simply potential—access to healthcare services. The report found that Medi-Cal lagged Medicaid programs in other states in four of eight measures of utilization and was comparable in the other four. Results for children were slightly better, with Medi-Cal being superior to Medicaid programs in other states on one measure, equal on four, and worse on three. Adults and children in California were also more likely not to have had preventive care, a dental visit, or a specialist visit than Medicaid enrollees in other states. These results remained true when controlled for healthcare needs and socioeconomic status. In spite of Medi-Cal being a no- to low-cost program, Medi-Cal enrollees also appear to put off care more frequently because of self-reported affordability concerns,[17] with 33% of enrollees reporting that they had put off care because of affordability concerns versus 23% of enrollees in other Medicaid programs.[18]

Realized Access to Care in Medi-Cal Versus Medicaid Programs in Other States

Source: *Medical Versus Medicaid in Other States*, National Health Interview Survey, 2013



Access Versus Employer-Sponsored Insurance

Another standard by which to compare access in the Medi-Cal program is against other employed populations, specifically those with employer-sponsored insurance (ESI). This insurance often offers more generous benefit designs and reimbursement rates and is therefore seen as being of higher quality and providing better access. The CHCF *Medi-Cal Versus Employer-Based Coverage* report findings outline the differences in the characteristics of Californians with Medi-Cal and those with employer-sponsored insurance.

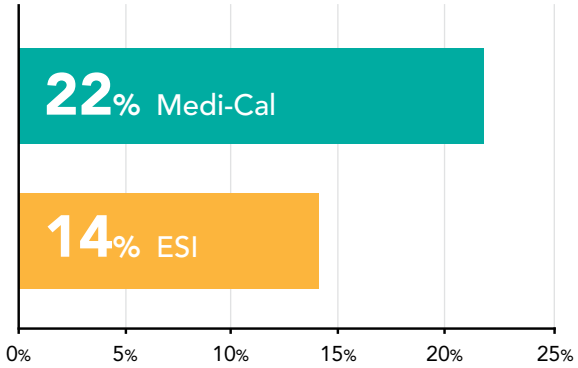
Using the California Health Interview Survey (CHIS), the study found significant gaps in access between Californians with Medi-Cal and those with ESI in 2012–2013. For example among adults, access to care for Medi-Cal enrollees was better than it was for ESI enrollees on 2 measures, worse on 29 measures, and the same on 14 measures. On several measures, the gaps were substantial, with adult Medi-Cal enrollees being more likely to report not having visited a doctor in the past year (22% versus 14%), not having a usual source of care other than the emergency room (18% versus 12%), and being more likely to delay medical care due to cost (12% versus 9%). Among children the gaps narrow, with access to care for those with Medi-Cal being better on 2 measures, worse on 6, and the same on 20 measures.

Comparisons across regions of the state showed significant differences in nearly half the measured areas of access. There were also significant differences by urban status, with rural and suburban enrollees facing nearly twice the difficulty in finding a usual source of care as those in urban areas. The findings of both reports underscore the importance of Medi-Cal for both working and nonworking Californians, and in particular for certain population subsets. They also highlight areas of difficulty in access for Medi-Cal enrollees, in particular for those in poor health.

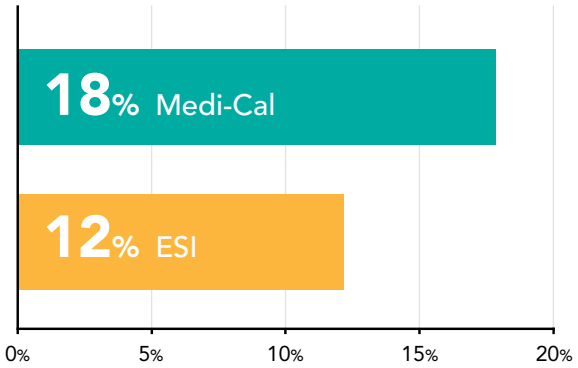
Access to Care: Medi-Cal Versus Employer-Sponsored Insurance

Source: *Medi-Cal Versus Employer-Based Coverage*, California Health Interview Survey, 2013

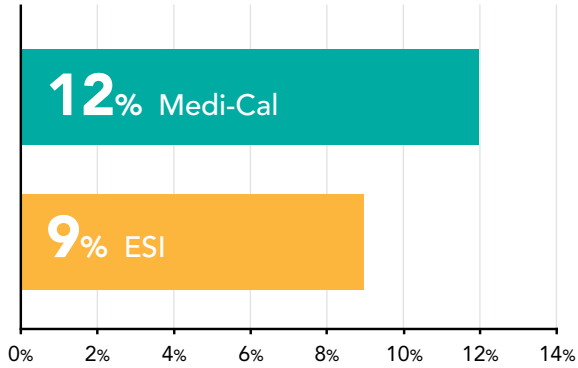
No Doctor Visit in the Past Year, Nonelderly Adults, 2013



Does Not Have Usual Source of Care, Nonelderly Adults, 2013



Delayed Medical Care Due to Cost or Insurance, Nonelderly Adults, 2013



Is the Medi-Cal Program Underfunded?

Low reimbursement rates for Medi-Cal providers may be a leading cause of these access challenges within the program. Throughout most of the 1990s, California's Medi-Cal reimbursement rates—the price Medi-Cal will pay providers for the services they deliver—largely remained stagnant. Rates finally rose at the end of the 1990s and early 2000s as California's economy saw rapid growth. However, rate increases again stalled following the dot-com bust in 2001, increasing only 2% from 2003 to 2008, while Medicare rates grew 15% nationwide and private rates as much as doubled.[19] In the wake of the Great Recession, the state enacted a 10% cut to Medi-Cal rates that remains in place today, despite pressure from various stakeholders and prolonged legal battles.

To put California's reimbursement rates in context, it is helpful to compare them across other states and against Medicare. Since 1993, the Urban Institute has conducted a survey of Medicare and Medicaid physician fees and developed a methodology for comparison.

California ranked 47th among states in the 2014 survey based on the Medicaid Fee Index for all services, and 48th for primary and obstetric care. The state ranked 48th when comparing the Medicaid-to-Medicare Fee Index among states, reimbursing physicians at just over half the Medicare rate for an equivalent service.[20]

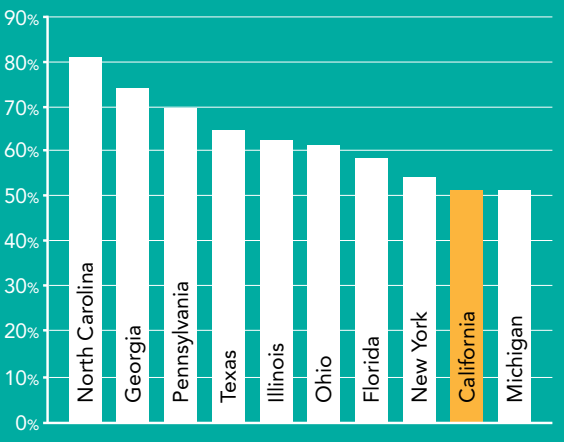
One major limitation in looking at these indices is that they do not include rates paid to managed care plans, which cover over three-quarters of Medi-Cal beneficiaries. The rates that the state negotiates with these plans are not public. Research by the Government Accountability Office, though, suggests that these expenditures are likely of a similar order of magnitude to fee-for-service Medicaid.[21] This suggests that California is, at least, among the states with lower Medicaid reimbursement, if not among the very lowest as measured by its Medi-Cal fee-for-service rates. Millions of Californians, though, remain in fee-for-service, a population larger than the Medicaid populations in most other states.

Medicaid "Fee Bump" Short Lived

To improve the incentive for healthcare providers to accept the millions of new enrollees under Medicaid expansion, the ACA included a provision known as the "Medicaid fee bump." Under this provision, Medicaid reimbursement rates for primary care were increased to equal those of Medicare from January 1, 2013, to December 31, 2014, with the difference entirely funded by the federal government. California declined to extend the fee bump when it expired in 2015, leaving the state with one of the lowest reimbursement rates in the nation.

Medicaid-to-Medicare Fee Index for the Ten Largest Medicaid Programs, 2014

Source: Urban Institute Medicaid Physician Survey
Analysis: Bay Area Council Economic Institute

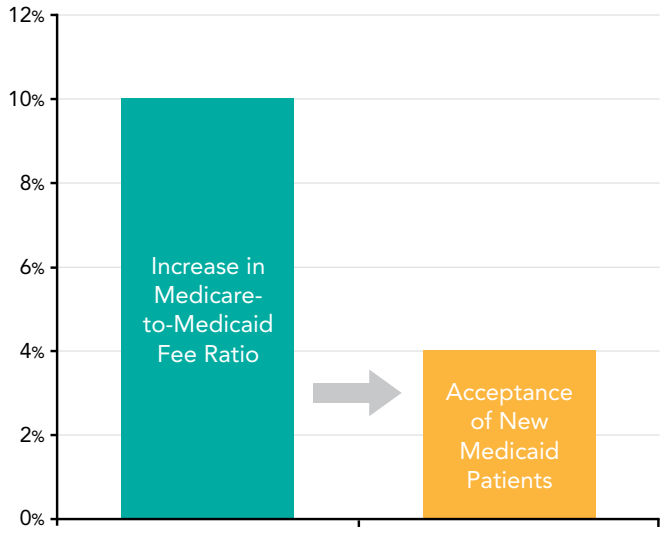


The Impact of Low Reimbursement on Access

Persistently low Medi-Cal reimbursement rates have been a concern among providers and patient advocates, who often cite them as a primary reason for low provider participation and poor access in the program.

Persistently low Medi-Cal reimbursement rates have been a concern among providers and patient advocates, who often cite them as a primary reason for low provider participation and poor access in the program. These low rates in turn put pressure on the entire system, eventually negatively impacting access even for people who have coverage through private plans and other public programs. One piece of evidence to support the connection between rates and access is the fact that only 62% of California physicians report a willingness to accept new Medi-Cal patients.[22]

The Effect of Payment Generosity on Access
Source: *Health Affairs*, 2012



More systematic research on the impact of reimbursement on access reinforces this concern. A 2005 study found that higher payments to physicians increase the probability of enrollees having at least one doctor's visit within the last year, though higher payments had no effect on other measures such as the probability of receiving preventive care or the probability of having unmet healthcare needs.[23] By comparison, a 2012 study published in *Health Affairs* found that raising fees would have a more broadly beneficial effect on access. Using data from the Centers for Disease Control, the study found that while 96% of physicians were willing to accept new patients in 2011, only 31% were willing to accept new Medicaid patients. By examining differences in acceptance and reimbursement rates by state, the authors were able to study the effect of higher fees. The study concluded that payment generosity did have a significant effect on access, with a 10 percentage point increase in the Medicaid-to-Medicare fee ratio yielding a 4 percentage point increase in the acceptance rate of new Medicaid patients.[24]

Overall, though, there are many more factors that explain challenges to access within the Medi-Cal program, and it is not simply a question of raising rates and producing more access. An increasing number of health insurers are participating in covering Medi-Cal enrollees, and these health plans have certain stipulations regarding the access they must provide given the negotiated rates they accept. Effectively regulating the access these plans provide, therefore, is essential. Another factor that may explain many primary care physicians' reluctance to accept Medi-Cal patients is the small number of specialists who accept Medi-Cal, and hence it is important to look at access across the specialties as well as to primary care. Finally, as will be discussed in greater detail below, there is a tremendous amount that we must do to reform the healthcare system in order to get better value for state spending and better access for Medi-Cal enrollees.

Cost Shifting

In addition to the issues related to access, low reimbursement rates may transfer the cost of providing Medi-Cal services onto private payers. The practice by which a provider charges one payer more in order to balance lower payments received from another is known as *cost shifting*. There is contentious debate about the factors that lead to cost shifting. This debate is generally focused on potential cost shifting from public payers—usually Medicare—to private payers.

Empirical analyses have documented varying levels of cost shifting, with some suggesting that there are instances in which lower payments from public providers may force hospitals to become more efficient, thus lowering rates for all.[25] Though the evidence may be mixed at the national level, the ability of providers to cost-shift is heavily dependent on both market characteristics and cost trends, and several characteristics of California's healthcare marketplaces suggest that cost shifting will have greater impacts in this state. A 2006 analysis estimated the total cost shift from public programs to private payers in California at $210 million for 2001.[26] Using the same dataset and extrapolating to the latest available year, the cost shift to private payers is estimated to have been $502 million in 2014.

Improving Value for Spending in Medi-Cal

Increasing access to quality coverage through the Medi-Cal program is not simply a matter of increasing the amount that we spend on this program. There are also many opportunities for the state to lower its costs while improving quality and increasing the value that we get for our healthcare spending—which is an essential piece of any reform effort.

Complexity and "Churning" Complicate Reform Efforts

There is no shortage of proposals, both within and outside California, on how to get better value for healthcare spending. However, it may be challenging for any of these proposals to gain real traction at scale given the level of complexity that exists within the Medi-Cal program.

It might be most accurate to say that the state has 58 different Medi-Cal programs, one for each county. These programs are organized in various ways, with three templates that predominate.[27] In "County Organized Health Systems," the health plan that finances Medi-Cal access is run by the county; under "Geographic Managed Care," the state contracts with multiple commercial plans; and in "Two Plan" counties there is both a county-organized "Local Initiative" and a commercial plan. The actual organization of the financing and delivery of Medi-Cal is an order of magnitude more complex than this outline. Medi-Cal has also had challenges in updating the basic software systems on which its administration relies. The program is now starting again from scratch to develop a new IT system after scrapping a project that was originally put out to bid in 2007.[28]

Another challenge associated with improving the Medi-Cal program is that ultimately we are interested in improving the health of individual Californians, not simply the performance of an individual government program or commercial product. People move or "churn" among these programs in great numbers over years and even within years. They gain and lose jobs; they marry and divorce and have children. In turn, these events all influence their incomes and whether they have access to employer-sponsored healthcare and, consequently, the governmental programs or subsidies they can access.

There is a significant amount of churn between Medi-Cal and Covered California, the state's marketplace for private health insurance created as a result of the Affordable Care Act. In some cases families are split, since at certain income levels parents qualify for Covered California while their children can enroll in Medi-Cal. Although a new IT system was created to facilitate enrollment into both Covered California and Medi-Cal, because it is not the "system of record" for Medi-Cal, the state does not itself have complete real-time data on the extent to which people are moving even among the different programs it administers.

Given this complexity and churn, one very positive development is increasing coordination across payers on important delivery system reform projects. One example is the recent joint project to track and ultimately reduce unnecessary C-sections through multipayer engagement in the California Maternity Quality Care Collaborative (CMQCC). These efforts involve Covered California, the Medi-Cal program, and CalPERS, the program that administers health benefits for state employees, as well as the large business purchasers in the Pacific Business Group on Health.[29]

This is just one of a number of existing or proposed projects that coordinate more effectively across payers to move the needle on healthcare quality and cost. Alignment across payers is essential given the complexity of and churn within the healthcare system. A broad set of promising initiatives—from creating

"Accountable Care Communities" to improving end-of-life care—is being advanced under the banner of "Let's Get Healthy California,"[30] and there are many other ongoing projects at the local, state, and federal levels.

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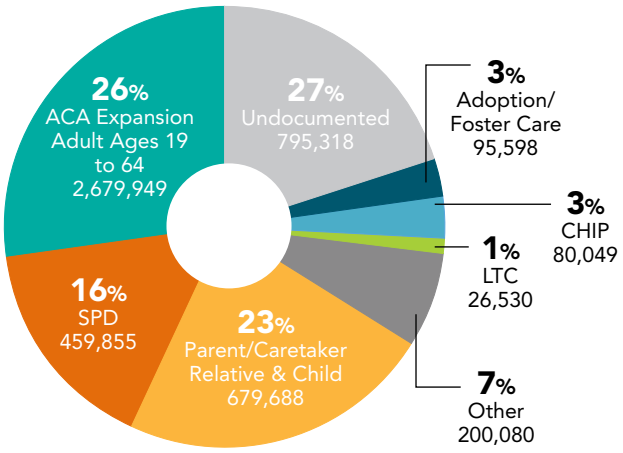
In all of this, we cannot forget that the patient must also be engaged with the healthcare system in the right way and must be the central part of the alignment that occurs. Creating better access within the Medi-Cal program also requires us to look at how people access care and ask whether there are ways we can redesign the delivery system and reengineer patient behaviors to make the system more efficient. A recent analysis by Sutter Health examined emergency room usage at three hospitals in the San Francisco Bay Area and ascertained that over half of the emergency department visits at these hospitals were for nonurgent uses. Further, most of the people accessing the emergency department in this manner had health coverage and lived within one mile of a Federally Qualified Health Center that provided these services at no charge.[31]

Financial Incentives for Providers

In addition to projects that focus on one or a particular set of procedures, California has a long history of providing broad financial incentives to encourage high-value care under the managed care framework. The Medi-Cal Managed Care program began in 1973 and now covers the vast majority of Medi-Cal enrollees in all 58 California counties. These enrollees receive care through one of the managed care delivery system models across the state, for which Medi-Cal pays a per-enrollee-per-month reimbursement, instead of through traditional fee-for-service Medi-Cal, in which providers are reimbursed for each service provided. The theory is that more centrally organizing the care of enrollees and paying providers for value rather than the volume of services will lead to better outcomes at lower cost.

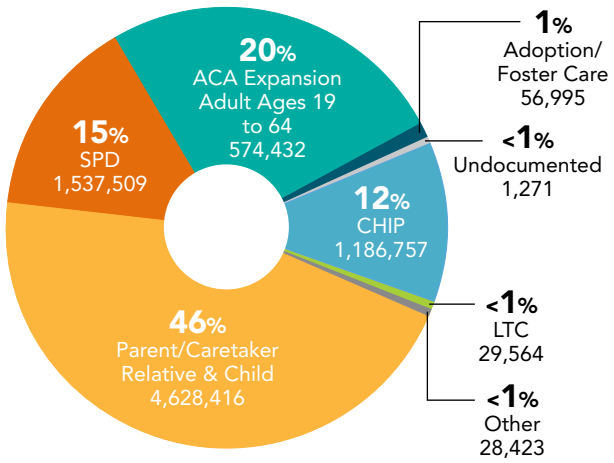
Aid Group for Fee-for-Service Participants

Source: DHCS Monthly Medi-Cal Enrollment Fast Facts, October 2015



Aid Group for Managed Care Participants

Source: DHCS Monthly Medi-Cal Enrollment Fast Facts, October 2015



California has been making significant expansions of managed care in recent years. These have been focused on enrolling children and families, seniors, individuals with disabilities, low-income pregnant women, and those dually eligible for Medicare and Medi-Cal. These populations are more vulnerable than average Medi-Cal enrollees, and transitioning them to managed care is intended to improve outcomes for these high-cost populations.

However, enrolling Medi-Cal recipients in managed care plans is just the first piece of the puzzle. Better financial incentives alone will not improve value for spending. In fact, if the delivery system is not set up to respond to these incentives through a well-developed capability to provide better, more efficient care at a lower cost, the incentive to spend less on Medi-Cal enrollees could have negative effects. Fortunately, on a parallel track with the broad move into managed care, the state and its healthcare providers have made major investments to improve the coordination and quality of care that recipients receive.

Medi-Cal 2020: Federal Support for State-Based Innovation

State-based innovation was baked right into the Medicaid program at its outset in the 1960s. Under the Social Security Act that created Medicaid, the Department of Health and Human Services is permitted to approve experimental and pilot projects aligned with the goals of the program. These "demonstration waivers" give states the flexibility to adjust and improve their programs, as well as to develop innovative solutions that may one day be adopted by other states.

California's previous demonstration waiver, known as "A Bridge to Reform," had the goal of improving health outcomes, slowing spending growth, and preparing for an unprecedented expansion of the program. California's current waiver, approved in December 2015 and called "Medi-Cal 2020", builds on these goals.[32] The discussion below summarizes some of the more promising current and proposed reforms to Medi-Cal, many of which are included in Medi-Cal 2020.

One primary locus of access for the state's Medi-Cal population is its public hospitals. A large piece of California's previous waiver was its first-in-the-nation Delivery System Reform Incentive Payment (DSRIP) program. This program made federal funds available to public hospitals as incentives for making infrastructure upgrades and setting performance outcome goals. Medi-Cal 2020 contains a successor to this incentive program, known as Public Hospital Redesign and Incentives in Medi-Cal (PRIME). Similar to its predecessor, this $3.7 billion incentive program contains a new requirement that hospitals shift from fee-for-service models to alternate payment methodologies. These new mechanisms are intended to begin to move the system toward value-based payments. Under Medi-Cal 2020, the Global Payment Program (GPP) also redesigns existing payments to county hospitals and their contractors to incentivize prevention, provide timely access to care, and reduce incentives encouraging emergency room visits and hospital admissions.

Building teams to include professionals and family members outside the traditional provider-patient relationship can have a positive impact on outcomes and costs.

Building teams to include professionals and family members outside the traditional provider-patient relationship can have a positive impact on outcomes and costs. These professionals might include pharmacists, physical therapists, dieticians, and others, depending on an individual's needs. Such teams are especially important for those with complex care needs who are dually eligible for Medi-Cal and Medicare.

Medi-Cal 2020 also contains a project aimed at improving care for those with complex health requirements. Individuals with various co-morbidities are responsible for a large share of overall healthcare spending, and mental illness, substance abuse issues, and homelessness often complicate addressing their needs. Under the whole-person care pilots, a county, hospital authority, or regional consortium can coordinate various agencies to manage this care better and more efficiently. The funding made available is specifically for use in achieving these goals through coordination, data sharing, and case management. It cannot be used for services otherwise available for standard Medi-Cal fee-for-service reimbursement.

Another piece of California's Medi-Cal 2020 waiver is an optional county-based delivery system model designed to facilitate better care for individuals with substance abuse problems, who often have multiple other chronic conditions. Counties that choose to implement this system model will be responsible for provider contracting, ensuring access, managing utilization, and coordinating care. Counties will also have the option to contract with local managed care plans if they do not want to operate the system themselves. The system will offer a full range of services and operate on the principle that organized care for these patients with complex needs will improve outcomes and reduce costs.

Social Determinants of Health

A lack of affordable housing, poor access to quality nutrition, and low-quality public schools are just a few of the areas now known to be key social determinants of health. Substandard housing, in particular, is associated with a wide range of chronic health conditions, poor mental health, and negative childhood development.[33] Similar impacts on health have been shown to result from poor transportation infrastructure,[34] and from barriers to a quality education.[35]

Making progress on Californians' health, therefore, means looking far beyond the healthcare sector. In fact, it may be that changes within the healthcare sector are the least impactful in terms of improving the overall health of the Medi-Cal population and others in the state.

Making progress on Californians' health, therefore, means looking far beyond the healthcare sector. In fact, it may be that changes within the healthcare sector are the least impactful in terms of improving the overall health of the Medi-Cal population and others in the state. It is better and far cheaper to forestall the development of chronic conditions than to pay for them once they have set in. The key to preventing disease is "primary prevention," the redesign of public communities and personal habits to create better health outcomes. One of the most important reasons to increase the value received for healthcare spending in the Medi-Cal program is to improve access to high-quality care at a lower cost that will preserve state resources for other critical investments, including education and public safety.

Conclusion

It is important to be modest about what we can achieve through incremental reforms to our existing, extremely complex system of financing and delivering healthcare to Medi-Cal enrollees. More comprehensive changes may be needed that better position the Medi-Cal program to promote health through payment in ways that are better aligned with other payers. And ultimately, the persistence of a half dozen or more systems of financing healthcare within the United States means that delivering value for spending will remain a difficult collective action problem regardless of our best efforts.

It is also critical to acknowledge, however, that Medi-Cal is a massive program that despite challenges related to access and reimbursement, is a good source of coverage for over 13 million Californians and is a vastly superior alternative to this population being uninsured.

It is also critical to acknowledge, however, that Medi-Cal is a massive program that despite challenges related to access and reimbursement, is a good source of coverage for over 13 million Californians and is a vastly superior alternative to this population being uninsured. Like any other governmental or private program, Medi-Cal has room for continuous improvement, but the providers who care for Medi-Cal enrollees, the state employees who oversee the program, and the public and commercial health plans that administer it provide a vital service on which nearly a third of our state's adults and half of children rely. As a state, we need to think seriously about what this commitment entails and strive to continue to serve these populations to the best of our ability while making the best possible use of the taxpayer dollars that support the program.

Endnotes

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