



A Close Look at Medi-Cal Managed Care: Quality, Access, and the Provider's Experience Under Geographic Managed Care

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Executive Summary

Background

In most counties in California, the Department of Health Care Services (DHCS) contracts with one or two managed care plans (MCPs) to deliver services to Medi-Cal enrollees. In just two counties, Sacramento and San Diego, DHCS contracts directly with five or more MCPs. This approach, the Geographic Managed Care (GMC) model, provides enrollees in those counties with more options. It is unclear whether greater competition among MCPs has led to higher quality of care, better access to services, or better experiences for Medi-Cal enrollees and their providers, or whether market fragmentation leads to navigational challenges and poor coordination of care.

In 2020, DHCS is scheduled to release its Request for Proposals (RFPs) to begin the procurement process to select commercial MCPs for the Medi-Cal program starting in January 2023.¹ This makes it the ideal time to assess the GMC model of managed care and whether, and under what circumstances, DHCS should continue to support it. Using a mixed-methods approach that combines quantitative and qualitative analysis, this report examines how quality of care, access to care, and patient satisfaction in GMC counties compare with similar urban counties that use a County Organized Health System (or COHS, a single public MCP) or the Two-Plan model (where a public MCP and a commercial MCP compete).

Results

This assessment reveals a mixed picture of GMC performance and its ability to accomplish purported goals for Medi-Cal enrollees. This analysis of data on access to care, MCPs' quality performance, and patient satisfaction suggests that the promise of GMC has not been fully realized.

Key findings include the following:

- ▶ Access to care for Medi-Cal enrollees in GMC counties appears to be no better than for enrollees in the comparison urban COHS and Two-Plan counties.
- ▶ The quality of care delivered by MCPs in GMC counties was lower, on average, for 22 of 30 measures compared with MCPs in the comparison counties. Quality scores were the same on six measures and better on two. The biggest difference was found in immunization rates for children and adolescents, where GMC plans had lower rates by 8% and 7%, respectively, than comparison plans.
- ▶ Enrollees in the two GMC counties have many MCP options, and they exercise their ability to move between MCPs at higher rates than enrollees in similar counties. This multiplicity of MCP options, however, does not clearly manifest in better patient satisfaction: Average scores for MCPs in GMC counties were higher on some satisfaction measures and lower on others.
- ▶ Many providers in GMC counties contract with multiple MCPs, resulting in overlap across MCPs. This is more common among primary care providers than specialists. Some providers, particularly specialists, may be found on only one MCP's network listings, resulting in some differentiation across networks. Consequently, enrollees moving between plans and networks might be able to keep their primary care provider but are more likely to change their specialists.
- ▶ Interviews with consumer groups, health care providers, and other stakeholders in Sacramento and San Diego Counties noted that the multiplicity of MCPs creates a confusing patchwork of networks, providers, benefits, and services. As a result, they report, some enrollees struggle to find and use services, particularly specialists. For providers, this multiplicity of MCPs presents many redundancies in contracting, administrative requirements, and clinical approaches to care and quality improvement, which bring significant transaction costs.

Considerations for Improvement

There are significant barriers to changing from the GMC model to the COHS or Two-Plan model in either county.² However, numerous approaches should be considered to improve access, quality, and consumer and provider experience in GMC counties, including the following:

- ▶ **Demand more from participating MCPs.** DHCS could use the forthcoming procurement to raise expectations and demand more from MCPs bidding on a contract. For example, DHCS could:
 - ▶ Strengthen oversight of network adequacy by calculating accurate physician-to-patient ratios for each MCP. Require MCPs to report, for each in-network physician, the percentage of their practice spent seeing that MCP's Medi-Cal enrollees.
 - ▶ Set measurable quality improvement targets and require MCPs to describe their approaches for making significant and sustainable improvements in quality consistent with these targets.
 - ▶ Require MCPs to make investments to expand access to care, strengthen the local delivery systems, and address enrollees' social determinants of health.
- ▶ **Adopt positive financial incentives tied to MCP performance.** Several other states have adopted such programs to foster performance improvements, whereas DHCS relies primarily on penalties for poor performance.³
- ▶ **Foster greater collaboration among county and state stakeholders.** DHCS could commit resources to working collaboratively with county officials, consumer advocates, and MCP and provider representatives in San Diego and Sacramento to establish and advance improvement priorities and goals. Moreover, DHCS or the legislature could give Healthy San Diego and the Sacramento Medi-Cal Managed Care Advisory Committee, both of which are legislatively mandated, a more direct role in establishing procurement priorities, reviewing MCP bids, and overseeing MCP performance.

By raising the bar on performance and other expectations, these actions might naturally reduce the number of MCPs interested in pursuing a contract with DHCS to serve Medi-Cal enrollees in Sacramento and San Diego Counties. If not, DHCS, working collaboratively with San Diego and Sacramento, should consider reducing the number of MCPs with which it contracts in these GMC counties. Although there was no consensus among interviewees on what the ideal number should be, the authors also did not find evidence that more MCP competition leads to improvements in any of the outcomes studied. By limiting the number of MCPs with which it contracts in a given county, DHCS could use its leverage to create greater competition for those contracts. MCPs that receive a contract might be more willing to make the investments DHCS and San Diego and Sacramento County officials want than they would if they had to divide up the market among four to six competitors. Moreover, enrollees' health care providers might benefit from greater efficiency and improved navigational ease associated with working with fewer MCPs. Were DHCS and the counties to take this approach, they should also develop plans to minimize potential disruptions to enrollees and providers during the transition period.

The upcoming DHCS procurement of commercial MCP contracts in GMC and other model counties is an infrequent and important opportunity to catalyze significant improvements in quality, satisfaction, and health outcomes for Medi-Cal enrollees. California's experience with the GMC model provides useful lessons that should be applied to the upcoming procurement process and ongoing performance expectations for Medi-Cal MCPs.

Introduction

California pioneered the use of managed care for Medicaid in the 1970s. Over the next four decades, the state progressively expanded managed care to include most Medi-Cal enrollees across all 58 counties. As of March 2019, 10.6 million low-income Californians were enrolled in Medi-Cal managed care. This represents 82% of all Medi-Cal enrollees.⁴

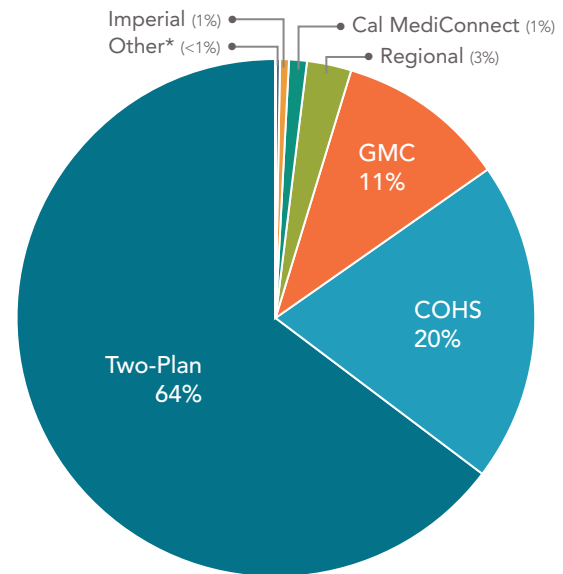
The Medi-Cal managed care program is organized using three distinct approaches: (1) counties with a single public managed care plan (MCP), called a County Organized Health System (COHS); (2) counties with competition between a public MCP and a commercial MCP (Two-Plan model); and (3) counties with competition among two or more commercial MCPs (Geographic Managed Care, Regional, and Imperial models). Managed care enrollment is mandatory for most Medi-Cal enrollees in 57 of 58 counties. In San Benito County, only one commercial MCP participates and enrollment is voluntary.

This study examines California’s experience with the Geographic Managed Care (GMC) model, which operates in two counties, Sacramento and San Diego, and accounts for 11% of Medi-Cal managed care enrollment (Figure 1). With its evolution over time and distinct complexity, California’s experience with the GMC model is not well understood. The availability of multiple MCPs, and the competition among them, can offer unique advantages but may also come with challenges and costs. This study assesses the GMC model’s overall performance relative to other managed care models in urban counties, comparing quality of care, access to care, and the overall patient experience.

The study was conducted to inform California’s reprocurement of commercial managed care contracts. Earlier this year, the Department of Health Care Services (DHCS) released a Request for Proposal (RFP) schedule to procure MCPs for each of the different models in their respective counties.⁵ For GMC

counties, DHCS is planning the release in 2020 with implementation scheduled for January 2023 (these dates are subject to change). This reprocurement provides an opportunity to review and evaluate the ways in which managed care is implemented in California and to foster significant performance improvements.

Figure 1. Managed Care Enrollment, by MCP Type, July 2019



*Includes enrollment in the following programs: CCS Demonstration (0.00%), Primary Care Case Management (0.01%), Special Project (0.04%), PACE (0.05%), San Benito Model (0.07%), and SCAN (0.13%).

Notes: CCS is California Children’s Services; CHHS is California Health and Human Services; PACE is Program of All-Inclusive Care for the Elderly; SCAN is Senior Care Action Network.

Source: Department of Health Care Services, “CHHS Open Data,” *Medi-Cal Managed Care Enrollment Report*, accessed August 9, 2019, data.chhs.ca.gov.

Geographic Managed Care

The GMC model was created in 1992 by Assembly Bill 336 and Senate Bill 485. Its regulatory authority exists in *Welfare and Institutions Code*, Section 14089, and *California Code of Regulations*, Title 22, Sections 53900-53928. The GMC model was created to “improve the Medi-Cal program by increasing access, improving quality of care, reducing episodic care, and achieving an overall cost savings for the program.”⁶

Currently, DHCS has contracts with five commercial MCPs in Sacramento County and seven in San Diego (Table 1). The most recent MCP entrants to GMC are United Healthcare and Aetna, which began enrolling Medi-Cal enrollees in both counties in 2017 following a competitive procurement process in which DHCS sought to expand the number of commercial MCPs serving enrollees in these counties. United subsequently exited the Medi-Cal market in Sacramento in November 2018.

Potential Benefits and Challenges of the GMC Model

There are several potential benefits of the GMC model in which multiple MCPs contract with DHCS to provide services to enrollees. They include the following:

- ▶ **More options for enrollees.** To the extent that MCPs differentiate and enrollees are aware of and understand these differences, the GMC model provides more options for enrollees to select an MCP based on their individual preferences, such as quality of care, provider network and availability, care models, community-based services, culturally appropriate care, and member services. Furthermore, an enrollee can leave an MCP and select another each month based on their preferences. In most other counties, enrollees have only one other MCP or no other MCP option.
- ▶ **Competition among MCPs.** Beyond meeting minimum contractual requirements to serve enrollees, MCPs may compete to increase their share of Medi-Cal enrollees, seeking to differentiate themselves by demonstrating better quality, larger networks for access to care, or better customer service than competitors. This competition might lead to better

Table 1. GMC Enrollment, by MCP and County, July 2019

	SACRAMENTO		SAN DIEGO		TOTAL GMC	
	NUMBER	% OF COUNTY	NUMBER	% OF COUNTY	NUMBER	% OF TOTAL
Aetna	7,347	1.7%	9,737	1.4%	17,084	1.5%
Anthem Blue Cross	176,889	41.4%			176,889	15.9%
Blue Shield Promise (Care1st)			80,600	11.7%	80,600	7.2%
Community Health Group			254,797	37.0%	254,797	22.8%
Health Net	105,593	24.7%	67,130	9.8%	172,723	15.5%
Kaiser Foundation	87,289	20.4%	49,289	7.2%	136,578	12.2%
Molina Healthcare	50,339	11.8%	215,578	31.3%	265,917	23.8%
United Healthcare			11,125	1.6%	11,125	1.0%
Total	427,457	100.0%	688,256	100.0%	1,115,713	100.0%

Source: Department of Health Care Services, “CHHS Open Data,” Medi-Cal Managed Care Enrollment Report, accessed August 9, 2019, data.chhs.ca.gov.

performance for individual MCPs or collectively relative to other models. Competition might also drive down costs.

- ▶ **Greater leverage for DHCS over MCP performance.** With enrollment spread across five to seven MCPs, DHCS may have greater leverage over poorly performing MCPs in that terminating an MCP contract would be disruptive to fewer enrollees than in a model with fewer MCPs.
- ▶ **More options for providers.** MCPs may compete for providers to have a broad network through better rates, more efficient administrative processes, and better technological and other support. In addition, MCPs can attract providers by offering access to Medicare and commercial lines of business. With more MCPs offering potential contracts, providers would also have more negotiating leverage on rates and other factors.

There are also potential challenges and costs to a model with multiple MCPs. These include the following:

- ▶ **MCP selection challenges and delay of care.** It may be difficult for enrollees to choose from among multiple MCP options. Research, discussed below, has shown that enrollees with multiple options are more likely to delay enrollment, resulting in higher health care costs due to delaying needed care.
- ▶ **Navigation and challenges with gaps in care when changing MCPs.** The availability of multiple MCPs, fragmented provider networks, and enrollees' ability to change monthly bring logistical challenges and transactional costs for everyone involved: Enrollees must undertake the MCP change requirements (ideally, after comparing MCPs based on their preferences and priorities) and, after switching MCPs, learn the unique aspects of the new MCP's policies and procedures; MCPs must exchange and process data for the disenrollment and enrollment; and health care providers must process a new patient intake and associated health assessments. The challenges and costs could include gaps in care, confusion from changing formularies, and duplication of services.

- ▶ **Administrative costs for providers.** Providers must meet myriad contractual and administrative requirements of each MCP and the costs associated with them. While standard DHCS contract requirements and the role of independent physician associations (IPAs) may mitigate the duplicative nature of many requirements, providers must establish, staff, and navigate care coordination protocols, information technology, formularies, pre-authorizations and referrals, and claims processes for each MCP. In addition, MCPs may also have varying quality priorities and payment incentive schemes.
- ▶ **Administrative costs to DHCS.** Likewise, there may be additional costs to DHCS related to the administration of contracts, financial compliance, quality reporting, and other requirements of multiple MCPs.
- ▶ **Provider leverage over MCPs and network fragmentation.** With multiple MCPs building their networks, providers may be able to avoid contracting with one or more MCPs if the terms are not to their liking, resulting in more provider leverage and potentially higher costs for MCPs (and ultimately the state). For patients, such provider leverage and selective contracting may result in fragmented networks and difficulties with access to care.

Health Plan Choice in the Literature

In private health care markets, increased competition and a higher number of competing MCPs are associated with decreased costs.⁷ However, the links between cost savings, quality of care, and patient satisfaction are not always clear. Rivers and Glover's (2008) review of studies examining competition could not conclude whether competition-related cost savings were due to improved efficiency or decreased quality of care.⁸ Enthoven and Baker (2018) found that providing patients more options is generally associated with higher patient satisfaction.⁹ Conversely, a study of national MCPs found that quality of care is not necessarily positively impacted by competition.¹⁰ Critics of private market competition among MCPs argue that a larger number of MCPs is more complicated, involves

more administrative costs, and increases consumer confusion.¹¹

Millet, Chattopadhyay, and Bindman (2010) found that enrollees with MCP options from which to choose (consisting of GMC and Two-Plan models) were more likely to take longer to select an MCP and more likely to have shorter MCP enrollment than in counties with only one MCP (County Organized Health System).¹² They concluded that enrollees delaying MCP selection, when faced with multiple MCPs, were more likely to have higher adjusted hospital admission rates for ambulatory care-sensitive conditions.

Additionally, Bindman (2018) raised concerns about competition among Medicaid MCPs in decreasing the network size of available providers, thus reducing enrollee access to care.¹³ A negative association between number of MCPs and quality of care was also found among managed care competition in New York's State Children's Health Insurance Program (SCHIP). Counties with a greater number of MCPs saw lower Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.¹⁴

Research Approach and Methods

Study Questions

Using a combination of quantitative and qualitative analysis, the authors assessed the effectiveness of the GMC model and compared the results to those in comparable counties with different managed care delivery models. The authors were able to use data analysis and interviews to assess a subset of the theoretical rationales listed above.

The authors set out to answer the following questions about the potential benefits of multiple MCPs:

- ▶ Do multiple MCPs, with potentially larger networks, improve access to care for enrollees?
- ▶ Does competition between MCPs lead to higher quality performance?
- ▶ Do enrollees take advantage of having more options by changing MCPs more frequently?
- ▶ Do multiple MCPs and the ability of enrollees to move between them lead to higher patient satisfaction?
- ▶ Are MCPs' provider networks differentiated, and do networks expand when additional MCPs enter the market?

The authors also set out to answer these questions about the potential challenges of the GMC model:

- ▶ Does the multiplicity of MCP options contribute to higher default rates due to challenges for enrollees making a choice among them?
- ▶ Are there navigational challenges for enrollees and providers with multiple MCPs, care models, and networks?
- ▶ What are the types of transaction costs incurred because of the model's complexity?

Methodology

The authors collected and analyzed available data on patient satisfaction and experience, access to care, measures of MCP quality performance, and provider networks. Specifically, the authors collected and analyzed data from the following:

- ▶ HEDIS
- ▶ CAHPS
- ▶ California Health Interview Survey (CHIS)
- ▶ Selected DHCS Medi-Cal Managed Care Performance Dashboard measures
- ▶ DHCS data on enrollee MCP selections and changes
- ▶ DHCS MCP provider directory files

The authors compared the data analysis results from GMC counties with those in a comparison group of counties. Counties were classified based on the percentage of the population that lived in urbanized areas according to the 2010 census. San Diego and Sacramento are both urban, so comparison counties were selected that were similarly urban. Table 2 lists the comparison counties and MCPs.

In order to assess the performance of the GMC model, the authors identified specific comparison metrics and outcome measures and compared the results from GMC counties with comparison urban group counties. In addition, the authors conducted a regression analysis using data from CHIS in which the authors assessed key access measures from the survey while controlling for factors such as patient demographic characteristics.¹⁵

The authors also conducted more than 30 structured interviews with stakeholders and experts from clinics, IPAs, hospital associations, counties, advisory groups (e.g., Healthy San Diego), MCPs, and consumer advocacy organizations. The interviews provide narrative insights and detail into the performance of the model

from stakeholders and leaders. These interviews were aimed at assessing the benefits and challenges of the GMC model and at surfacing recommendations for improvements that could be made. See Appendix A for the list of interviewees.

Table 2. GMC Comparison Group Counties

	MCP(S)
Alameda	Anthem Blue Cross Alameda Alliance for Health
Contra Costa	Anthem Blue Cross Contra Costa Health Plan
Los Angeles	Health Net LA Care
Orange	CalOptima
Riverside	Molina Health Care Inland Empire Health Plan
San Bernardino	Molina Health Care Inland Empire Health Plan
San Francisco	Anthem Blue Cross San Francisco Health Plan
San Mateo	Health Plan of San Mateo
Santa Barbara	CenCal Health
Santa Clara	Anthem Blue Cross Santa Clara Family Health Plan
Ventura	Gold Coast Health Plan

Source: Blue Sky Consulting Group analysis, 2019.

Findings: Access, Quality, and Consumer Experience

Access to Care in GMC Counties Is Not Better than in Comparison Counties

The authors analyzed survey results from 2017 CHIS to compare selected self-reported access-to-care measures between GMC and other urban model counties.¹⁶ First, the authors compared how respondents answered selected access-to-care questions. The authors report these comparisons using the survey question categories and language employed by CHIS. Second, to test initial findings, the authors developed several regression models, as explained below.

The initial comparison of respondents' self-reported access to care (Table 3) found differences for several measures, suggesting poorer access to care in GMC model counties:

- ▶ Did not have usual source of care
- ▶ Usual source of care at emergency room (ER) or some other place
- ▶ Had difficulty finding primary and specialty care
- ▶ Insurance not accepted by medical specialist in past year
- ▶ Had difficulty getting doctor's appointment in two days

To further test these findings, the authors developed several regression models. Using these same 2017 CHIS data, the authors specified a regression model to test the effect of the managed care model on specific dependent variables measuring access to care: no usual source of care, ER visits, delayed care, and any access. The authors controlled for numerous respondent demographics, self-reported health status and health conditions, and self-reported mental health status.

The regression analyses, presented in Appendix B, do not show any statistically significant differences of the managed care model on these selected CHIS access-to-care measures. That is, access to care in GMC counties appears to be no better than in counties with only one or two MCPs.

Table 3. CHIS Access-to-Care Measures, GMC and Comparison Counties, 2017

	GMC	URBAN
Did not have usual source of care	18%	17%
Usual source of care: ER, some other place, no usual place	21%	21%
Had difficulty finding primary care	11%	8%
Had difficulty finding specialty care	27%	17%
Insurance not accepted by medical specialist in past year	22%	16%
Sometimes/never able to get doctor's appointment within two days	38%	35%

Source: California Health Interview Survey (2017) and UCLA Center for Health Policy Research, AskCHIS [online health query system], accessed August 9, 2019, ask.chis.ucla.edu.

Quality of Care Is Generally Lower in GMC Counties

HEDIS is the most widely used measure set for evaluating and comparing quality among MCPs. According to the Centers for Medicare & Medicaid Services (CMS), HEDIS measures can be used by MCPs "to identify opportunities for improvement, monitor the success of quality improvement initiatives, track improvement, and provide a set of measurement standards that allow comparison with other plans."¹⁷ The state of California uses HEDIS to measure the effectiveness of Medi-Cal MCPs, and publishes the results annually in *Medi-Cal Managed Care External Quality Review Technical Report*.¹⁸

DHCS collects and reports more than two dozen HEDIS measures from Medi-Cal MCPs. Examples include measures relating to immunization status, cancer screening, heart disease and diabetes management, emergency department utilization, and hospital readmissions.

In order to facilitate analysis of available data for this study, Medi-Cal MCP HEDIS measures for 2015–2018 were summarized into four categories:

- ▶ **All-measures average.** This measure includes the simple average for all available measures.¹⁹
- ▶ **Child and adolescent access to primary care.** This summary measure includes the average of the following individual measures: Childhood Immunization Status—Combination 3, Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years, Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years, Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years, Immunizations for Adolescents—Combination 2, and Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.
- ▶ **Chronic disease management.** This summary measure includes the average of the following individual measures: Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Annual Monitoring for Patients on Persistent Medications—Diuretics, Asthma Medication Ratio—Total, Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg), Comprehensive Diabetes Care—Eye Exam (Retinal) Performed, Comprehensive Diabetes Care—HbA1c Control (<8.0%), Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, Comprehensive Diabetes Care—Medical Attention for Nephropathy, and Controlling High Blood Pressure.

▶ **All-cause readmissions.** This measure is reported in its original form.

To assess HEDIS quality measures in GMC and urban model counties, the authors compared all measures and aggregated the results here. Measures for Aetna and United Healthcare, the newest MCPs to participate in GMC counties, were not included in the 2017–2018 measurement year.²⁰ The authors also excluded Kaiser from the analysis in GMC counties.²¹ In a subsequent section below, the authors present quality scores in San Diego and Sacramento Counties with and without Kaiser in the analysis.

As shown in Table 4, quality of care among MCPs participating in GMC was worse, on average, compared with quality of care among MCPs in comparison urban counties on the all-measures average (69% GMC versus 72% urban), on access to primary care for children and adolescents (76% GMC versus 80% urban), and on chronic disease management measures (68% GMC versus 70% urban). There were no differences in rates of All-Cause Readmissions between model types.

Individual HEDIS measures show that GMC performance, as reflected in these aggregate scores, was generally lower than the comparison urban counties (Table 5, page 12). Of the 30 measures, GMC counties performed worse on 22 measures, the same on six, and better on two. The biggest difference was found in immunization rates for children and adolescents, where GMC plans had lower rates (by 8% and 7%, respectively) than comparison plans. The two measures where GMC plans outperformed comparison county plans were nutrition counseling for children and adolescents and outpatient visits per 1,000 member months.

Table 4. Aggregated HEDIS Measures for All Years, GMC and Comparison Counties, 2015–2018

	ALL-MEASURES AVERAGE	CHILD AND ADOLESCENT ACCESS TO PRIMARY CARE	CHRONIC DISEASE MANAGEMENT	ALL-CAUSE READMISSIONS
GMC	69%	76%	68%	16%
Urban	72%	80%	70%	16%

Source: Blue Sky Consulting Group analysis of Department of Health Care Services, *Medical Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2015–June 30, 2016; July 1, 2016–June 30, 2017; and July 1, 2017–June 30, 2018), www.dhcs.ca.gov.

Table 5. Average HEDIS Score, by Quality Measure, 2015–2018

	GMC	URBAN
Prenatal and Postpartum Care—Postpartum Care	58%	62%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	78%	82%
Childhood Immunization Status—Combination 3	66%	74%
Immunizations for Adolescents—Combination 2	28%	35%
Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months	91%	93%
Children and Adolescents’ Access to Primary Care Practitioners—25 Months–6 Years	82%	85%
Children and Adolescents’ Access to Primary Care Practitioners—7–11 Years	84%	87%
Children and Adolescents’ Access to Primary Care Practitioners—12–19 Years	81%	84%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Nutrition Counseling—Total	73%	72%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Physical Activity Counseling—Total	64%	64%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70%	74%
Breast Cancer Screening	56%	59%
Cervical Cancer Screening	52%	58%
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs	86%	87%
Annual Monitoring for Patients on Persistent Medications—Diuretics	86%	86%
Asthma Medication Ratio—Total	58%	58%
Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)	58%	61%
Comprehensive Diabetes Care—Eye Exam (Retinal) Performed	50%	56%
Comprehensive Diabetes Care—HbA1c Control (<8.0%)	49%	52%
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)	40%	38%
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing	83%	86%
Comprehensive Diabetes Care—Medical Attention for Nephropathy	87%	87%
Controlling High Blood Pressure	55%	58%
All-Cause Readmissions	16%	16%
Ambulatory Care—Emergency Department (ED) Visits per 1,000 Member Months	46.08	43.74
Ambulatory Care—Outpatient Visits per 1,000 Member Months	268.12	264.31
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	35%	36%
Screening for Clinical Depression and Follow-Up Plan—Performance Rate	30%	30%
Screening for Clinical Depression and Follow-Up Plan—Reporting Rate	4%	3%
Use of Imaging Studies for Low Back Pain	73%	79%

Source: Blue Sky Consulting Group analysis of Department of Health Care Services, *Medical Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2015–June 30, 2016; July 1, 2016–June 30, 2017; and July 1, 2017–June 30, 2018), www.dhcs.ca.gov.

When examining differences in all aggregated HEDIS measures between GMC and comparison group counties from 2015 through 2018, the GMC model consistently had lower performance, on average, in each year (Table 6). There are many factors that can affect MCP performance, and while the authors have attempted to compare GMC only to like counties, factors other than MCP performance or managed care model likely explain a significant portion (or all) of observed differences. Moreover, the authors did not test the statistical significance of these differences. Nevertheless, these findings are consistent with those from a contemporary study showing that quality scores are generally superior for MCPs in COHS and Two-Plan counties, on average, than for MCPs in competing commercial models, which include GMC, Regional, and Imperial models.²² The same study found that many of these differences are statistically significant.

Table 6. All HEDIS Measures Average, GMC and Comparison Counties, 2015–2018

	2015	2016	2017	2018
GMC	69%	69%	68%	70%
Urban	72%	72%	71%	72%

Source: Blue Sky Consulting Group analysis of Department of Health Care Services, *Medical Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2015–June 30, 2016; July 1, 2016–June 30, 2017; and July 1, 2017–June 30, 2018), www.dhcs.ca.gov.

Quality of Care Within San Diego and Sacramento

MCP performance on aggregated HEDIS scores across several years varied within each county (Table 7, page 14). Kaiser consistently has higher aggregate scores than the other MCPs. This should be interpreted with caution because, as explained earlier, Kaiser’s Medi-Cal member mix is different from that of other MCPs as they have several controls over enrollee entrance into their MCP. San Diego county MCPs appear to have performed somewhat better than Sacramento MCPs except on All-Cause Readmissions.²³

Individual MCP performance remained relatively consistent year-to-year in both counties without large swings in performance (Table 8, page 15). In San Diego, Community Health Group Partners and Molina Healthcare showed modest improvements between 2015 and 2018. Molina’s performance also improved some in Sacramento.

Table 7. Aggregated HEDIS Measures for All Years, San Diego and Sacramento MCPs, 2015–2018

	ALL-MEASURES AVERAGE	CHILD AND ADOLESCENT ACCESS TO PRIMARY CARE	CHRONIC DISEASE MANAGEMENT	ALL-CAUSE READMISSIONS
San Diego County				
Care1st	68%	70%	69%	18%
Community Health Group Partners	73%	79%	73%	16%
Health Net, San Diego	68%	77%	69%	22%
Kaiser SoCal	86%	86%	87%	15%
Molina Healthcare, San Diego	72%	79%	72%	16%
All plans	73%	78%	74%	17%
All plans, excluding Kaiser	70%	76%	71%	18%
Sacramento County				
Anthem Blue Cross, Sacramento	67%	74%	65%	16%
Health Net, Sacramento	67%	72%	66%	16%
Kaiser NorCal	82%	85%	82%	15%
Molina Healthcare, Sacramento	68%	72%	68%	16%
All plans	71%	76%	70%	16%
All plans, excluding Kaiser	67%	73%	66%	16%
GMC, Urban, and Statewide				
GMC	69%	75%	69%	17%
Urban	72%	79%	71%	17%
All plans statewide	71%	78%	70%	15%
All plans, excluding Kaiser	70%	77%	69%	15%

Source: Blue Sky Consulting Group analysis of Department of Health Care Services, *Medical Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports* (July 1, 2015–June 30, 2016; July 1, 2016–June 30, 2017; and July 1, 2017–June 30, 2018), www.dhcs.ca.gov.

Table 8. All HEDIS Measures Average, San Diego and Sacramento MCPs, 2015–2018

	2015	2016	2017	2018
San Diego County				
Care1st	69%	68%	67%	68%
Community Health Group Partners	72%	72%	73%	75%
Health Net, San Diego	68%	69%	67%	69%
Kaiser SoCal	89%	86%	84%	86%
Molina Healthcare, San Diego	71%	71%	71%	73%
All MCPs	74%	73%	72%	74%
All MCPs, excluding Kaiser	70%	70%	69%	71%
Sacramento County				
Anthem Blue Cross, Sacramento	67%	68%	67%	67%
Health Net, Sacramento	68%	67%	65%	67%
Kaiser NorCal	84%	83%	81%	82%
Molina Healthcare, Sacramento	67%	67%	67%	70%
All MCPs	71%	71%	70%	72%
All MCPs, excluding Kaiser	67%	67%	66%	68%
GMC, Urban, and Statewide				
GMC	69%	69%	68%	70%
Urban	72%	72%	71%	72%
All MCPs statewide	71%	71%	70%	71%
All MCPs, excluding Kaiser	70%	70%	69%	71%

Source: Blue Sky Consulting Group analysis of Department of Health Care Services, Medical Managed Care Quality Improvement Reports: External Quality Review Technical Reports with Plan-Specific Evaluation Reports (July 1, 2015–June 30, 2016; July 1, 2016–June 30, 2017; and July 1, 2017–June 30, 2018), www.dhcs.ca.gov.

Providers Often Participate in Multiple MCP Networks, Particularly Primary Care Providers

One of the most important potential benefits of the GMC model relates to the size of available provider networks. To the extent that individual MCPs have unique provider networks, adding additional MCPs would increase the available provider networks. Using provider network files from DHCS for January 2017 through November 2018, the authors assessed GMC MCPs’ networks and the extent of differentiation therein by examining the percentage of providers that participate in multiple MCP networks. The authors also assessed the number of providers participating in only one MCP. Finally, the authors examined whether available provider networks expanded when new MCPs joined GMC in 2017.

Although the provider network files represent the best available data on the size of each MCP’s network, there are important caveats and limitations with these files. First, the provider files list all providers in the MCP network, but they do not indicate whether these providers actually provide services to or are accepting new Medi-Cal patients. Second, these data are not systematically audited or verified by DHCS and are known to contain inaccuracies. Nevertheless, they were the best data available for this analysis.

In order to prepare the files, data was limited to all providers with a Sacramento or San Diego address (some MCPs listed providers from outside of the region). The authors examined only license types for physicians, physician assistants, and nurse practitioners and excluded behavioral health and other nonmedical provider types. The files also designate physicians as primary care and/or specialists. Providers were matched across MCPs using the National Provider Identifier (NPI).²⁴ For each MCP, the authors calculated how many providers were unique to that MCP and how many providers were in that MCP and multiple other MCPs for the November 2018 period. For this analysis, the authors excluded Kaiser as their providers do not contract with other MCPs.

While nearly 60% of providers listed in Sacramento MCPs' networks were exclusive to one MCP, there are notable differences between primary care providers and specialists (Table 9). Primary care providers were much more likely to be listed on multiple MCP networks; over half of primary care providers were included in three MCPs' network files. Furthermore, one-quarter of primary care providers were included on all four MCPs' provider files. Specialists, on the other hand, were less likely to be included in multiple MCPs' networks, with more than 60% being exclusive to one MCP's listing. However, over one-third of specialists were included in two MCPs' networks.

Table 9. Sacramento GMC MCPs' Provider Network Listings (excluding Kaiser), November 2018

	UNIQUE PROVIDERS	NUMBER/PERCENTAGE OF MCPs			
		1	2+	3+	4
All providers	3,233	1,945 60.2%	1,288 39.8%	692 21.4%	300 9.3%
Primary care	458	134 29.3%	324 70.7%	242 52.8%	110 24.0%
Specialists	2,550	1,629 63.9%	921 36.1%	452 17.7%	246 9.6%

Source: Blue Sky Consulting Group analysis of DHCS Provider Network Files provided April 11, 2019.

In San Diego, there is much less provider exclusivity on networks, with only 30% of all providers listed on only one network (Table 10). Half of all primary care providers were listed on four MCPs' networks, and more than one-fourth on five MCPs' lists. Specialists showed a similar likelihood to be listed on multiple MCPs' network filings with DHCS. Interestingly, one in six specialists was included on all six MCPs' provider listings, while more than one in four specialists was exclusive to a single MCP.

As shown in Tables 9 and 10, many providers participate in at least two MCP networks, although a significant fraction of providers (60% in Sacramento and 30% in San Diego) are exclusive to a single MCP. These data suggest, therefore, that while there is overlap of providers across networks, there nevertheless can be some differentiation between MCPs. Again, it is important to reiterate the important caveat that while these files list the providers in an MCP's network, they do not indicate the extent of a provider's practice time devoted to Medi-Cal patients and the MCP's adequacy to address access-to-care needs, either primary care or specialty.

Table 10. San Diego GMC MCPs' Provider Network Listings (excluding Kaiser), November 2018

	UNIQUE PROVIDERS	NUMBER/PERCENTAGE OF MCPs					
		1	2+	3+	4+	5+	6
All providers	6,399	1,920 30.0%	4,479 70.0%	3,401 53.1%	2,576 40.3%	1,738 27.2%	759 11.9%
Primary care	1,325	273 20.6%	1,052 79.4%	884 66.7%	673 50.8%	397 30.0%	73 5.5%
Specialists	4,492	1,215 27.0%	3,277 73.0%	2,554 56.9%	2,034 45.3%	1,469 32.7%	722 16.1%

Source: Blue Sky Consulting Group analysis of DHCS Provider Network Files provided April 11, 2019.

Provider Networks by MCP

In Sacramento, network file submissions to DHCS suggest that primary care and specialist providers have contracts across multiple MCPs (Table 11). There is a notable exception, however: Anthem Blue Cross appears to offer a much larger network of specialists who contract exclusively with their MCP. In Sacramento, network differentiation occurs largely with this one MCP, Anthem.

In San Diego, individual MCPs' submitted lists also revealed significant overlap of providers across MCP networks. Unlike Sacramento, there isn't an MCP wherein a preponderance of providers are listed exclusively with that MCP's network. This supports interviewees' observations in San Diego that MCPs' networks were not very differentiated.

Table 11. GMC MCP Provider Network Listings (excluding Kaiser), by MCP and County, November 2018

	ALL PROVIDERS			PRIMARY CARE			SPECIALISTS		
	Total	Exclusive	%	Total	Exclusive	%	Total	Exclusive	%
Sacramento									
Aetna Better Health	950	88	9%	271	15	6%	623	54	9%
Anthem Blue Cross	2,799	1,608	57%	384	71	18%	2,296	1,430	62%
Health Net	1,178	174	15%	306	29	9%	765	88	12%
Molina Healthcare	586	75	13%	173	19	11%	485	57	12%
San Diego									
Aetna Better Health	3,312	349	11%	610	13	2%	2,624	297	11%
Care1st	2,454	175	7%	490	1	0%	2,015	159	8%
Community Health Group	4,226	542	13%	994	53	5%	2,800	199	7%
Health Net	2,891	191	7%	577	2	0%	2,116	113	5%
Molina Healthcare	3,008	274	9%	866	114	13%	2,375	161	7%
United Healthcare	3,461	389	11%	867	90	10%	2,618	286	11%

Source: Blue Sky Consulting Group analysis of DHCS Provider Network Files provided April 11, 2019.

New MCPs Can Bring Network Expansion

The departure of United Healthcare from Sacramento GMC allowed for an investigation of how many providers did not migrate to other MCPs when United left the market (i.e., the extent to which United's presence in the market expanded the available provider network). The addition of United and Aetna in San Diego provided an opportunity to investigate how many providers were drawn from other MCPs as opposed to how many were added as a result of these MCPs entering the market.

As shown in Table 12, only about one in five providers who had been exclusive to United's network migrated to other GMC MCPs after United left the market in November 2018 (i.e., nearly 80% of United's providers did not remain available to Medi-Cal patients). Relatively more primary care providers had migrated

compared with specialists. The data indicate that these migrating providers largely ended up contracting with one new GMC MCP.

An analysis of the providers who were exclusive to one of the two new GMC model entrants (United and Aetna) in San Diego indicates that the overwhelming majority of these providers were new to GMC and were not drawn from other MCPs. In the case of United (Table 13), of its 363 exclusive providers, only 45 (or about 12%) had contracts with other Medi-Cal MCPs prior to United's entrance into the market. In the case of Aetna (Table 14, page 20), only about 18% (or 59) of its exclusive providers were previously part of another MCP's network. These findings suggest that new MCP entrants can bring networks that increase the number of new providers available to Medi-Cal enrollees.

Table 12. Migration of United-Exclusive Providers to Other GMC MCPs, Sacramento, 2017–18

	NUMBER OF PROVIDERS EXCLUSIVE TO UNITED, NOVEMBER 2017	NUMBER/PERCENTAGE OF OTHER SACRAMENTO GMC MCPs IN WHICH PROVIDER WAS LISTED, NOVEMBER 2018					TOTAL MIGRATION
		1	2	3	4	5	
All providers	412	70 17.0%	11 2.7%	9 2.2%	4 1.0%	0 0.0%	94 22.8%
Primary care	83	27 32.5%	2 2.4%	5 6.0%	1 1.2%	0 0.0%	35 42.2%
Specialists	297	41 13.8%	9 3.0%	3 1.0%	3 1.0%	0 0.0%	56 18.9%

Table 13. San Diego GMC Providers Exclusive to United Healthcare in November 2018

	NUMBER OF PROVIDERS EXCLUSIVE TO UNITED, NOVEMBER 2018	NUMBER/PERCENTAGE OF OTHER SAN DIEGO GMC MCPs IN WHICH PROVIDER WAS LISTED AS OF JANUARY 2017					TOTAL MIGRATION
		1	2	3	4	5	
All providers	363	29 8.0%	11 3.0%	4 1.1%	1 0.3%	0 0.0%	45 12.4%
Primary care	88	8 9.1%	6 6.8%	3 3.4%	0 0.0%	0 0.0%	17 19.3%
Specialists	261	20 7.7%	5 1.9%	1 0.4%	1 0.4%	0 0.0%	27 10.3%

Source (Tables 12 and 13): Blue Sky Consulting Group analysis of DHCS Provider Network Files provided April 11, 2019.

Table 14. San Diego GMC Providers Exclusive to Aetna in November 2018

	NUMBER OF PROVIDERS EXCLUSIVE TO AETNA, NOVEMBER 2018	NUMBER/PERCENTAGE OF OTHER SAN DIEGO GMC MCPs IN WHICH PROVIDER WAS LISTED AS OF JANUARY 2017					TOTAL MIGRATION
		1	2	3	4	5	
All providers	322	37 11.5%	10 3.1%	9 2.8%	3 0.9%	0 0.0%	59 18.3%
Primary care	8	1 12.5%	0 0.0%	2 25.0%	0 0.0%	0 0.0%	3 37.5%
Specialists	271	28 10.3%	7 2.6%	7 2.6%	3 1.1%	0 0.0%	45 16.6%

Source: Blue Sky Consulting Group analysis of DHCS Provider Network Files provided April 11, 2019.

MCP Selection by Enrollees Is Similar to Two-Plan Counties

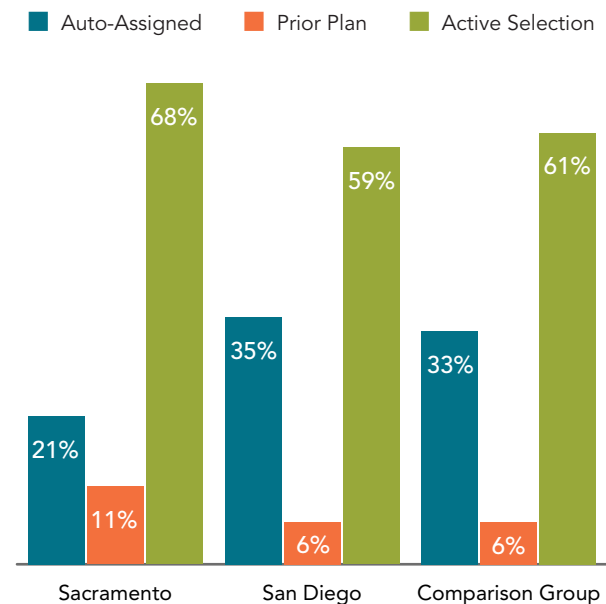
New or returning Medi-Cal enrollees in counties with multiple MCP options have three enrollment pathways into an MCP²⁵:

- ▶ **Active selection.** All enrollees may select an MCP by submitting an enrollment form (DHCS refers to this as “regular” enrollment).
- ▶ **Passive/prior MCP.** Enrollees who do not select an MCP may be assigned to one based on prior enrollment or because other family members are enrolled in that MCP.
- ▶ **Auto-assigned.** Those not enrolled in an MCP using the other two pathways are assigned to one using an algorithm that employs eight HEDIS and safety-net measures to enroll a higher percentage of this group into MCPs with higher performance scores.²⁶

The authors analyzed MCP selection data (Figure 2) to compare enrollee pathways in GMC and Two-Plan counties.²⁷ San Diego enrollment over two years was quite similar to Two-Plan counties, with roughly 59% of enrollees making an active selection among their options, just under 6% enrolling into a prior MCP, and roughly 35% defaulted by the auto-assignment algorithm. In Sacramento, just under 68% made active MCP selections, which was higher than the rate in

comparison Two-Plan counties. In addition, more than 11% were enrolled in a prior MCP. The Sacramento default rate was therefore correspondingly lower, at 21%, compared with 33% in comparison counties.

Figure 2. Enrollment in GMC and Comparison Counties, September 2016–September 2018



Source: Blue Sky Consulting Group analysis of DHCS auto-assignment data provided June 6, 2019.

These data suggest that the selection pathways for enrollees in GMC counties are not much different from those in comparison Two-Plan counties, although the rate of active selection is higher in Sacramento. The authors did not have data on the enrollees' MCP selection experience, such as time taken or difficulty making an MCP selection, so the authors can't comment on enrollees' ease or challenges selecting among five or seven MCPs.

Enrollees in GMC Counties Change MCPs More Frequently

As noted earlier, one rationale for multiple MCPs is to offer choice to enrollees who can exercise this right monthly. While offering enrollees the opportunity to use specific providers or seek better services, these MCP changes do have transactional costs.

The authors examined DHCS MCP change data from September 2016 through September 2018, specifically examining MCP changes within the respective GMC county. The authors compared these with MCP change rates in all other counties where enrollees can change MCPs with the county.²⁸ Perhaps not surprisingly, enrollees in GMC counties are more likely to change MCPs than those in counties with only two choices (Table 15). Across all counties with choice, about 5% of enrollees changed MCPs annually. In GMC counties, nearly 8% changed MCPs over the course of a year.

Specifically, nearly 2,800 enrollees (or 7.6% per year) changed MCPs each month, on average, in Sacramento over the 24-month period. In San Diego over this same period, nearly 4,800 enrollees (or 7.9% per year) changed MCPs each month. In total for the two GMC counties, over 7,500 enrollees (or 7.8% per year), on average, moved between MCPs each month.

While transactional costs are challenging to quantify, each MCP change entails such costs. For enrollees, the cost of changing MCPs can include the disruption of care and time invested in learning a new MCP's network, services, pharmacy formularies, and other features. For MCPs, these transactional costs can include enrollment and patient care data exchange between MCPs, new patient intake assessments, and data exchange with primary care and other providers. Providers also incur similar transactional costs when enrollees change MCPs, most notably, the possible interruption or complete loss of a clinical relationship.

These costs are known to DHCS, providers, and consumer advocates. Policy discussions surface with some regularity about moving away from the monthly right to change MCPs to an annual open enrollment, which then locks members into an MCP for a year. MCPs and providers generally prefer the annual open enrollment and lock-in. Advocates, however, have long worked to maintain the monthly change right for enrollees, allowing them to seek specific providers or express other preferences.

Table 15. Enrollee MCP Changes Within County, September 2016–September 2018

	AVERAGE NUMBER OF MCP CHANGES PER MONTH	CHANGES AS A PERCENTAGE OF ENROLLMENT			
		Minimum	Maximum	Monthly Average	Annualized
All counties (with GMC)	34,699	0.34%	0.56%	0.41%	4.88%
All counties (without GMC)	27,113	0.30%	0.53%	0.37%	4.42%
Sacramento	2,794	0.54%	0.86%	0.63%	7.58%
San Diego	4,792	0.50%	0.83%	0.66%	7.91%
All GMC counties	7,586	0.52%	0.82%	0.65%	7.79%

Source: Blue Sky Consulting Group analysis of DHCS ad hoc plan changes data provided March 18, 2019.

GMC Enrollees' Satisfaction with Their Care Is Mixed Compared with Enrollees in Other Counties

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a patient satisfaction survey conducted every three years. The most recent survey was fielded in 2016 and published in January 2018.²⁹ The CAHPS survey is administered to patients in all Medi-Cal MCPs and covers patient satisfaction with both their MCP and providers. Results are summarized by MCP, allowing for a comparison across MCPs or for aggregation of data across managed care models.³⁰ In order to calculate the results in Table 16, the authors took the average score across all MCPs in the respective model counties and then calculated the percentile rank represented by that score when compared with all MCPs statewide.³¹

Table 16. Percentile Rank of Aggregated CAHPS Measures, 2016

	GMC	URBAN
Rating of all health care	37%	44%
Rating of personal doctor	53%	46%
Rating of specialist seen most often	46%	48%
Getting needed care	59%	46%
Getting care quickly	64%	46%
How well doctors communicate	48%	51%
Customer service	66%	49%

Source: Blue Sky Consulting Group analysis of DHCS data from Department of Health Care Services, Managed Care Quality and Monitoring Division, *2016 CAHPS Medicaid Managed Care Survey Summary Report*, January 2018, www.dhcs.ca.gov.

These results reveal a mixed picture of patient satisfaction. According to these percentiles, GMC MCPs earned some scores below urban comparison MCPs when compared with all MCPs statewide. For example, having a 37th percentile score means that 63% of scores for other statewide MCPs were higher. These lower GMC percentile scores, compared with urban percentiles, were for ratings of all health care, specialist seen most often, and how well doctors communicate.

For other measures, however, GMC percentile scores were higher when compared with urban percentile scores. GMC MCPs earned higher patient satisfaction scores for ratings of personal doctor, getting needed care, getting care quickly, and customer service.

Other Measures Also Paint a Mixed Picture of GMC Performance

In addition to HEDIS, CAHPS, and CHIS data, the authors also examined several measures from the DHCS Managed Care Performance Dashboard. These measures included mild-to-moderate mental health visits, medical exemption requests, and grievances filed. The GMC model delivered more mild-to-moderate mental health visits per 1,000 members (Table 17) than comparison model counties.

Table 17. Selected Managed Care Performance Dashboard Measures, 2017–18

MEASURE	GMC	URBAN
All MCPs		
Mild-to-moderate mental health visits per 1,000 members	17.6	13.4
Medical exemption requests per 10,000 members	4.7	0.7
Grievances per 1,000 member months	116.9	65.6
Excluding Aetna and United		
Mild-to-moderate mental health visits per 1,000 members	17.5	13.4
Medical exemption requests per 10,000 members	1.0	0.7
Grievances per 1,000 member months	89.3	65.6

Source: Blue Sky Consulting Group analysis of DHCS Managed Care Performance Dashboard data provided March 12, 2019.

GMC model counties had significantly more medical exemption requests per 10,000 members and grievances per 1,000 member months than in comparison counties. This suggests that enrollees experienced more challenges with MCP services, accessing specific providers, and other issues for which they sought formal redress than enrollees in other urban counties with different models. Without Aetna and United in these data, the rates are lower for both measures but still higher than in comparison counties, suggesting that adding MCPs may have contributed to some enrollees' struggles to understand and navigate MCP networks and services.

Summary of Quantitative Findings

The performance of MCPs participating in GMC counties was, on average, generally similar to or worse than the performance of MCPs participating in similarly urban COHS or Two-Plan model counties. Specifically:

- ▶ **Access to care.** Medi-Cal enrollees in GMC counties were more likely to report difficulty accessing specialty care than enrollees in other urban counties; however, following a regression analysis, the managed care model type does not appear to be a significant factor in explaining differences in access to care across counties.
- ▶ **Quality of care.** MCPs in the two GMC counties performed worse across the majority of HEDIS measures than other MCPs; this lower performance was consistent across years from 2015 through 2018. Quality performance was somewhat better, on average, among MCPs in San Diego when compared with Sacramento MCPs.
- ▶ **Choice of providers.** It is impossible to draw much meaning from data on the adequacy of MCP networks without data on what share of physician time is spent caring for that MCP's Medi-Cal members. Nevertheless, the data show that providers contract with multiple MCPs, resulting in some provider overlap across networks. This is more common among primary care providers. Providers, particularly specialists, may be found on only one MCP's network files, resulting in some differentiation

across networks. In San Diego, MCP networks were less differentiated than in Sacramento. The high percentage of providers who were exclusive to one of the two new GMC model entrants (United and Aetna) in San Diego indicates that the overwhelming majority of these providers were new to GMC and not drawn from other MCPs. How much care these new providers provide to Medi-Cal enrollees could not be determined from the data.

- ▶ **MCP selection.** New or returning enrollees to Medi-Cal in GMC counties have the same or higher active MCP selection rates than comparison counties with two plans from which to choose. In Sacramento, notably, active MCP selection is modestly higher than in comparison counties.
- ▶ **MCP switching.** Enrollees change MCPs within the GMC counties at a higher rate than in non-GMC comparison counties. While important for choice, the multiplicity of MCPs does bring difficult-to-measure transactional costs to MCPs, providers, and enrollees themselves.
- ▶ **Member satisfaction.** These data from 2016 show a mixed picture in which GMC MCPs score higher on some measures but lower on others. While these satisfaction data do not paint a compelling picture one way or the other of enrollees' reported satisfaction, GMC model counties had significantly higher rates of medical exemption requests and grievances than in comparison counties, suggesting that enrollees experienced more challenges for which they sought formal redress.

Findings: Stakeholder Interviews

Interviewees Were Generally Supportive of the GMC Model

There was general agreement among interviewees that MCP choice, in principle, can benefit both providers and enrollees by fostering competition among MCPs. Many consumer advocates, in particular, prefer to give Medi-Cal enrollees multiple MCP options, so that they can switch MCPs to access a specific hospital or specialist or to receive better benefits (e.g., care coordination, transportation). Moreover, attempts by MCPs to differentiate themselves to enrollees through their provider networks, care models, member services, language accessibility, and community-based services are viewed positively. Interviewees also noted that MCPs can bring unique expertise and economies of scale and scope to services, particularly if the MCPs have numerous lines of business (e.g., commercial, Medicare) across the state or nation.

To build a network, MCPs may try to distinguish themselves competitively with providers through an overall “value proposition.” This can include higher payment rates, access to other lines of business (e.g., commercial or Medicare Advantage), organizational efficiencies, and better quality-improvement resources and technical assistance. This competition may give providers increased leverage over MCPs, especially when compared with COHS counties, where some interviewees noted that providers have little leverage with the MCP. Providers agreed that MCPs can be more responsive to them when they have to compete for contracts.

DHCS officials also share the view that the GMC model with multiple, competing MCPs has the potential to achieve better outcomes. In addition, with numerous MCPs, the state has more leverage over poorly performing MCPs as the industry responds to purchasing power and the threat of lost business. Interviewees suggested that the relatively poor performance of existing MCPs in Sacramento motivated the decision of DHCS to procure additional MCPs in 2015.

Views Were Mixed on the Benefits of Adding Two MCPs to GMC Counties in 2017

After a competitive procurement process, in 2015 Aetna and United Healthcare, both large commercial MCPs and new to Medi-Cal, were added to San Diego and Sacramento GMC in early 2017. Interviewees observed that the MCPs brought the benefits of national experience and scale, showed innovative approaches to service, and made investments to enter the GMC market. Their entrance also appears to have brought new providers into Medi-Cal, although the numbers added were modest, and it is not clear how meaningful their participation is.

Some provider interviewees noted, however, that these additional MCPs haven’t added much and that the overall quality of care and access to services hasn’t yet improved. A Sacramento interviewee observed that although there are four major health systems in the county, their specialists don’t meaningfully participate in GMC MCPs’ networks. To build sufficient enrollment and financial viability, these MCPs relied on default enrollments but also used marketing to differentiate their MCPs to new enrollees and to draw enrollment from existing MCPs. Due to low enrollments, interviewees observed, the MCPs don’t yet have the lives, scale, and risk mix to innovate. Indeed, a poor risk mix and loss of the UC Davis hospital contract contributed to United’s departure from Sacramento in November 2018.

Interviewees Perceive “Diminishing Returns” from Adding More MCPs

While interviewees agreed, in principle, that providing more MCP options for enrollees can foster greater competition, many also noted that there is a point of diminishing returns with additional MCPs, and that this threshold is difficult to discern. Adding more MCPs to GMC counties increased administrative and navigational complexity and, according to several interviewees, “diluted and diffused” the benefits of differentiation and competition. This administrative

multiplicity also brings increased transactional costs, which are discussed below.

In San Diego, interviewees struggled to describe how adding additional MCPs improved enrollees' and providers' experiences. Several interviewees observed that having two additional MCPs hadn't made much difference in the delivery or quality of services. In Sacramento, interviewees also agreed that the GMC model was conceptually beneficial but operationally problematic.

The GMC Model Introduces Navigational Complexities for Enrollees

Numerous interviewees observed that the multiplicity of MCPs results in a fragmented system of networks, providers, and services. They added that this complex "patchwork" of choices contributes to enrollees' confusion and difficulties selecting MCPs in the first place, and then navigating an MCP's providers and services thereafter. Interviewees noted that GMC is a challenging system for any consumers to navigate, let alone for refugees, the homeless, those with limited English proficiency, and those with serious mental illness or substance use disorders. A Sacramento interviewee opined that the GMC model is "a ragtag system that we've patched together and made work for patients."

These navigational complexities and resulting confusion can lead to enrollees changing MCPs frequently. One interviewee shared that one MCP's network and medical groups were particularly confusing and hard to understand, leading enrollees to erroneously assume that providers were in other MCPs' networks and then to change MCPs. In another example, when a provider leaves one MCP's network and joins another, it may take months before that provider appears available on the new network, leaving enrollees seeking that provider in limbo. The frequency of MCP changes by enrollees, and a discussion of potential costs, was presented in a previous section.

The GMC Model Also Creates Administrative Challenges and Transaction Costs for Providers

For providers, contracting with multiple MCPs can bring significant redundancy and transaction costs due to MCPs' idiosyncratic and duplicative contracting and administrative requirements. There are multiple business and administrative requirements that often differ by MCP for service pre-authorizations, billing and claims adjudication, information technology, and quality monitoring and improvement approaches.

Both providers and enrollees also have to understand and navigate multiple networks, benefit plans, and care processes, which may differ by population (e.g., dual eligibles). This navigational maze includes differences in specialist networks, pharmacies and urgent care options, prescription drug formularies, care coordination and management approaches, and member services and portals. One interviewee noted that care coordinators in their clinic created "road map" algorithms for navigating each MCP's service approval requirements.

Multiple MCPs Result in Diffuse Initiatives Meant to Incentivize Providers and Benefit Patients

This organizational patchwork also has the effect of diffusing the impact of specific initiatives by MCPs, particularly quality improvement and pay-for-performance incentives. For these to work, interviewees observed, MCPs and providers must make significant investments over time with a stable population. The ability of enrollees to change MCPs monthly makes for an often-evolving patient panel.

The promise and impact of pay-for-performance and other quality improvement programs can be diluted with a multiplicity of priority HEDIS and other measures, different incentive payments, and varying expert and information technology support for clinicians. An interviewee noted that MCPs' selection of performance priorities feels arbitrary and not at all coordinated with other MCPs. In the end, the interviewee noted, these

initiatives all become “a jumble to understand and effectuate,” and providers lose interest and commitment. Population health interventions also become diluted and poorly coordinated; another interviewee opined that “one plan’s QI or population health initiative won’t get my attention.”

Collaboration Differs in San Diego and Sacramento Counties

Both counties have statutorily created GMC advisory groups convened and led by the county health department, though their evolution and oversight roles differ considerably. Healthy San Diego (HSD) was created in 1995 to inform the county’s implementation of, and contracting for, the GMC model.³² Interviewees labeled HSD as having a “quasi-governance” role built on a history of MCP communication and collaboration to standardize and streamline contracting and other processes.

Healthy San Diego is composed of the Joint Consumer and Professional Advisory Committee, two subcommittees, and two advisory groups. Interviewees observed that MCPs “collaborate and compete,” contributing to a Medi-Cal managed care market that generally serves enrollees well. Several interviewees did observe that tensions can arise when county and MCP priorities or implementation approaches differ. The county deputy chief medical officer and an administrative secretary staff HSD. MCPs make an annual \$1,500 contribution to HSD, and funds are used to host trainings and other such events.

When three new MCPs bid to win contracts in 2015 in San Diego, HSD members interviewed them and made a recommendation to the county to approve specific MCPs and then communicate this to DHCS for their consideration. This process, whereby the county approves those MCPs with which DHCS can contract, is unique to San Diego and included in their original statute.³³

The Sacramento Medi-Cal Managed Care Advisory Committee, created in 2010 by SB208 (Steinberg), is charged with improving services and health outcomes

for enrollees.³⁴ In addition to the committee itself, there is an additional work group focused on care coordination. Compared with San Diego, interviewees painted a different picture of the role played by this advisory body. Interviewees observed that the committee largely served as a communication venue for MCPs, providers, and other stakeholders and that some collaboration occurred here. One interviewee noted that the committee often served as a venue for providers and advocates to express their frustration to MCPs. Working relationships between MCPs and providers sometimes developed outside of the committee. The committee has one dedicated staff person and some additional staff support from the Sacramento County Department of Health Services.

Interviewees in both counties remarked that neither committee had “real oversight or enforcement authority” around MCP performance. This oversight and compliance authority ultimately fell to DHCS, and the counties’ roles were largely to convene stakeholders and advise MCPs. While San Diego stakeholders lauded HSD collaboration, they also admitted that MCPs were frequently reluctant to share specific details about operations or innovations.

Clinic Consortia and IPAs Offer Some Efficiencies

Numerous interviewees described how independent physician associations (IPAs) and clinic consortia provide some efficiencies in the GMC model through economies of scale and scope and the standardization of administrative procedures for providers, and may reduce some of the transaction costs. Their role, however, differs in the two GMC counties.

In San Diego, Health Center Partners of Southern California is a nonprofit clinic consortium that represents and supports 10 community-based health center organizations as a clinically integrated network through its subsidiary Integrated Health Partners.³⁵ IHP brings negotiating leverage for clinics and manages risk, contracting, billing, and other fundamental issues, thereby insulating Federally Qualified Health Centers (FQHCs) from the administrative complexity

of dealing with multiple MCPs. The negotiating leverage of IHP with MCPs is considerable as it serves as the largest clinic network in the area with both primary care and specialists. IHP has also prepared these clinics to take on value-based payments and to participate in alternative payment methodologies.

Sacramento, however, does not have a clinic consortium organized around, and in support of, FQHCs and other clinics. Interviewees noted that Sacramento's FQHC community is less well developed and less collaborative than San Diego's. FQHCs only proliferated in the Sacramento market over the last decade. Instead, non-Kaiser MCPs in Sacramento delegate 97% of lives to four commercial IPAs: River City, Hill Physicians, Imperial Health Holdings, and Nivano Physicians.³⁶ River City IPA plays, according to some interviewees, an outsized role in Sacramento, where it serves 72% of all delegated lives. Interviewees noted that IPAs in Sacramento, particularly River City, played a role in standardizing some administrative and contracting processes rather than having to manage these with all of the MCPs individually. Several interviewees noted that the large delegated role to IPAs has made accountability for access to care, quality, and patient satisfaction a challenge and has contributed to enrollee confusion.

Discussion

This assessment reveals a mixed picture of the performance of the GMC model and its ability to realize the potential benefits of greater competition and more options for enrollees. The data analysis and interviews conducted for this study show that, despite the theoretical advantages of competition among multiple MCPs, Medi-Cal enrollees do not receive better access or quality of care from the GMC model than if they were served by a model with only one or two MCPs. To the contrary, across most measures, quality of care appears to be worse, on average, for MCPs operating in GMC counties than for MCPs operating in urban COHS and Two-Plan counties. Furthermore, there was little to no improvement in quality scores for most MCPs in GMC counties from 2015 through 2018. These findings are consistent with several other studies, noted earlier, about multiple competing Medicaid managed care plans.

The large numbers of Medi-Cal MCPs participating in Sacramento and San Diego Counties have also created a confusing patchwork of networks, providers, and services for enrollees who can, as a result, struggle to find and use services, particularly specialists. For providers, this multiplicity of MCPs presents many redundancies in contracting administrative requirements and clinical approaches to care and quality improvement, which bring significant transaction costs.

This assessment of the GMC model isn't singular; there are differences in how the model operates in San Diego and Sacramento. Stakeholders in San Diego express more support for the model than those in Sacramento, and provider adaption to GMC in Sacramento is less mature than in San Diego. In both counties, however, stakeholders agreed that improvements to the model were warranted. In Sacramento particularly, the county health director, stakeholders, and State Senator Richard Pan have held convenings to address concerns about GMC and potential solutions. These concerns, laid out in a recent issues and options paper, include poor access to primary and specialty care, fragmentation and navigational challenges, uneven quality, and the lack of local control.³⁷

Considerations for Improvement

This assessment of California's experience with managed care in GMC counties calls into question the rationale that multiple MCPs competing for Medi-Cal enrollees drives quality and patient satisfaction higher among competitors.³⁸ Short of changing the model type to a Two-Plan or COHS model, numerous approaches should be considered to improve the GMC model's performance.³⁹

DHCS should clarify its purchasing goals and objectives and strengthen quality monitoring of MCP performance in GMC counties. Other recent papers have proposed approaches DHCS could embrace to strengthen its purchasing power and move toward value-based purchasing.⁴⁰ These approaches, among others, should be considered to improve access, quality, and consumer and provider experience in GMC counties. Specifically, DHCS should undertake the following:

- ▶ **Demand more from participating MCPs.** DHCS could use the forthcoming procurement to raise expectations and demand more from MCPs bidding on a contract. For example, DHCS could:
 - ▶ Strengthen oversight of network adequacy by calculating accurate physician-to-patient ratios for each MCP. Require MCPs to report, for each in-network physician, the percentage of their practice spent seeing that MCP's Medi-Cal enrollees.
 - ▶ Set measurable quality improvement targets and require MCPs to describe their approaches for making significant and sustainable improvements in quality consistent with these targets.
 - ▶ Require MCPs to make investments to expand access to care, strengthen the local delivery systems, and address enrollees' social determinants of health.

- ▶ Require MCPs to demonstrate capacity and experience with all Medi-Cal enrollees, including persons dually eligible for Medi-Cal and Medicare and persons with serious mental illness or substance use disorders.
- ▶ Require MCPs to work collaboratively with other Medi-Cal MCPs to coordinate administrative and other requirements to ease navigational and transactional challenges for both providers and enrollees.
- ▶ **Adopt positive financial incentives tied to MCP performance.** Several other states have adopted such programs to foster performance improvements, whereas DHCS relies primarily on penalties for poor performance.⁴¹
- ▶ **Foster greater collaboration among county and state stakeholders.** DHCS could commit resources to working collaboratively with county officials, consumer advocates, and MCP and provider representatives in San Diego and Sacramento to establish and advance improvement priorities and goals. Moreover, DHCS or the legislature could give Healthy San Diego and the Sacramento Medi-Cal Managed Care Advisory Committee, both of which are legislatively mandated, a more direct role in establishing procurement priorities, reviewing MCP bids, and overseeing MCP performance.

By raising the bar on performance and other expectations, these actions might naturally reduce the number of MCPs interested in pursuing a contract with DHCS to serve Medi-Cal enrollees in Sacramento and San Diego Counties. If not, DHCS, working collaboratively with San Diego and Sacramento, should consider reducing the number of MCPs with which it contracts in these GMC counties. Although there was no consensus among interviewees on what the ideal number should be, the authors also did not find evidence that more MCP competition leads to improvements in any of the outcomes studied.

By limiting the number of MCPs with which it contracts in a given county, DHCS could use its leverage to create greater competition for those contracts. MCPs that receive a contract might be more willing to make the investments DHCS and San Diego and Sacramento County officials want than they would if they had to divide up the market among four to six competitors. Moreover, enrollees' health care providers might benefit from greater efficiency and improved navigational ease associated with working with fewer MCPs. Were DHCS and the counties to take this approach, they should also develop plans to minimize potential disruptions to enrollees and providers during the transition period.

The upcoming DHCS procurement of commercial MCP contracts in GMC and other model counties is an infrequent and important opportunity to catalyze significant improvements in quality, satisfaction, and health outcomes for Medi-Cal enrollees. California's experience with the GMC model provides useful lessons that should be applied to the upcoming procurement process and ongoing performance expectations for Medi-Cal MCPs.

Further Research

In addition to these actions, several avenues for future research were identified, mostly related to the costs associated with the GMC model. They include the following:

- ▶ **Leverage with providers.** Interviewees noted that providers have leverage when there are multiple MCPs, creating the possible drawback of higher costs. Does this leverage result in higher provider prices and rates, on average, when compared with other model counties where MCPs have more leverage? If so, how does this impact the total costs of care?
- ▶ **Administrative costs.** How large is the additional administrative burden on health care providers of contracting with multiple MCPs, each with its own policies and procedures related to utilization review, claims payment, and other processes, and how does this impact the total cost of care? Conversely, are administrative and other costs lower due to economies of scale and scope and to competition? Finally, what are the administrative costs and burdens to DHCS of having multiple MCP contracts in GMC counties? Can economies of scale and scope for DHCS be quantified?
- ▶ **Network adequacy.** The state's analysis on the adequacy of MCP networks does not reflect providers' time serving Medi-Cal enrollees. For example, one provider listed on an MCP's network may see only a handful of patients annually, whereas other providers on the network list may see a high volume of Medi-Cal patients every month. To better understand MCP network contributions to Medi-Cal, DHCS could require MCPs to track and report providers' Medi-Cal encounters on a routine basis.
- ▶ **MCP switching.** This study finds that enrollees move between and among MCPs in GMC counties; however, the reasons for this are less clear. Interviewees described many navigational challenges for enrollees. It would be valuable to better understand enrollees' experiences with the GMC model and its benefits and drawbacks from their perspective.
- ▶ **Provider satisfaction.** This study did not assess providers' satisfaction with individual MCPs or the GMC model generally; however, providers interviewed did express frustration with the multiplicity of MCPs and confusion about the roles of IPAs. MCPs and IPAs could survey providers through an independent survey to reveal providers' satisfaction and dissatisfaction.

Appendix A. Structured Interview Participants

Dimitrios Alexiou, President/CEO, Hospital Association of San Diego & Imperial Counties

Sean Atha, Senior Vice President, Business & Network Development, River City Medical Group

William Barcelona, Senior Vice President of Government Affairs, America's Physician Groups

Athena Chapman, Chapman Consulting

Abbi Coursele, Senior Attorney, National Health Law Program

Jack Daily, HCA Coordinator, Consumer Center for Health Education and Advocacy, Legal Aid Society of San Diego, Inc.

Sandy Damiano, PhD, Deputy Director, Department of Health Services, Sacramento County

Sarah De Guia, Executive Director, California Pan-Ethnic Health Network

Paul Durr, Senior Vice President and Chief Executive Officer, Sharp Community Medical Group

Jeff Dziedzic, Chief Operating Officer, Aetna Better Health of California

Jeff Gering, Vice President of Support Services & Planning, Family Health Centers of San Diego

Britta Guerrero, Chief Executive Officer, Sacramento Native American Health Center

Brian Jensen, Regional Vice President, Hospital Council of Northern and Central California

Kevin Kandalaft, Chief Executive Officer, UnitedHealthcare Community Plan of California

Greg Knoll, Healthy San Diego Board Chair, CEO/Executive Director/Chief Counsel, Legal Aid Society of San Diego, Inc.

Kim Lewis, Managing Attorney, National Health Law Program

Meaghan McCamman, California Primary Care Association

Branch McNeal, Senior Partner, Mercer

Jane Ogle, Consultant and Former Deputy Director for Healthcare Delivery Systems at the Department of Health Care Services

Jonathan Porteus, Chief Executive Officer, Wellspace Health Sacramento

Kiran Savage, Deputy Director, California Pan-Ethnic Health Network

George Scolari, Chair, Healthy San Diego Behavioral Health Work Group, Community Health Group

Margaret Tatar, Managing Principal, Health Management Associates

Liza Thantranon, Regional Counsel and Managing Attorney, Legal Services of Northern California, Sacramento

Abbie Totten, Medi-Cal Program Officer, Health Net

Jennifer Tuteur, MD, FAAFP, Deputy Chief Medical Officer, Health and Human Services Agency, County of San Diego

Henry Tuttle, President and Chief Executive Officer, Health Center Partners of Southern California

Chet Uma, Chief Executive Officer, Aetna Better Health of California

Christy Ward, Chief Executive Officer, One Community Health, Sacramento

Bobbie Wunsch, Founder and Partner, Pacific Health Consulting Group

Judith Yates, Senior Vice President, Hospital Association of San Diego & Imperial Counties

Nicholas Yphantides, MD, MPH, Chief Medical Officer, Health and Human Services Agency, County of San Diego

Appendix B. Regression Analysis Methodology and Results

The authors conducted regression analyses using patient-level data from the California Health Interview Survey (CHIS). The CHIS survey is a random-dial telephone survey conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health and the Department of Health Care Services, and includes over 20,000 Californians each year across all 58 counties. The survey includes adults, teens, and children, and it collects detailed demographic information from the respondents, such as age, gender, and level of educational attainment. The survey also asks questions on a variety of health-related topics, such as health insurance coverage and access to health-related services. The data used in regressions included annual survey responses for the years 2014 through 2017.

The authors tested numerous models to compare members of MCPs in GMC counties against members of MCPs in the comparison group counties. Specifically, the authors tested whether these MCP members differed with regard to their responses for the following survey questions:

- ▶ Member had used the ER in the past 12 months for any reason
- ▶ Member had a usual place to go to receive health care when feeling sick or needing health advice
- ▶ Member had a preventive care visit in the past 12 months
- ▶ Member had difficulty getting a doctor's appointment within two days (if needed)
- ▶ Member had difficulty finding a primary care provider
- ▶ Member had difficulty finding a specialty care provider (if needed)
- ▶ Member had difficulty understanding his or her doctor

Note that these responses are all binary, or yes/no answers to the survey question. Because of this, it was

necessary to use a specialized form of regression called a logistic (or logit) regression, where the dependent variable is categorical rather than continuous. Using these responses as dependent variables, the authors constructed logistic models that included a dummy variable to indicate whether the member belonged to an MCP in a GMC county (based on respondent's county of residence). The authors also included a variety of other explanatory variables, including demographic variables such as the member's age, gender, race, income, and level of educational attainment, in addition to variables to capture whether the member was married or had a partner, was a native English speaker or had a high level of English proficiency, worked full-time, was clinically obese, or was a smoker. The authors also included health variables such as whether the member had diabetes, asthma, high blood pressure, heart disease, or psychological distress in the past year or needed help for emotional or mental issues or alcohol or drug problems. Finally, the authors also included dummy variables for the year of the survey.

The authors tested numerous specifications using various combinations of these explanatory variables, and in all these analyses the authors found no statistically significant difference in outcomes based on the respondent's Medi-Cal managed care model (i.e., GMC Model versus other urban counties with COHS or Two-Plan managed care delivery models). An example of one model the authors tested is presented in Table B1 (see page 31).

Table B1 presents numerous statistics from the logistic regression. The coefficient estimate is calculated using maximum likelihood estimation, or MLE. The odds ratio is the exponential of the coefficient estimate and can be used to compare the relative importance of the explanatory variables. The percentage increase in odds is the transformation of the logit coefficient using the formula $100(e^b - 1)$, where b is the logit coefficient, and expresses the result as a percentage. Therefore, if this value is X , one may say "each additional unit of the explanatory variable results in an

increase of about X% in the odds of the dependent event occurring.” Finally, the “Wald Prob > Chi-Sq” value represents 1 minus the confidence level at which the hypothesis that the coefficient value equals zero cannot be rejected. Thus, a value of 0.05 indicates that the coefficient estimate is statistically significant at the 95% confidence level.

In this model, the dependent variable was assigned a 1 if the member’s survey response indicated he or she had no place to go to receive health care when sick or in need of health advice. The CHIS data had 7,785

responses from Medi-Cal members in GMC counties or in similar urban counties, and 1,290 (16.6%) of those respondents said they did not have such a place to go. Of the explanatory variables tested, the only significant explanatory variables were age, gender, English proficiency, whether the respondent ever had high blood pressure, and whether the respondent had an emotional or drug problem. The variable denoting whether the respondent was a member of an MCP in a GMC county (“GMC Plan Member”), however, was not statistically significant.

Table B1. Regression Results

- ▶ Dependent variable: 1 if member had no usual place to go to receive healthcare
- ▶ Number of observations: 7,785
- ▶ Number of observations where dependent variable is 1: 1,290
- ▶ Pseudo R-square: 0.06090
- ▶ Max rescaled R-square: 0.09663

	COEFFICIENT	ODDS RATIO	PERCENT CHANGE IN ODDS	WALD PROB>CHI SQ
Intercept	(0.3213)			0.2842
GMC Plan Member	(0.0634)	0.9386	(6.1388)	0.7230
Year = 2015	(0.1067)	0.8988	(10.1187)	0.5737
Year = 2016	(0.0719)	0.9307	(6.9346)	0.7191
Year = 2017	0.0241	1.0244	2.4379	0.9211
Age	(0.0133)	0.9868	(1.3204)	0.0167 [†]
Gender = Male	0.6799	1.9736	97.3619	0.0000 [†]
Race = White	(0.0828)	0.9205	(7.9459)	0.6231
Diabetes	(0.3832)	0.6817	(31.8346)	0.0731*
Asthma	(0.0811)	0.9221	(7.7930)	0.6514
High Blood Pressure	(0.6894)	0.5019	(49.8099)	0.0000 [†]
Emotional or Drug Problem	(0.1804)	0.8349	(16.5074)	0.2678
Married or Has Partner	(0.2008)	0.8181	(18.1929)	0.1813
English Speaker (Well/Very Well)	(0.8623)	0.4222	(57.7803)	0.0000 [†]
Education of BA or higher	0.1225	1.1303	13.0307	0.4783
Works full time	0.1606	1.1742	17.4236	0.2825

*Indicates significance at the 90% level.

[†] Indicates statistical significance at the 95% level.

Source: Blue Sky Consulting Group Analysis of California Health Interview Survey data, 2019.

Appendix C. CAHPS Measures Comparison: GMC and Urban Counties

For patient satisfaction survey responses, a three-point mean score is calculated for each CAHPS measure (Table C1).⁴² For the global ratings, scores are determined in this manner:

- ▶ Response values of 9 and 10 were given a score of 3.
- ▶ Response values of 7 and 8 were given a score of 2.
- ▶ Response values of 0 through 6 were given a score of 1.

This three-point global rating mean was the sum of the response scores (1, 2, or 3) divided by the total number of responses to the global rating question.

For composite measures, response values were scored as follows:

- ▶ Responses of “Always” were given a score of 3.
- ▶ Responses of “Usually” were given a score of 2.
- ▶ All other responses were given a score of 1.

The three-point composite mean was the average of the mean score of each question included in the composite.

Table C1. Aggregated CAHPS Scores, GMC and Urban Counties, 2016

	GMC		URBAN	
	Adults	Children	Adults	Children
Rating of all health care	2.3	2.5	2.3	2.5
Rating of personal doctor	2.4	2.6	2.4	2.6
Rating of specialist seen most often	2.5	2.6	2.5	2.6
Getting needed care	2.1	2.1	2.1	2.3
Getting care quickly	2.2	2.3	2.1	2.4
How well doctors communicate	2.6	2.5	2.5	2.6
Customer service	2.4	2.5	2.4	2.4

Source: Blue Sky Consulting Group analysis of DHCS data from Department of Health Care Services, Managed Care Quality and Monitoring Division, 2016 CAHPS Medicaid Managed Care Survey Summary Report, January 2018, www.dhcs.ca.gov.

Endnotes

1. Department of Health Care Services, *Medi-Cal Managed Care Request for Proposal (RFP) Schedule by Model Type*, updated March 11, 2019, www.dhcs.ca.gov (PDF).
2. For a discussion of the policy and feasibility issues related to changing the managed care model type to a Two-Plan or County Organized Health System, please see the appendix in the authors' companion paper, *A Close Look at Medi-Cal Managed Care: Quality, Access, and the Provider's Experience Under the Regional Model*, available at www.chcf.org.
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15. Additional details of the data analysis approach and regression results are presented in Appendix B.
16. Importantly, these are not the access standards to which plans are contractually held by DHCS. For the time and distance access standards by provider type, refer to Department of Health Care Services, *Medicaid Managed Care Final Rule: Network Adequacy Standards*, July 19, 2017, www.dhcs.ca.gov (PDF).
17. Centers for Medicare & Medicaid Services, *Healthcare Effectiveness Data and Information Set (HEDIS)*, modified July 6, 2017, www.cms.gov.
18. Department of Health Care Services, *Managed Care Quality and Monitoring Division, Medi-Cal Managed Care External Quality Review Technical Report (July 1, 2017–June 30, 2018)*, April 2019, www.dhcs.ca.gov (PDF).
19. For measures where a lower score is better (e.g., hospital readmissions and HbA1c Poor Control (>9.0%)), the score was rescaled to make it comparable with the other measures by subtracting the reported value from 1.
20. Aetna became operational in January 2018 and United Healthcare in October 2017. The external quality review organization (EQRO) review requires that members be enrolled continuously for 11 of 12 months to collect HEDIS measures during the Measurement Year 2017.
21. The authors excluded Kaiser from the analysis as it limits enrollment in both GMC counties and is not an option for enrollees to select unless they meet certain conditions. As a result, Kaiser's risk mix is generally different from that of other plans.
22. Andrew Bindman, Denis Hulett, and Taewoon Kang, *A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade*, California Health Care Foundation, September 25, 2019, www.chcf.org.
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24. Note that for some periods more than 10% of provider records were missing the NPI.
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27. The authors excluded COHS counties in the comparison as enrollees do not have a choice of plans.
28. These results are likely underestimated as the authors assumed one person changing plans (it could have been as many as five) where data were suppressed due to small reporting cell sizes.
29. Department of Health Care Services, Managed Care Quality and Monitoring Division, *2016 CAHPS Medicaid Managed Care Survey Summary Report*, January 2018, www.dhcs.ca.gov (PDF).
30. More CAHPS measure detail is available in Appendix C.
31. GMC county CAHPS scores do not include Kaiser for reasons described earlier. Furthermore, these scores do not include Aetna and United as they were not under contract with DHCS in 2016.
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