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Moving Medi-Cal Forward on the Path to Delivery System Transformation

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Introduction

Over the past few years, California's Medicaid program, known as Medi-Cal, has been catapulted into a new role. It has evolved from a program designed to provide health coverage to a subset of low income individuals and help counties meet their longstanding obligations to provide indigent care to a program that is the largest single source of health insurance in the state and the foundation of the state's healthcare coverage continuum for people who do not have affordable insurance through the workplace. Medi-Cal needs a vision and structure that recognize and support this evolution.

In 2015, Medi-Cal covered one in three Californians and was responsible in large part for helping to drive the state's uninsurance rate to a record low.[1]

The program is at a pivotal juncture. Medi-Cal has brought coverage, care and long-term services and supports to millions of Californians, but key aspects of the design and financing of the program have not kept pace with the dramatic changes in the size and composition of the Medi-Cal population and the responsibilities of the program. The relationship between Medi-Cal and the counties continues to have a large impact on how care is delivered and financed, and the county construct, along with the overlay of marketplace developments and multiple initiatives that have been adopted throughout the years, have resulted in a complex, patchwork and somewhat opaque system for providing and paying for care. The results in terms of quality of care, access to care, care coordination and patient satisfaction are mixed.

Like other states, California is looking to advance delivery system and payment reforms to drive greater value, defined as timely access to high quality, coordinated and cost effective care. Medi-Cal is not alone in its "hunt for value" – the Affordable Care Act (ACA) has triggered a shift toward value-based purchasing in the commercial marketplace, Medicare

and Medicaid. These reforms are challenging in any environment, but the structural underpinnings of California's Medicaid program make such changes all the more difficult to address.

Medi-Cal has accomplished a great deal in a short time, including a significant expansion of coverage, and important delivery system innovations are underway in a number of communities throughout the state. With Medi-Cal's augmented role and the new Medi-Cal 2020 waiver recently launched, the state and its partners have an extraordinary opportunity to reset the table and establish a clear direction for Medi-Cal to spearhead delivery system reform in collaboration with other California payers. To do so, California needs a vision and a plan for advancing the goal of delivering better care and promoting better health in ways that serve the needs of enrollees and that are sustainable for both those who finance and those who provide the services.

The California Health Care Foundation (CHCF) retained Manatt Health to consider the current state of the Medi-Cal program and potential pathways for the next chapter of delivery reform, focusing particularly on Medi-Cal managed care.[2] Manatt conducted a landscape review and in-depth interviews with a diverse array of Medi-Cal stakeholders and thought leaders, including current and former Medi-Cal officials, other state and local government officials, legislators and their staff, representatives from managed care and provider organizations, patient representatives and advocates, labor groups and policy experts.[3]

This report provides an overview of the Medi-Cal landscape and stakeholder perspectives, assesses the key challenges and opportunities, and articulates a pathway for advancing Medi-Cal delivery system and payment reform.

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Medi-Cal Today

Medi-Cal is the largest Medicaid program in the nation as measured by both enrollment and total spending. It is a significant source of insurance coverage and its purchasing power has enormous potential to improve care and health outcomes throughout the state.

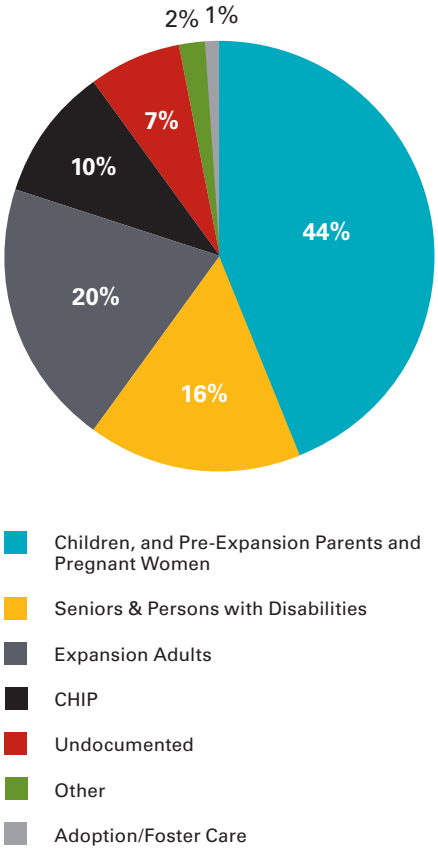
- **Enrollment:** Medi-Cal covers over 13 million individuals, more than 30% of the state's population. Between December 2013 and January 2015, total Medi-Cal enrollment grew by 41% as a result of California's adoption of the ACA's Medicaid expansion for low income adults.
- **Spending:** Medi-Cal costs have grown nearly threefold over the last 10 years and today total $92 billion in annual expenditures (including federal and nonfederal funds). Medi-Cal is one of the largest state budget items, accounting for nearly 16% of California's general fund budget and, at the same time, it is the largest source of federal revenues for the state.[4,5,6] A review of the spending data revealed three important facts:

1. Spending growth has been driven largely by new coverage, with only modest growth occurring on a per beneficiary basis of just 3.1% annually between 2005-06 and 2015-16.
2. Even with the expansion, most of the spending remains focused on high needs beneficiaries, with just 5% of beneficiaries accounting for 51% of all spending.
3. Fiscal responsibilities for the program have shifted significantly in the past decade – the shares paid by the federal government, providers and counties have grown while the share borne by the state general fund has dropped by nearly half. Beginning in calendar year (CY) 2017, the state will start to assume some financial responsibility for the expansion population – as reflected in the Governor's fiscal year (FY) 2017 budget proposals.

While Medi-Cal is the largest Medicaid program in the country in terms of people enrolled and total expenditures, California's Medi-Cal spending per enrollee ranks among the ten lowest-spending states in the country.

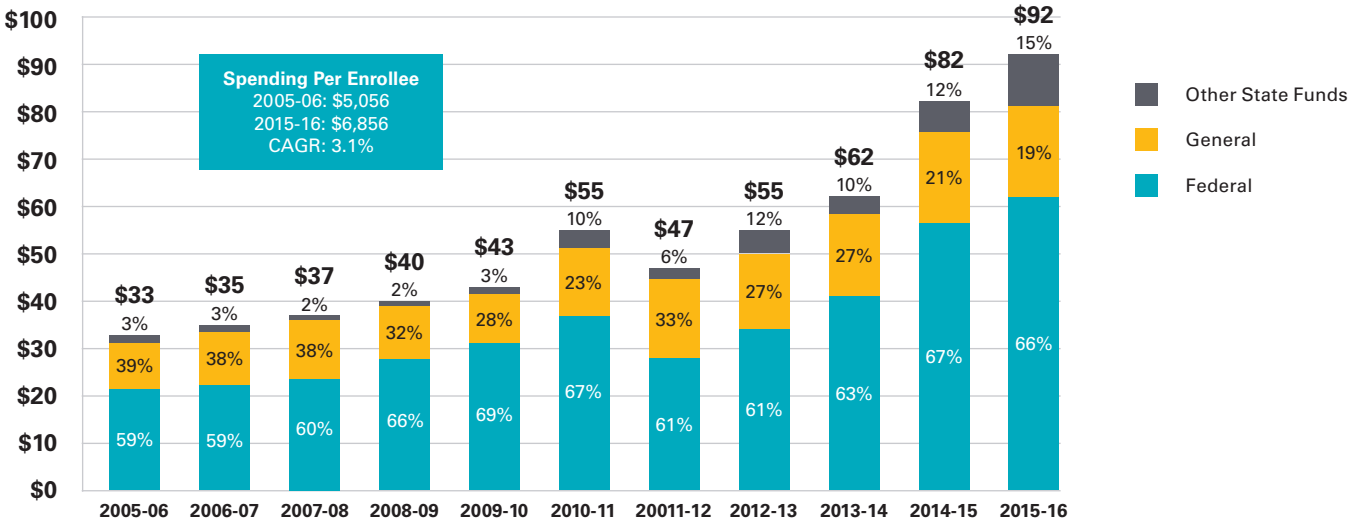
Figure 1. Medi-Cal Enrollees

Distribution of Medi-Cal Enrollees, December 2014



Source: Medi-Cal Statistical Brief, August 2015

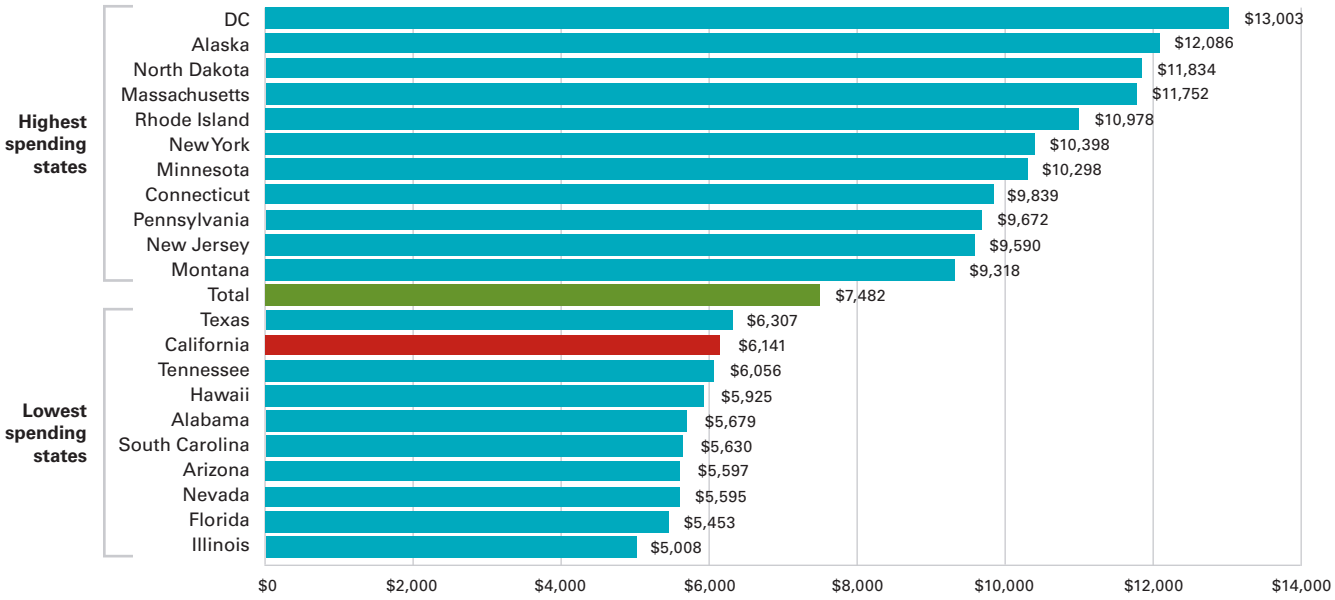
Figure 2. Medi-Cal Spending Over the Last Decade ($B)



Note: Total annual spending is pulled from the Department of Health Care Services (DHCS) May Estimate for the subsequent year (i.e., 2005-06 costs sourced from May 2006 Medi-Cal Estimate), except in the case of 2015-16, in which total spending is pulled from the November 2015 Estimate.

Source: State Budget Appropriations, Medi-Cal Local Assistance Estimates, DHCS.

Figure 3. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Full Benefit Enrollees For Top Highest and Lowest Spending States, FY 2012



Note: Excludes enrollees reported by states in the Medicaid Statistical Information System (MSIS) as receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services.

Source: Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2012, MACPAC, December 2015.

- **Managed Care:** In recent years, California has moved aggressively to enroll more people, including those with significant healthcare needs, into managed care. Over 10 million of the 13 million Medi-Cal beneficiaries (nearly 80%) are now enrolled in managed care, including most of the elderly and people with disabilities who the program covers. As a result, the state and managed care organizations (MCOs) are changing their contracting and care management models to serve beneficiaries who have very different healthcare needs than those who have traditionally been cared for through managed care. Four primary models of managed care – Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), and the Regional Model (RM) – operate in California's 58 counties resulting in state contracts with 21 MCOs. In some areas, the plan or county subcontracts to other plans and in many areas, the plans (the primary plan and/or the subcontracted plan) delegate risk to independent practice associations (IPAs), medical groups, and sometimes hospitals.
- **Medi-Cal Delivery System:** Beneficiaries covered by Medi-Cal get their primary and acute care in doctors' offices, at community clinics and health centers, and in hospitals. Federally Qualified Health Centers (FQHCs) play an important role in delivering care to Medi-Cal enrollees, and their importance has grown with the ACA expansion; they now serve 41% of Medi-Cal MCO enrollees – with both county-based and commercial MCOs relying on FQHCs to deliver primary care to their beneficiaries. For hospital-based care, California has 21 designated public hospitals (DPHs) and 40 district and municipal hospitals (DMPHs) which account for 21% of the inpatient care for Medi-Cal beneficiaries;[7] other hospitals (i.e., private, nonprofit, and publically-traded hospitals) make up the remaining 79%.[8]
- **Beneficiary Characteristics:** Medi-Cal beneficiaries are, by definition, low-income. The expansion has shifted the demographic characteristics of the Medi-Cal population, spurring an influx of adults into the program, such that today nonelderly adults and children make up 84% of the population, up from 77% in 2011. Even with the coverage expansion, seniors and nonelderly adults with disabilities – who are now mostly served through managed care – account for most (60%) of the spending.

  Medi-Cal covers a diverse population that includes the very young and the very old, full-time workers and the unemployed, and people from many different ethnicities, who speak many different languages, and have a wide range of educational backgrounds. Medi-Cal enrollees are more likely than the general population to have chronic illnesses and disabilities that may constrain their daily activities.[9] Overall, Medi-Cal beneficiaries report lower health status than other Californians. Mental health and serious mental illness are some of the most commonly treated conditions among Medi-Cal patients, particularly for the most costly enrollees, and tend to co-occur with physical health conditions.[10]
- **Access, Quality and Health Outcomes:** While publicly available data on utilization and outcomes are limited, reports suggest that Medi-Cal is not meeting expectations of health access, quality, and equity throughout the state. For example, adult Medi-Cal enrollees are twice as

likely as Californians with employer-sponsored coverage to report difficulty getting care from a provider due to insurance and four times more likely to visit the ER for a chronic condition because they couldn't see their own doctors.[11] Emergency room use is significantly higher for the Medi-Cal population than for other Californians.[12]

Within Medi-Cal managed care, quality reports show that MCOs have highly variable performance on quality of care indicators; while some consistently perform above the minimum contractually required levels in all indicators and in all counties they service and there are examples of exceptional performance, innovation and investment (see *"Examples of Local Innovation in Medi-Cal Managed Care"*), many MCOs are performing below the minimum performance benchmark and national averages.[13] MCO members are generally satisfied with their personal doctors, but their overall ratings of their health plans and their ability to get care quickly is below national benchmarks.[14]

Figure 4. Medi-Cal Managed Care 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS) National Comparison Results

Measure	Adult Medicaid	Child Medicaid
Global Ratings		
Rating of Health Plan	★★	★★
Rating of All Health Care	★★	★
Rating of Personal Doctor	★★★	★★★
Rating of Specialist Seen Most Often	★★★	★★★★
Composite Measures		
Getting Needed Care	★★	★
Getting Care Quickly	★	★
How Well Doctors Communicate	★★	★
Customer Service	★★★	★★★

Note: To conduct a national comparison, results for four Consumer Assessment of Healthcare Providers and Systems (CAHPS) global ratings and four composite measures were aggregated and then compared to NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) Benchmarks and Thresholds for Accreditation. Based on comparison, each measure received one to five stars, with one being the lowest possible (i.e., "poor") and five being the highest possible rating (i.e., "excellent").

Source: Medi-Cal Managed Care 2013 CAHPS Survey Summary Report, DHCS, April 2014.

Examples of Local Innovation in Medi-Cal Managed Care

Expanding Capacity

Many Medi-Cal plans have ramped up investment earmarked to expand capacity. For example, the Central California Alliance for Health (CCAH) has created a Medi-Cal Capacity Grant Program to increase service capacity for its more than 340,000 Medi-Cal members in Santa Cruz, Monterey and Merced counties. It focuses on increasing provider capacity, improving access to behavioral health and substance abuse services, and expanding the availability of support resources for frequent users of health services. CCAH's Provider Recruitment Program makes $20 million available to subsidize recruitment-related expenses for primary care, specialty care, and behavioral health professionals. CCAH's Equipment Program makes $1.5 million available to providers to subsidize the cost of equipment. A third program, the Practice Coaching Program, will invest $1 million in technical assistance and coaching to practices committed to adopting the Patient Centered Medical Home model of care. Through this program, CCAH intends to advance engaged leadership, patient empanelment, evidence-based care, same-day access to primary care appointments, team-based and patient-centered care, greater coordination of care, and data-driven quality improvement.

Integrating Physical and Behavioral Health

Several Medi-Cal plans have prioritized better integration of physical and behavioral healthcare for their members. One standout is Inland Empire Health Plan (IEHP), which has created an in-house behavioral health program to address the mild-to-moderate mental health needs of its members, integrated behavioral health into every department, trained staff, and expanded its behavioral health provider network to ensure timely access. The network design was based on the "No Gate Keeper" model where the member can freely access mental health or substance abuse treatment services without a referral from his or her primary care physician (PCP) or any requirement of symptom severity.

IEHP created a state-of-the-art web-based coordination of care (COC) system to facilitate communication and collaboration among behavioral health providers, the member's PCP and IEHP behavioral healthcare managers. The online system enables behavioral health providers to view their members' health histories through the electronic health record (EHR). IEHP reports that, as a result of these and other changes, the number of outpatient behavioral visits has increased while inpatient behavioral health bed days have dropped significantly.

IEHP is also investing in a $20 million initiative to integrate behavioral healthcare at the point of care with 13 entities across 34 sites (including county-operated primary care clinics; FQHCs; a community-based adult services center; an assisted living facility; and behavioral health clinics). IEHP support includes staffing, consulting, active coaching and data management and transfer, all designed to provide integrated, collaborative physical, behavioral and substance use treatment for members. UC San Diego will conduct a formal evaluation of this initiative.

Medi-Cal Managed Care Vision

Gleaned from months of an inclusive public process, the state articulated a high-level vision for Medi-Cal in its "Medi-Cal 2020" waiver application – to foster "shared accountability among all providers to achieve high-value, high-quality, and whole person care."[15] Overall, the stakeholders interviewed expressed strong agreement with this vision. These stakeholders focused on the following three components:

- **Coordinated systems of care:** The next generation of Medi-Cal managed care needs to support and advance systems of care, or at least much deeper and more effective coordination of health services across the spectrum of care delivery sites, with special focus on the integration of physical and behavioral health services, particularly for members with highly complex health needs.
- **Value and accountability:** The flow of funds between the state and these systems of care, and among the entities within the systems of care, needs to be oriented to invest in and reward initiatives that support explicitly defined goals consistent with the vision. Tying funding to value requires mechanisms for holding components of the system accountable for achieving results.
- **Stable and adequate financing and strong state-level leadership:** Stakeholders consistently noted that delivery system and payment reform efforts will only be successful if built upon a platform of sustainable financing – one that can weather recessionary impacts on the state budget – and guided by strong leadership and management at the state level. There were diverse views on whether California's overall investment was adequate; many felt the program has long suffered from underinvestment while some believe that investing current resources in new ways could be sufficient to support reform.

Stakeholders also articulated barriers to achieving this vision for Medi-Cal and noted that it will take more than a "business as usual" approach to bring about meaningful improvements in today's highly fractured delivery and financing system. Their vantage points varied, but overall their views offered a telling story of structural roadblocks to reform.

Barriers to Achieving the Vision

1. Fragmented Administration and Delivery of Care

The current Medi-Cal delivery system is composed of a complex mix of plans, counties and provider systems with lines drawn based on geography, beneficiary age and health condition, funding source, and a mix of older and more recent policy goals.

California's managed care system typically involves multiple layers of delegation and sub-delegation of risk and responsibilities for the coordination and provision of patient care. California is somewhat unique in its use of delegation of risk from plans to providers, not just in Medi-Cal but across business lines, including Medicare Advantage and commercial products. In some ways, its history of delegating risk can pave the way for successful delivery system reform since plan-to-provider delegation can align the goals of MCOs and providers around managing the total cost of care and achieving quality outcomes. However, although many MCOs use pay-for-performance programs to foster improvements in access and quality, much of the delegation and sub-delegation that exists in Medi-Cal today is not necessarily designed to create accountable systems of care across primary, specialty, behavioral health, hospital and post-acute care. Rather, most are arrangements to pass along risk from the plans to different (largely siloed) segments of their provider networks.

> "We can't get to five star performance in Medi-Cal managed care without changing the structure of the program"
> *– Provider trade group*

Plan-to-plan delegation in Los Angeles County, which accounts for 28% of Medi-Cal beneficiaries, adds yet another

L.A. County Sub-Contracting and Delegation

Los Angeles County, which operates the so-called two-plan model, actually has six plans – the two plans that contract with the State (HealthNet and LA Care), three additional plans (Anthem, CareFirst and Kaiser) that subcontract with LA Care and a sixth plan (Beacon) that subcontracts with some plans to provide some mental healthcare for enrollees with mild to moderate mental health conditions. Together, the enrollment for the three subcontracted health plans (not including Beacon) exceeds the direct enrollment of LA Care and HealthNet, the two plans that have a direct contractual relationship with the state. All but one plan shares risk with some of its providers, in most cases not for managing the total cost of care, but for the provision of and payment for a particular service (e.g., physician care, hospital care). In some cases, provider organizations contract with other providers, meaning that some providers that are carrying out the plan's responsibilities have no contractual relationship with that plan.

layer to an already complex system. The two plans that contract directly with the state subcontract to other plans, retaining a portion of the premium for administrative services that may be redundant to services being delivered by the delegated entity. Given the complex and often nontransparent arrangements, stakeholders noted that the organization of care often leads to confusion in roles and responsibilities for providers and plans, challenges for consumers to navigate and oversight complexities.

These complexities are further exacerbated because certain services (e.g., treatment for serious mental illness, pediatric services for certain complex conditions and some long-term services and supports) are "carved out" of the primary health plan's responsibilities, leaving no single entity responsible for the whole person. While it is critical to ensure that patients with complex care needs have the specialized care they require, bifurcating the organization, payment and oversight of care for these populations and services fractures the delivery of care. This problem is particularly acute for mental healthcare. The counties administer services to treat serious mental health problems, while the state administers care through the managed care system to address physical healthcare and mild to moderate mental healthcare needs of the same population. Plans are now required to establish memoranda of understanding (MOUs) with the counties to promote systems for coordinating care, but interviewees indicated that integration efforts have either not begun or are at a very early stage in many parts of the state.[16]

2. Fragmented Financing

Like the delivery system, financing of the care delivered to managed care enrollees is highly fragmented, with large dollar amounts being transferred as institutional subsidies rather than as payments for services and outcomes. An estimated 25% to 30% of the payments for hospital services provided under contract to the plans are made through supplemental payments that are passed through to the counties and hospitals at the end of the plan year. Public and private hospitals generate the nonfederal share of these payments through the hospital provider tax and county-generated intergovernmental transfers, both legal and common sources of financing for Medicaid programs. The payments, however, are not tied to particular services or any quality measures but are generally seen as a way to compensate for low base payments to the hospitals, and support counties' care delivery systems. While these are both legitimate objectives, this method of payment limits the state's ability to use its purchasing power to promote accountability and reward value.

The Challenge of Care Coordination

"The mental health system for Medi-Cal is broken. The carve-in of mild to moderate mental illness into MCOs has helped bring greater clarity regarding the division of responsibilities between MCOs and counties, but there is limited accountability and transparency for mental health services at the county, and clinicians don't have the systems to talk to each other to coordinate care."
– Medi-Cal provider

FQHCs are also compensated for their care of Medi-Cal beneficiaries partly through supplemental payments; these payments, which are required by federal law, are based on the volume of care provided to patients. Recent state legislation seeks to pilot ways to shift this volume-based system of payment to one that is more grounded in value-based principles.

Medi-Cal's payment structure is further fragmented by carve out arrangements. Under federal law, the state is responsible for the care provided to Medi-Cal beneficiaries for mental health conditions, but in California the funds for the care of people with serious mental illness go to the counties (which pay the nonfederal share), and the state Medi-Cal agency, pursuant to a provision adopted in the state constitution in 2012, has no authority over how those funds are spent. Mental health is a major cost driver for the program. Over half (59%) of Medi-Cal's top 5% most costly enrollees have a mental health condition, including 45% of enrollees with a serious mental illness.[17]

Medi-Cal's rate setting methodology further undermines efforts to advance accountable, coordinated systems of care and reward value. Rates are generally based on prior year utilization and are pegged at the lower end of the range of what is determined to be actuarially sound. There is no mechanism for the state to share savings to provide financial incentives that drive improvements in care delivery and redirect care to less costly settings. In fact, to the extent that plans and providers are successful in reducing utilization of costly care (e.g., reducing preventable hospital inpatient admissions), they are likely to see a reduction in payments in subsequent years.

The lack of a payment methodology that provides incentives for and helps to finance care improvements, combined with what are generally viewed as low payment rates, has important implications for the system overall. It prompts more sub-capitation arrangements and system fragmentation as risk continues to get shifted downstream, challenging the drive towards the desired accountable, coordinated systems of care.

3. Uneven Access to Providers

Historically, provider participation in Medi-Cal has been lower than participation in the commercial market.[18] With respect to primary care, California still falls significantly short of the national benchmark for a sufficient supply of Medi-Cal participating primary care providers to meet the needs of beneficiaries.[19] While the data indicate that California has a sufficient supply of Medi-Cal specialty care providers overall to meet the needs of beneficiaries, there is variation in access by specialty and by geography,[20] and anecdotal reports of significant access challenges. In some cases, plans report having to pay higher than contracted rates to providers, such as specialists, to ensure access and meet network adequacy requirements. In the case of hospitals, payments by plans include retroactive supplemental payments intended to compensate for low base payments. Unfortunately, there is little publicly available information on network capacity or on utilization within the managed care system, which could shed more light on access questions. In addition to addressing provider reimbursement rates, stakeholders suggested that provider participation could be improved, to the extent that the State or its contracting plans reduced administrative hurdles to enrollment and certification and streamlined prior authorization procedures within and across plans.

4. Workforce Challenges

Stakeholders noted challenges recruiting primary care physicians and specialists, especially to safety net institutions and FQHCs, which do not have the resources to offer salaries on par with health systems that serve an exclusively or heavily commercially insured population. The state had outlined workforce development initiatives in its original waiver renewal proposal to provide incentives to providers to participate in Medi-Cal, expand the workforce, and enhance their cultural competency to serve Medi-Cal beneficiaries, but these proposals were dropped in the approved waiver terms.

5. Lack of Transparency and Effective Accountability Mechanisms

Under federal law, the Department of Health Care Services (DHCS) is accountable for the overall administration and oversight of Medi-Cal, including its managed care system. DHCS contracts with plans, sets the rates for the plans with which it contracts directly and establishes the rules and regulations for the program. To carry out its plan oversight, DHCS works with the Department of Managed Health Care (DMHC), the state agency that oversees full-service health plans (whether or not they are contracting with Medi-Cal) and their compliance with California's Knox-Keene Health Care Service Plan Act of 1975.[21] Some stakeholders raised concerns that the state's oversight activities do not necessarily ensure accountability, noting that the DHMC's requirements are typically more process- than outcomes-oriented.

Compounding the challenge of program oversight is the limited visibility into (and oversight of) the networks and performance of contracted and delegated entities. For instance, DHCS requires all plans to collect and report on HEDIS measures for quality oversight, but the reports do not provide the performance of subcontracted plans or provider groups. Therefore, in locales with a high degree of subcontracting or delegation, it is not possible to identify outlier performance issues and underperforming plans or provider groups from publicly available data. DHCS has a responsibility to ensure members have the information they need to make good choices about the network they choose, but without visibility down to the delegated entity level, members often do not have adequate information to make well-informed decisions.

> "Consumers and regulators are challenged to understand true adequacy of provider networks. Consumers will review the parent plan network information but it's the delegated IPA network that reflects actual access and is the level on which utilization is managed."
> *– Consumer Advocate*

State representatives noted that the state has limited levers for achieving a high degree of accountability, citing that previous attempts at removing under-performing plans from the Medi-Cal program were appealed and overturned, and that, due to litigation-related settlements, the state is locked into certain contracts with plans for several more years.

Additionally, as noted, under the state constitution, DHCS has very limited ability to oversee the provision of services for Medi-Cal beneficiaries with serious mental health conditions treated by the county systems.

6. Under-Resourced Program Management

Stakeholders interviewed noted that bandwidth, skill sets, and the infrastructure for accountability functions have not kept pace with the growth and changes in Medi-Cal managed care. Recently the effectiveness of the state's oversight of network adequacy, consumer complaints, and quality has been called into question.[22] The state has taken steps to address these concerns, including passing legislation to establish accurate provider directories, increasing the frequency of health plan audits, and regularly publishing a Medi-Cal managed care performance dashboard.[23,24] Implementing Medi-Cal reform at the scale described in this paper will require enhanced capabilities at the agency level.

A Path Forward

Stakeholders are generally very supportive of the program and proud of its accomplishments. They are also eager for reform, but worry that there are clear limits as to what can be done within current constraints. They point to there being little appetite at the federal or state level to increase investments, dysfunctional care delivery mechanisms and financing arrangements entrenched in statute, and political barriers to change. Yet, given the evolution of Medi-Cal's role, its size and importance to Californians and the state's healthcare system, maintaining the status quo is not a viable option. The interviews and a review of the landscape suggest that it is time to reconsider the longstanding assumptions and constraints that underpin the Medi-Cal program – including how it is financed and how care is delivered, and to engage in a more far-reaching and disruptive dialogue than has yet occurred.

The recently renewed "Medi-Cal 2020" waiver will contribute to positive change but it does not tackle the significant realignment, restructuring and financing issues many stakeholders identified as being critical to successful transformation. The new initial federal investment is limited to just over $6 billion, well below the $17 billion request but similar to the level of support provided under the previous waiver. And like the previous waiver, the primary focus of the new waiver is largely on the public hospitals, a critical component of the Medi-Cal delivery system and California's healthcare safety net, but still only a slice of the healthcare system.[25] While the waiver presents new opportunities and investments, its scope is limited and implementation will generally not address the system as a whole.

The newly released federal managed care regulations present new opportunities but will also prompt some changes in the Medi-Cal managed care system. Certain rate setting practices relied on by California may no longer be viable, and payments to providers passed through managed care plans will need to be revised over time. At the same time, the regulations encourage state-designed value-based payment strategies and provide some new tools for accomplishing those strategies.

Achieving the broadly shared vision of accountable, coordinated systems of care will require a phased, multi-year approach. Below are a set of near term priorities to improve care and strengthen the foundation for reform.

Many of these priorities take the waiver initiatives to a higher level. They are considered near term because they are on the state's agenda, largely triggered by the new waiver and do not require new state legislation or waivers to be implemented. But they still will require significant state resources and stakeholder commitment to be implemented successfully.

At the same time as these near term initiatives are pursued, a process is needed to delineate and implement the type of structural reforms discussed in the final section of this paper.

Near Term Change

1. Intensify efforts to coordinate care for people with serious mental illness. Given the high burden of mental illness and the consensus among stakeholders that coordination of care for people with serious mental health issues is particularly challenging in the current environment, a more concerted effort to promote integration of care is needed.[26] Achieving complete integration for people with serious mental illness would require a change to the state's Constitution, but there are steps that can be taken today, under current law, to improve coordination of care for this vulnerable population. The MOUs between plans and counties can help clarify roles and responsibilities, but stakeholders generally seem disconnected from or even unaware of this process. The state and counties should take the following steps:

- Establish a clear and public set of expectations and milestones for achieving integration of care.
- Actively engage plans, providers, and consumer groups in implementation.
- Ensure that care teams have systems in place to communicate and coordinate patient care across the physical and mental health divide.

2. Invest in initiatives that address the pressing health-related needs of the Medi-Cal population with complex health conditions. The Medi-Cal 2020 waiver includes funding to implement voluntary, county-based "whole-person" care pilot programs, which present an opportunity for bringing together healthcare, social services and community-based service providers to design and test innovative models of care that go beyond the traditional definition of healthcare.

Based on the experiences of other states, this is difficult work. There is much interest among stakeholders in this

Meeting the Needs of Populations with Limited Income

"The current Medi-Cal delivery system is a "middle class" healthcare system; it assumes people can drop everything and go see the doctor in the middle of the day, and it assumes health is everyone's number one priority. The truth is that low-income people have a variety of other issues that may be more pressing, like access to housing or food, and they often cannot leave work to go to a healthcare appointment, but there is no interested party advocating for coverage for those services, the way there is for imaging or surgery." – Medi-Cal Provider

initiative, but the waiver financing is limited and the infrastructure to support the effort is not in place. To promote success, the pilots should, where possible, align and coordinate with the health home initiative for people with multiple chronic conditions. Furthermore, the pilots should be supported with model contracting and cross-learning opportunities on roles and responsibilities. To supplement the funds provided through the waiver, revisions in rate setting (discussed below) can help support these efforts, particularly if they are targeted to those for whom interventions are most likely to result in lower costs.

3. Strengthen accountability by revising rate setting methodologies. Medi-Cal can address the current disincentives to shifting care out of emergency departments and costly institutional settings and into ambulatory, community-based care settings; waiver authority and special waiver funding are not essential to moving forward. Given the strong and consistent message from plans and other stakeholders that the current rate setting methodology not only does not reward care improvements, but is actually a disincentive for such improvements, a change in rate setting and payment strategies is needed. One approach would be to allow health plans to share savings achieved through improvements in care; this approach was proposed in the state's waiver proposal, but was eventually dropped from the finalized waiver. A variation to this approach is to develop a new rate setting methodology that allows plans to keep the savings if those savings are reinvested in care improvements (which could be defined by the state in collaboration with plans and providers). This would not add costs relative to current rates and is a way to promote needed investments.

These relatively modest rate setting changes could be a prelude to and dovetail with the implementation of the alternate payment methodologies (APMs) required under the waiver for the Designated Public Hospitals (DPHs). The APM initiative could help achieve the vision of greater value and accountability for patient outcomes, but if limited to the DPHs, this initiative will have modest impact and would further fragment how care is financed and quality is measured. With the goal of eventual statewide adoption, APMs should be extended to health systems that are prepared to take on some level of "whole person" risk, particularly given that multiple

Alternative Payment Models

Payment approaches designed to drive better outcomes are often referred to as "alternative payment models," (APMs) meaning they are alternatives to paying for the volume of care provided. APMs can take different forms, ranging from relatively modest pay for performance type mechanisms (which are already being pursued by some Medi-Cal managed care plans today) to the assumption of full risk for the total cost of care. States are adopting different systems, recognizing that many providers are not ready to take on full risk. Arkansas and Tennessee are building payment models around episodes of care while New York is planning to have four different types of alternative payment methodologies, each with different levels of risk, and to phase in those arrangements over time.

plans will need to be engaged to implement APMs for the public hospital systems. Instead of the bottom up approach adopted in the Bridge to Reform Delivery Systems Reform Incentive Payment (DSRIP) program, the development of APMs, whether or not limited to DPHs, will need direction from the State in close collaboration with the DPHs, plans and other stakeholders to effectively serve as a building block to broader payment reform.

4. Align incentives across Medi-Cal and across the marketplace. With some exceptions[27], Medi-Cal lacks common goals that it is seeking to achieve across its managed care delivery system, such as improved performance on a core set of quality indicators, or reduced readmissions and emergency room use. A core set of initiatives can help stimulate reform while simultaneously allowing for local strategies that take into account regional assets, challenges, and community needs. Greater standardization also makes sense given that providers are often contracting with multiple managed care plans and yet are pushed in different directions by the different plans. The development of APMs and new rate setting methods presents new opportunities for DHCS to encourage greater standardization of performance expectations within Medi-Cal managed care.

Medi-Cal should also intensify its collaboration with Covered California and CalPERS to promote opportunities for the three payers to align their delivery system reform strategies. Together, Medi-Cal, CalPERS and Covered California purchase health insurance for approximately 15 million Californians, with Medi-Cal representing by far the largest share. Each program may well have different emphases driven by the needs of its specific populations, but there are many cross-cutting priorities (for instance, the adoption of interoperable health information technology or the management of chronic conditions). Reform is most likely to take hold if the three state systems are moving in the same direction for those areas of overlapping priority.[28] Through greater collaboration, DHCS would benefit from the resources invested by other payers in analyzing performance incentive initiatives, and the efforts of these other payers would be strengthened by alignment with Medi-Cal, given its large footprint in the California health care market, and the churn of members across programs. Alignment could be promoted if the three state payers regularly report on key areas of delivery system and payment reform and how each of the programs is addressing areas of overlapping priority.

5. Focus on data improvement. Little can be accomplished

Aligning Value-Based Initiatives Across the State

The Integrated Healthcare Association (IHA) has been facilitating multi-stakeholder work groups to align quality measurement and incentive programs both within Medi-Cal (promoting the standardization of MCOs' pay-for-performance (P4P) program metrics across the state) and across state payers. It is currently facilitating a multi-stakeholder work group, led by CalPERS, DHCS, and Covered California, to reduce inappropriate and unnecessary care across public and private payers.

without a robust and dynamic data environment. Cost, quality, utilization, patient satisfaction, equity and access data from all plans and subcontractors/delegated entities (by entity) should be made publicly available to allow for an ongoing, meaningful assessment of the health of the system, how well it is meeting the needs of its diverse members and how effectively it is deploying its resources.

6. Invest in Health Information Technology and Health Information Exchange across the state. To promote the level of coordination of care and care management that can result in more appropriate utilization of resources, cost savings, and better patient outcomes, the state should deepen its efforts to help equip providers with the tools, technology and incentives to go digital.

7. Address workforce shortages. Though not approved as part of the renewed waiver, workforce investments are necessary to ensure access to care and the cultural competence of the workforce in treating the Medi-Cal population – many for whom English is not their first language. These investments can help ensure people get basic primary care services and prevent the need for costly emergency and acute care services. The programs envisioned in the waiver concepts are sound, including incentives for providers to participate in Medi-Cal, cultural competence training, and leveraging non-physician and front-line workers to help beneficiaries navigate the system and provide health education.

Structural Transformation

In parallel to these important near-term initiatives, the landscape review and the interviews suggest that a far more ambitious agenda of re-structuring the underlying Medi-Cal delivery and payment system is needed to achieve the vision of **coordinated and accountable systems of care**. This level of transformation cannot be achieved without further analysis and stakeholder engagement, and will likely require legislation (and perhaps a change in the state Constitution), regulatory changes, re-procurement, or all three.

1. Rethink the core structures of Medi-Cal managed care delivery. The current structure of Medi-Cal's managed care delivery system was designed when a much smaller and more homogenous group of enrollees was enrolled in managed care; much has changed since that system first took shape in 1993. Perhaps most notable is that the number of people served by managed care has grown almost threefold in the past six years and the demographics of those enrollees have changed just as dramatically.[29]

These developments, along with the highly variable performance across plans, suggest that it is time to consider whether these delivery models are best suited to achieve the level of performance and accountability that California and stakeholders believe should be achieved. The inquiry will raise difficult questions: Should all plans have a direct contractual relationship with the state? How can delegation be transformed to advance accountable systems of care? Should procurement cycles, plan and provider requirements and expectations be revised? What factors promote or hinder a county-run plan's ability to be successful?

Medicaid Delivery System Reform in Other States

Many states are developing new ways to organize their Medicaid care delivery systems. For example, Oregon has established locally driven regional coordinated care organizations (which bear full risk and, under federal rules, are considered managed care organizations); they have flexibility for how they will design their system of care and, to some degree, for the services they will provide, but are all responsible for meeting statewide metrics for quality and cost. Massachusetts and New York are moving to require health plans to contract with accountable care organizations or to adopt alternative payment methodologies with a large portion of their providers. Colorado does not rely on managed care plans but rather contracts directly with accountable care organizations.

Should counties' roles evolve, given the imperative of focusing on population health? Where should responsibilities for care management reside? Can the impact of value-based initiatives be measured and responsibility for results be attributed in the system that is in place today?

2. Re-examine Medi-Cal's financing system. Financing also needs a thorough examination including resolution of the following four financing-related questions:

- **Is the overall level of funding sufficient to support adequate networks and encourage coordinated systems of care?** There are strong opinions but neither a consensus among stakeholders nor sufficient data upon which to draw a definitive answer to this question. Nor is there any accepted measure of adequacy of funding – markets differ, as do population needs and costs. Medi-Cal is a lean program by any standard, and the evidence available indicates that it is not achieving the outcomes Californians expect. A robust examination of access, utilization, outcomes and the opportunities for achieving savings through care improvements should drive the determination of whether the overall level of resources or the distribution of resources is appropriate. Informative data on networks should be forthcoming; utilization data may require more time and resources, although the state has noted that it relies on such data to set rates. If so, such data could be made publicly available. In addition, federal regulators are requiring all states to improve their data systems or face compliance action.[30]
- **Is it possible to move to a value-based system of paying for care given how much money is directed to hospitals through supplemental payments?** Federal concern about the lack of transparency and efficacy of supplemental payments and new managed care regulations will trigger change, but California will need to drive that change and consider how to bring rates for hospitals and other providers to an appropriate level without relying on end-of-year payments that are not connected to services or outcomes, and how best to support safety net institutions. [31,32] Tying supplemental payments to the attainment of quality outcomes could be one way to begin to reorient this aspect of program financing towards

value and ensure that existing resources are being used to incentivize and reward system transformation. Payment rates within managed care can also be designed to specifically address the unique needs of safety net hospitals that serve a large number of Medicaid and uninsured patients.

- **Should the financing for serious mental healthcare be revised so that payment strategies support integration between mental healthcare and physical healthcare?** County financing and control of the funding for serious mental healthcare has a long history in the state, but now, with the expansion, many of those services are provided to Medi-Cal beneficiaries, leaving people who are receiving the care with a bifurcated delivery system financed through different funding streams. To align financing with delivery and promote accountability, options to "carve in" the care (while assuring capacity to care for patients) or to construct incentive payments that cross delivery system sites should be considered so that payment strategies promote alignment of care for the whole person. Carving in mental health would require a change to the California Constitution, which currently codifies the counties' role in the delivery of mental health services.
- **What are the implications of these issues for the nonfederal funding for the program?** Consideration of each of the first three questions inevitably raises the issue of who pays and what will make up the sources of the nonfederal share of Medi-Cal spending. Diversified financing, for example, through provider taxes and intergovernmental transfers, can help states fund the nonfederal share of Medicaid costs, and there is nothing inherently problematic about such diversification. However, if the source of funding drives payments in ways that do not promote accountable coordinated systems of care, efforts to promote value are compromised. In addition, a patchwork financing system can result in added costs. The financing of mental healthcare contributes to some of the highest cost Medi-Cal beneficiaries getting caught in the cracks between the county-based mental health system and the Medi-Cal managed care system. All those who contribute to financing Medi-Cal, including the state's general fund, are bearing additional and unnecessary costs.

California has tackled financing realignment many times over the years, and it is never easy. Many factors, including county indigent care obligations, the importance of sustaining the safety net hospitals, local property tax limitations, state laws directing certain resources to education, and the demands of other state priorities have shaped and will continue to shape California's Medi-Cal financing arrangements. These are all important considerations, but given the size and importance of Medi-Cal, it is also critical to consider the impact of the current financing structure on Medi-Cal's overall costs and its ability to serve its beneficiaries well and move forward with the next chapter of delivery system and payment reform. And, as California has just seen, it cannot continue to expect and rely on increases in federal funding through waivers to finance key initiatives.

Conclusion

California is a national leader in extending Medicaid to low-income people and in other aspects of healthcare reform. And yet, the Medi-Cal program's current status and trajectory raise deep concerns among stakeholders and external observers alike. In parallel to a series of near term and more incremental steps that can advance the program down the path of achieving greater value, open dialogue is required about how to address the structural impediments to change.

Medi-Cal is too large and too important to miss this opportunity to achieve the vision of accountable, coordinated systems of care.

About Manatt

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is a fully integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory healthcare practice. Manatt Health's extensive experience spans the major issues reinventing healthcare, including payment and delivery system transformation; health IT strategy; health reform implementation; Medicaid expansion, redesign and innovation; healthcare mergers and acquisitions; regulatory compliance; privacy and security; corporate governance and restructuring; pharmaceutical market access, coverage and reimbursement; and game-changing litigation shaping emerging law. With 80 professionals dedicated to healthcare—including attorneys, consultants, analysts and policy advisors—Manatt Health has offices on both coasts and projects in more than 20 states. For more information about Manatt Health, visit www.manatt.com/HealthcareIndustry.aspx.

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Appendix A: Interviewees

Maya Altman
Health Plan of San Mateo

Scott Bain
California Senate
Health Committee

Bill Barcellona
California Association of
Physician Groups

Kirsten Barlow
County Behavioral Health
Directors Association

Kim Belshé
First 5 LA (formerly, Secretary,
California Department of Health
and Human Services)

Catherine Blakemore and Deborah Doctor
Disability Rights California

Michelle Cabrera
SEIU State Council

Carmela Castellano-Garcia
California Primary
Care Association

Richard Chambers
Molina Healthcare of California

Dustin Corcoran
California Medical Association

Sarah de Guia
California Pan-Ethnic
Health Network

Diana Dooley
California Health and Human
Services Agency

Toby Douglas
Independent Health Care
Consultant (formerly, Director,
California Department of Health
Care Services)

Susan Ehrlich
San Mateo Medical Center

Susan Fleischman
Kaiser Permanente

Bob Freeman
CenCal Health

Brad Gilbert
Inland Empire Health Plan

Stuart Gray
Accountable Health Care IPA

Ed Hernandez
California State Senate

Russell Judd
Kern Medical Center

Mitch Katz
Los Angeles County Department
of Health Services

Jennifer Kent and Mari Cantwell
California Department of Health
Care Services

Don Kingdon and Molly Brassil
Harbage Consulting

Elizabeth Landsberg
Western Center on Law & Poverty

Agnes Lee
Office of Assembly Speaker
Toni Atkins

Peter Lee
Covered California

Chris Manson
St. Joseph Health

Ana Matosantos
Independent Financial and Budget
Consultant (formerly, Director,
California Department of Finance)

Louise McCarthy
Community Clinic Association
of Los Angeles County

Steve Melody
Anthem Blue Cross

Santiago Muñoz
UCLA Health System

Erica Murray and David Shearn
California Association of Public
Hospitals and Health Systems/
California Health Care Safety
Net Institute

Richard Pan
California State Senate

Jeff Rideout and Jill Yegian
Integrated Healthcare Association

Shelley Rouillard
Department of Managed
Health Care

Michael Schrader
CalOptima

Ralph Silber
Alameda Health Consortium

Marjorie Swartz
Office of Senate President Pro
Tempore Kevin de León

Farrah McDaid Ting and Michelle Gibbons
California State Association of
Counties

Tammy Wilcox
Dignity Health

Anthony Wright and Beth Capell
Health Access

[1] "Adult Medi-Cal Enrollment Surges, Uninsured Rate Plummets in 2014," *UCLA Center for Health Policy Research*, August 2015. Accessed at: http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/Medi-Cal-factsheet-aug2015.pdf

[2] Long-term services and supports (LTSS) were not part of the focus of the interviews and report.

[3] See Appendix A for list of interviewees.

[4] "Medi-Cal Statistical Brief," *DHCS Research and Analytic Studies Division*, August 2015. Accessed at: http://www.dhcs.ca.gov/dataandstats/statistics/Documents/New_24_Month_Examination.pdf
"California Enacted Budget Summary," *Department of Finance*, June 2015. Accessed at: http://www.ebudget.ca.gov/2015-16/Enacted/BudgetSummary/BSS/BSS.html

[5] The Medi-Cal budget estimated total spending of $91,305,437,300, with the General Fund providing $18,039,896,000. The total General Fund, as enacted by the 2015 Budget Act, was $115,369,000,000. Therefore, 15.6% of total General Fund spending was used for Medi-Cal. "Medi-Cal May 2015 Local Assistance Estimate for Fiscal Years 2014-15 and 2015-16," *DHCS*, May 2015. Accessed at: http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/may_2015_estimate.aspx

[6] "Medicaid Financing: How Does it Work and What are the Implications?" *Kaiser Commission on Medicaid and the Uninsured*, May 2015. Accessed at: http://kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/

[7] "Medi-Cal Managed Care Plans and Safety Net Clinics Under the ACA" *California Health Care Foundation*, Dec 2015. Accessed at: http://www.chcf.org/publications/2015/12/medical-winwin-surging-enrollment

[8] Manatt analysis of OSHPD Hospital Data, 2014.

[9] "California Health Interview Survey," *UCLA Center for Health Policy Research*, 2014. Accessed at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

[10] "Understanding Medi-Cal's High-Cost Populations," *DHCS Research and Analytic Studies Division*, March 2015. Accessed at: http://www.chcf.org/events/2015/medical-data-symposium

[11] California Health Care Foundation, "*Medi-Cal Versus Employer-Based Coverage: Comparing Access to Care*," July 2015. Accessed at: http://www.chcf.org/publications/2015/07/medical-access-compared

[12] Over 23% of those covered by Medi-Cal reported visiting an emergency room in the past 12 months, as compared to 15% of those not covered by Medi-Cal. "California Health Interview Survey," *UCLA Center for Health Policy Research*, 2014. Accessed at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

[13] In 2013, MCP [Medi-Cal Managed Care Plan] performance fell below the minimum contractually required performance for 21% of the 22 DHCS quality indicators […] This means one in five Medi-Cal performance metrics was in the bottom 25% of all Medicaid-contracted health plans in the US. "Medi-Cal Managed Care Program, Quality Strategy Annual Assessment," *DHCS*, October 2014 (Rev. February 2015). Accessed at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/MgdCareQualityStrategy2015.pdf

[14] "Medi-Cal Managed Care 2013 CAHPS Survey Summary Report," *DHCS*, April 2014. Accessed at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/CAHPS_Reports/CA2012-13_CAHPS_Summary_Report_F3.pdf

[15] "Medi-Cal 2020: Key Concepts for Renewal," *DHCS*, March 2015. Accessed at: http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal-Official-Submission.aspx

[16] See also: Nov 27, 2013 All-Plan Letter Regarding the Memorandum of Understanding requirements for Medi-Cal Managed Care Plans: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf

[17] "Understanding Medi-Cal's High-Cost Populations," *DHCS Research and Analytic Studies Division*, March 2015. Accessed at: http://www.chcf.org/events/2015/medical-data-symposium

[18] "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?," *California Health Care Foundation*, August 2014. Accessed at: http://www.chcf.org/publications/2014/08/physician-participation-medical

[19] The national benchmark is 60 to 80 primary care physicians per 100,000 in population and California is at 35 to 49 Medi-Cal providers per 100,000 Medi-Cal beneficiaries. "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?," *California Health Care Foundation*, August 2014. Accessed at: http://www.chcf.org/publications/2014/08/physician-participation-medical

[20] The national benchmark is 85 to 105 specialty care physicians per 100,000 in population and California is at 68 to 102 Medi-Cal providers per 100,000 Medi-Cal beneficiaries. 69% of all physicians accept-Medi-Cal, however only 47% of psychiatrists accept Medi-Cal. "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?," *California Health Care Foundation*, August 2014. Accessed at: http://www.chcf.org/publications/2014/08/physician-participation-medical

[21] While Knox-Keene applies to most of California's managed care systems, it does not apply to most of Medi-Cal's County Organized Health Systems (COHS) which account for over 21% of the Medi-Cal managed care population. As such, some stakeholders raise concerns about the lack of consistent oversight of the plans contracting with Medi-Cal, though others noted that the COHS have among the highest quality scores. Pending legislation would require that COHS be Knox-Keene licensed and confer more robust consumer protections for coverage through COHS, such as independent medical review and external review by DMHC. "SB-260: Medi-Cal: County Organized Health Systems Pilot Program," *California State Senate*, 2015-2016. Accessed at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB260

[22] "Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care," *California State Auditor*, June 2015. Accessed at: https://www.auditor.ca.gov/pdfs/reports/2014-134.pdf

[23] "SB-137 Health care coverage: provider directories," California State Senate, 2015-2016. Accessed at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB137

[24] "Medi-Cal Managed Care Performance Dashboard," DHCS. Accessed at: http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx

[25] In 2013, the public hospitals accounted for 21% of California's total inpatient Medicaid discharges. Manatt analysis of 2013 Hospital Annual Financial Disclosure Reports from the Office of Statewide Health Planning and Development. Reports available at: http://www.oshpd.ca.gov/HID/Hospital-Financial.asp#Profile

[26] California is not alone in tackling this challenge. States and health systems are pursuing a spectrum of approaches to achieving greater integration – including universal screening programs, patient navigators, co-location of services, health home models of care – with many showing promise. "Integrating Physical and Behavioral Health Care: Promising Medicaid Models," *The Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation*, February 2014. Accessed at: https://kaiserfamilyfoundation.files.wordpress.com/2014/02/8553-integrating-physical-and-behavioral-health-care-promising-medicaid-models.pdf

[27] DHCS produces an annual statewide quality strategy, and a Medi-Cal Managed Care Quality Dashboard to define quality goals across the program. Additionally, select HEDIS measures are used in the auto assignment process, with higher-performing health plans receiving a higher share of enrollees who do not affirmatively pick a plan.

[28] Covered California recently updated its contracts with plans for 2017 to enhance the quality performance requirements, address disparities, and promote quality over quantity of care. For more information, see http://news.coveredca.com/2016/04/covered-californias-board-adopts.html

[29] Medi-Cal managed care enrollment totaled 3.9 million in December 2009 and 10.2 million in December 2015. "MMC Enrollment Report," DHCS. Accessed at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

[30] "Federal Policy Guidance: Transformed Medicaid Statistical Information System (T-MSIS) Data," *CMS*, August 2013. Accessed at: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf

[31] "Improving Transparency and Accountability of Supplemental Payments and State Financing Methods," *Government Accountability Office*, November 2015. Accessed at: http://www.gao.gov/products/GAO-16-195T

[32] "Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability Proposed Rule," *CMS*, June 2015. Accessed at: https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

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