California HealthCare Foundation

Snapshot

Monitoring Performance:

A Dashboard of Medi-Cal Managed Care

December 2013

Introduction

Six million Californians receive health care through the Medi-Cal managed care program. Over the past three years, the program has expanded to reach new populations, provide more services, and operate statewide. The program will expand further as those newly eligible for Medi-Cal under the Affordable Care Act are enrolled in managed care and as plans assume responsibility for additional covered services. With so much change to Medi-Cal managed care, interest in understanding how the program measures up has never been greater among state legislators, California Department of Health Care Services (DHCS) leadership, and the public.

Against this backdrop, the California HealthCare Foundation developed a performance dashboard for the Medi-Cal managed care program. Key indicators were selected that program officials, policymakers, consumer advocates, the media, and the public can use to quickly assess the overall performance of the program, identify areas of strength, and guide priorities for improvement. The dashboard is expected to expand as other measures become available.

Among the key findings:

- Medi-Cal managed care performs at or above the national Medicaid median on 17 of 19 quality indicators. On the two measures for which Medi-Cal lags behind the national median — postpartum care and timeliness of prenatal care — the gap has persisted over the last four years.
- On most measures of consumer experience, the program performs below the national Medicaid median.
- Across all measures of quality, access, and consumer satisfaction, there are considerable differences in performance among participating plans, including significant variation in plan performance within counties.
- Most plans participating in Medi-Cal appear to be in sound financial health. Two plans, however, have had net losses in each of the last two years.

Contents

Medi-Cal Managed Care Timeline

1965 Title XIX of the Social Security Act creates Medicaid.

1966 California creates Medi-Cal.

1973 First Medi-Cal managed care plans established.

1982 State legislation creates three County Organized Health Systems (COHSs).

1990 Congress authorizes three additional COHSs in California.

1992 First county selected for Medi-Cal Geographic Managed Care.

1995 Twelve counties selected for Medi-Cal Two-Plan Model of managed care.

1996 Congress permits an individual COHS plan to operate in more than one county.

2011 Year-long transition of Medi-Cal-only seniors and persons with disabilities to mandatory managed care begins.

2013 Children in Healthy Families transition to Medi-Cal; Medi-Cal managed care expands statewide.

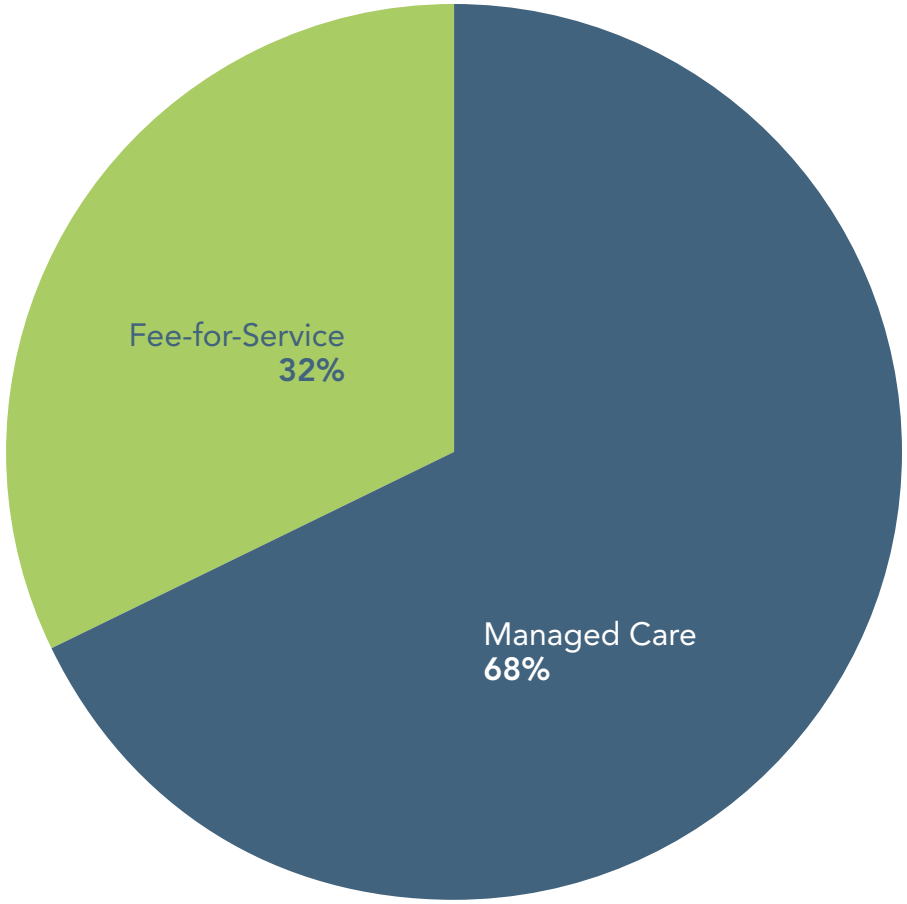
2014 Individuals newly eligible for Medi-Cal under the Affordable Care Act begin enrolling in Medi-Cal managed care.

Overview

The 40-year evolution of the Medi-Cal managed care program has been marked by two periods of major transformation due to changes in federal and state policies: first in the 1990s and again over the past few years.

Distribution of Medi-Cal Enrollees, 2013

TOTAL ENROLLMENT: 8,621,100



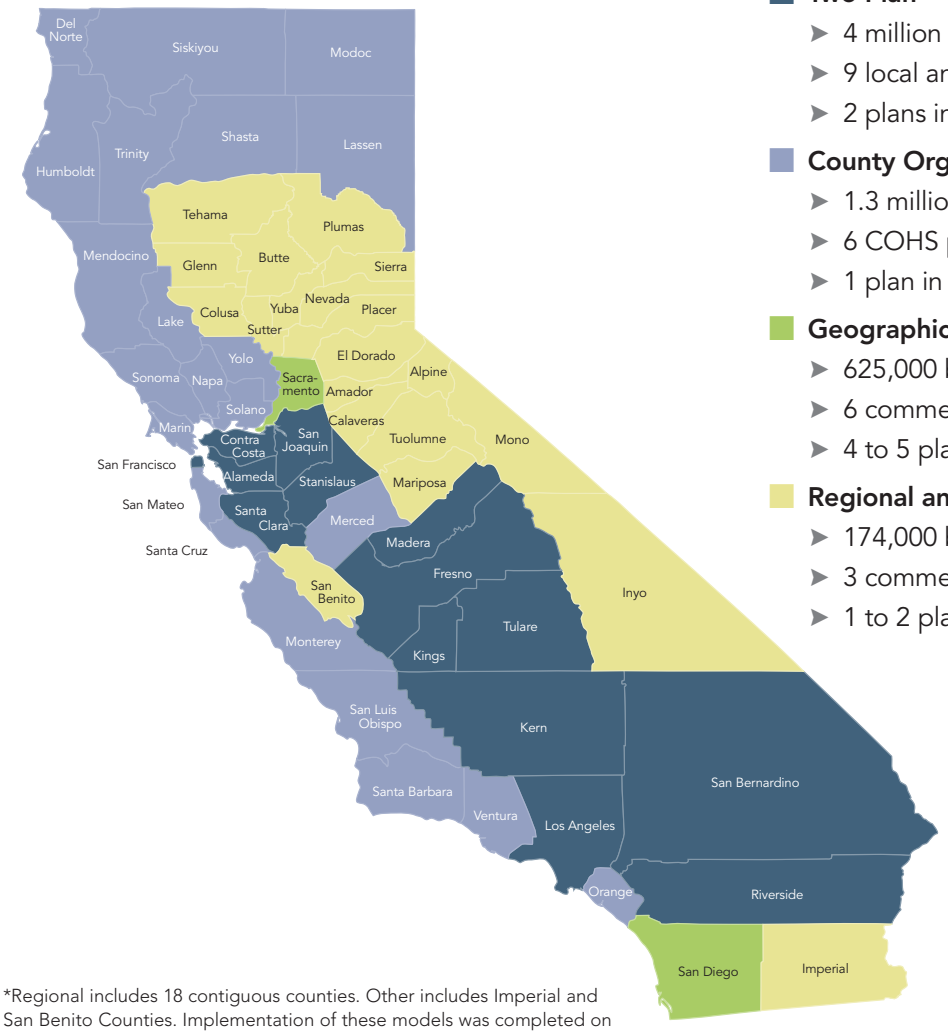
Note: Managed care reflects enrollment in capitated plans only — excludes 920 enrollees in primary care case management model.

Sources: California Department of Health Care Services (DHCS), Medi-Cal Managed Care Enrollment Reports (October 2013), www.dhcs.ca.gov. DHCS, Trend in Total Medi-Cal Certified Eligibles – Most Recent 24 Months (October 2013), www.dhcs.ca.gov, both accessed November 20, 2013.

Overview

In October 2013, 5.9 million Californians were enrolled in Medi-Cal managed care, making up 68% of all Medi-Cal enrollees.

Medi-Cal Managed Care Models
by County, November 2013



- **Two-Plan**
  - 4 million beneficiaries in 14 counties
  - 9 local and 3 commercial health plans
  - 2 plans in each county
- **County Organized Health System (COHS)**
  - 1.3 million beneficiaries in 22 counties
  - 6 COHS plans
  - 1 plan in each county
- **Geographic Managed Care (GMC)**
  - 625,000 beneficiaries in 2 counties
  - 6 commercial health plans
  - 4 to 5 plans in each county
- **Regional and Other***
  - 174,000 beneficiaries in 20 counties
  - 3 commercial plans
  - 1 to 2 plans in each county

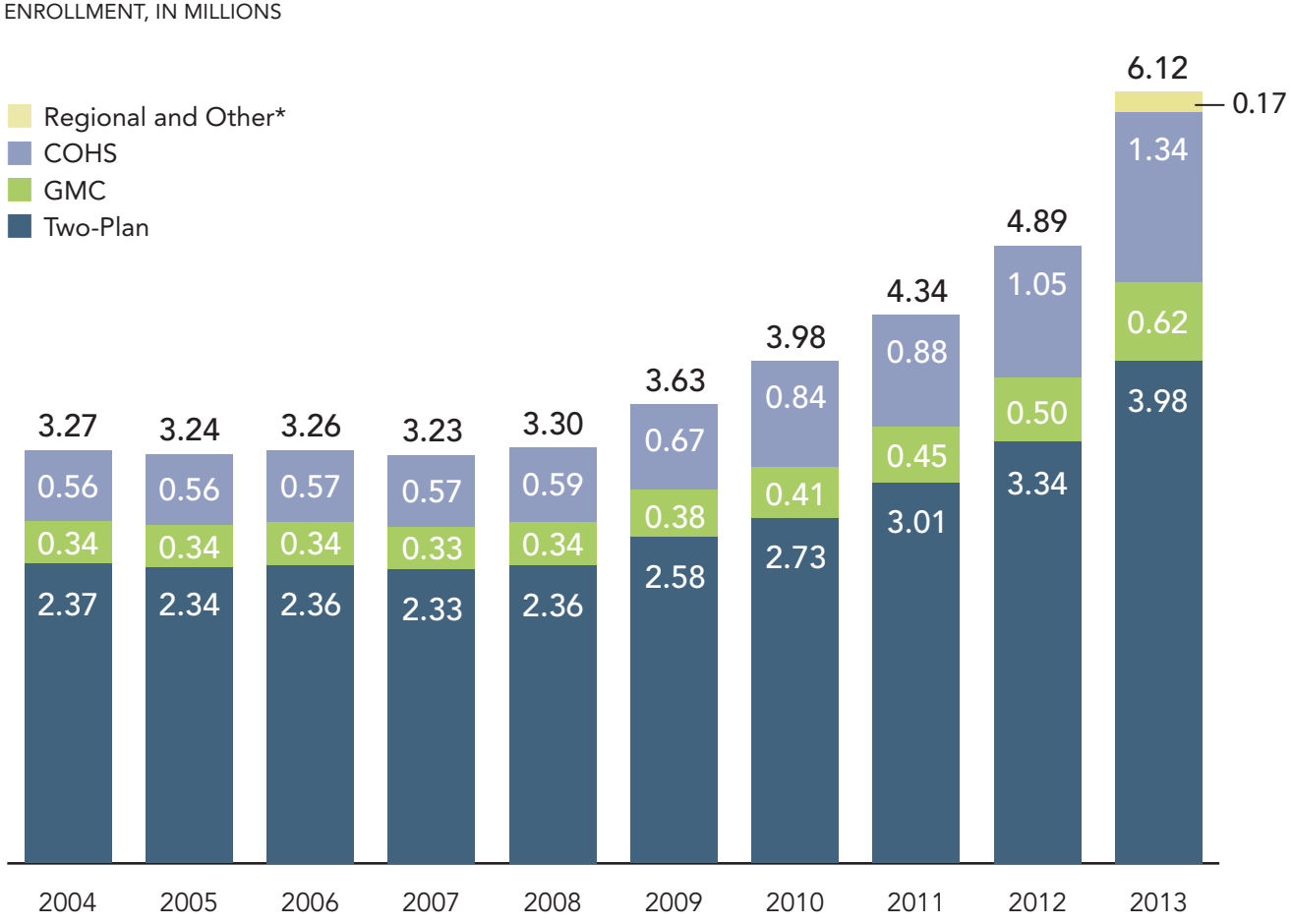
*Regional includes 18 contiguous counties. Other includes Imperial and San Benito Counties. Implementation of these models was completed on November 1, 2013. As many as 280,000 people are eligible in these counties. Health plan counts exclude Kaiser, which accounts for 1% of enrollment in the Regional Model.

Sources: California Department of Health Care Services (DHCS), Medi-Cal Managed Care Enrollment Reports (November 2013), www.dhcs.ca.gov. DHCS presentations to stakeholder advisory committee on rural managed care expansion, October 21, 2013 and November 20, 2013, www.dhcs.ca.gov.

Overview

Medi-Cal managed care was expanded to serve rural counties in 2013 and now operates statewide. Enrollment numbers by plan are available in Appendix A.

Managed Care Enrollment Trends
by Model, 2004 to 2013



*Implementation of Regional and Other Models was completed on November 1, 2013. Other includes Imperial and San Benito Counties.

Notes: COHS is County Organized Health System; GMC is Geographic Managed Care. Segments may not add to totals due to rounding. See Appendix A for enrollment numbers by plan.

Sources: Data for 2004 to 2008: Lewin/Ingenix analysis of MIS/DSS data for 12-month periods ending June 30 of respective year. Data for 2009 to 2013: California Department of Health Care Services (DHCS), Medi-Cal Managed Care Enrollment Reports, www.dhcs.ca.gov, accessed December 9, 2013.

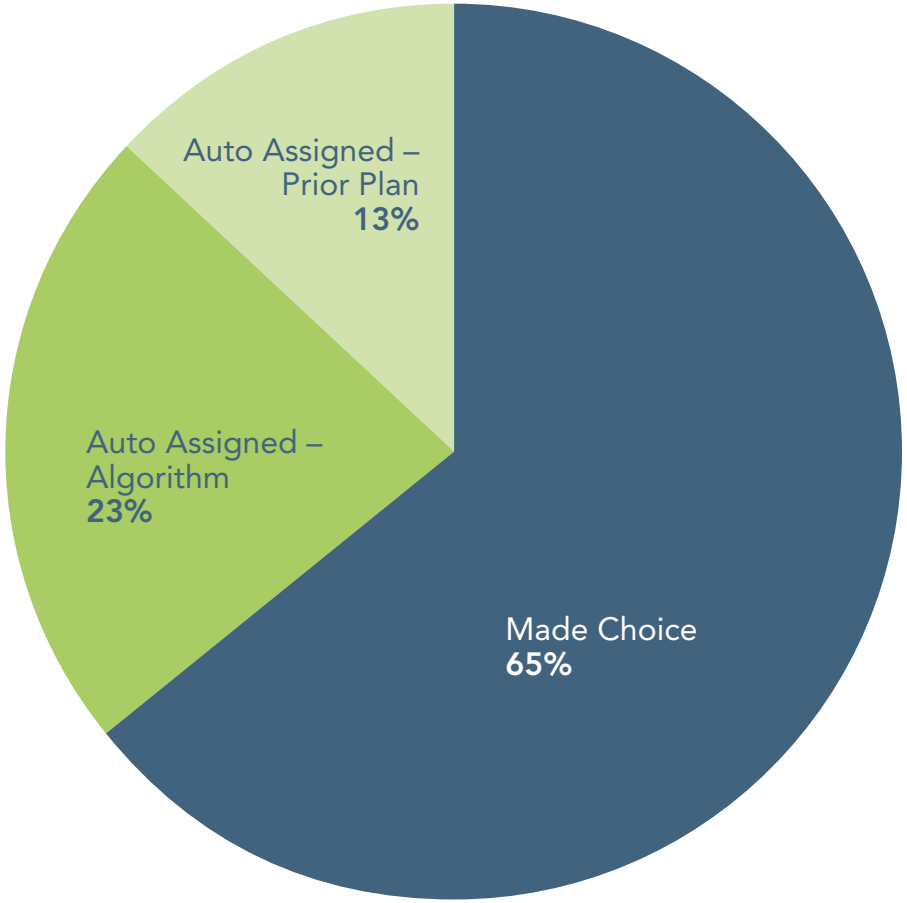
Overview

Enrollment in Medi-Cal managed care grew 69% in five years (2009 to 2013). The Two-Plan Model has consistently accounted for approximately two-thirds of enrollees.

Medi-Cal Plan Selection and Assignment

Among Enrollees, April 2012 to March 2013

TOTAL: 1,458,461



Notes: Auto Assigned – Algorithm refers to members who were assigned using Medi-Cal's auto-assignment algorithm. Auto Assigned – Prior Plan (formerly referred to as "Continuity of Care") refers to members who were assigned based on their prior enrollment in a plan or because other family members were enrolled in a plan. Excludes 37,581 members who were passively enrolled in a plan due to plan or policy change. Segments don't add to 100% due to rounding.

Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division. Monthly values from March 28, 2012, to March 26, 2013 (created June 4, 2013).

Overview

Nearly two-thirds of enrollees chose a plan for themselves, and just over one-third were assigned to a plan by Medi-Cal. Rates of plan self-selection reflect the availability of meaningful choices and the success of consumer education and outreach efforts.

Overview of HEDIS and CAHPS Measures

HEDIS was developed by the National Committee for Quality Assurance to measure health plans' clinical care quality performance. It contains measures for commercial, Medicare, and Medicaid populations, including many that overlap. The California Department of Health Care Services (DHCS) requires its contracted health plans to submit an annual report on a subset of the more than 60 HEDIS measures for Medicaid. For HEDIS 2012, Medi-Cal plans reported on 30 measures. DHCS compares 19 of these to national Medicaid benchmarks, including three measures of women's health, six measures of children's services, eight diabetes care measures, and two measures of appropriate use of services.

Another 11 performance measures reported to DHCS by Medi-Cal-participating health plans were not measured against national Medicaid benchmarks in HEDIS 2012 (see Appendix B). These include measures that were new for the HEDIS 2012 reporting year, two use measures, and one measure developed internally for the Medi-Cal statewide collaborative quality improvement project. Most of these measures could be included in future versions of a performance dashboard.

The measurement period for HEDIS results is the prior calendar year. For example, HEDIS 2012 reflects the measurement period of January 1, 2011, to December 31, 2011.

CAHPS is a survey of consumer satisfaction with adult and child health care services. DHCS requires Medi-Cal-contracted health plans to administer the CAHPS survey every two to three years. CAHPS 2010 includes four global ratings measures and five composite measures representing the experiences of nearly 40,000 adult and child Medi-Cal enrollees.

CAHPS 2010 rates were compared to NCQA's *2010 CAHPS 4.0H Benchmarks and Thresholds for Accreditation* with the following exceptions: NCQA did not publish benchmarks and thresholds for the "Adult Shared Decision Making composite" or any of the child CAHPS 2010 rates. Therefore, benchmarks for these measures were based on NCQA's 2009 Medicaid data.

Note: More information about HEDIS and CAHPS is available at www.dhcs.ca.gov.

National Measures

California monitors the performance of Medi-Cal contracted health plans using nationally recognized tools: Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Quality of Care National Comparison, HEDIS 2012

Measure	Stars*	Change*
Women's Health		
➤ Cervical Cancer Screening	★ ★ ★	▲
➤ Timeliness of Prenatal Care	★ ★	none
➤ Postpartum Care	★ ★	none
Children's Services		
➤ Childhood Immunizations Status, Combination 3	★ ★ ★ ★	▲
➤ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	★ ★ ★	none
➤ Adolescent Well-Care Visits	★ ★ ★	▲
➤ WWC† - BMI Percentiles Total	★ ★ ★ ★	▲
➤ WWC† - Counseling for Nutrition Total	★ ★ ★ ★ ★	▲
➤ WWC† - Counseling Physical Activity Total	★ ★ ★ ★	▲
Comprehensive Diabetes Care		
➤ Blood Pressure Control (< 140/90)	★ ★ ★	▲
➤ Eye Exam (Retinal) Performed	★ ★ ★	▲
➤ HbA1c Control (< 8.0%)	★ ★ ★	▲
➤ Poor HbA1c Control (> 9.0%)‡	★ ★ ★	▲
➤ HbA1c Testing	★ ★ ★	none
➤ LDL-C Control	★ ★ ★	▲
➤ LDL-C Screening	★ ★ ★	none
➤ Medical Attention for Nephropathy	★ ★ ★	▲
Appropriate Use of Services		
➤ Avoidance of Antibiotic Treatment for Adults with Acute Bronchitis	★ ★ ★	▼
➤ Use of Imaging Studies for Low Back Pain	★ ★ ★ ★	none

*Compared to HEDIS 2011 national benchmarks. Change shown if difference was +/– 1 percentage point.
†Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.
‡A lower rate is desirable. Improved performance corresponds with a decline in rate from 2011 to 2012.

Notes: HEDIS is the Healthcare Effectiveness Data and Information Set. For measure definitions, see "2012 Aggregate HEDIS Report for the Medi-Cal Managed Care Program" (www.dhcs.ca.gov).

Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (rates provided on June 5, 2013).

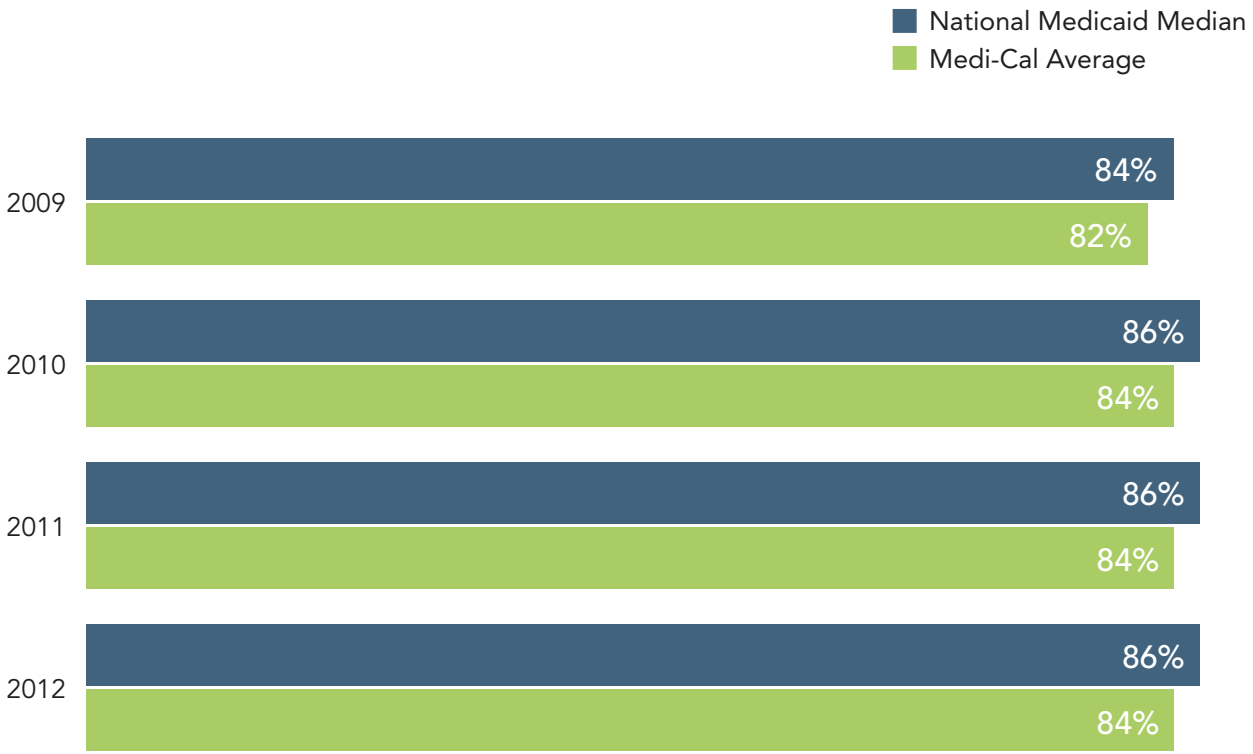
National Measures

Medi-Cal managed care plans performed at or above the national median on 17 of the 19 HEDIS measures in 2012. The plans performed worse than the national median on two women's health measures: postpartum care and timeliness of prenatal care.

Star Rating	Percentile Range
★ ★ ★ ★ ★	≥ 90th
★ ★ ★ ★	75th to 89th
★ ★ ★	50th to 74th
★ ★	25th to 49th
★	≤ 24th
Change	**Compared to 2011**
▲	Better rate
▼	Worse rate

Timeliness of Prenatal Care

California vs. US, 2009 to 2012



Notes: HEDIS is the Healthcare Effectiveness Data and Information Set. Years represents measurement over prior calendar year. For example, 2012 reflects HEDIS measurement period of January 1, 2011, to December 31, 2011. Timeliness of prenatal care reflects the percentage of deliveries in which the mother, as a member of the plan, received a prenatal care visit in the first trimester or within 42 days of enrollment in the plan. National Medicaid Median reflects the 50th percentile for the previous HEDIS year. Medi-Cal Average is a weighted average based on plan enrollment.

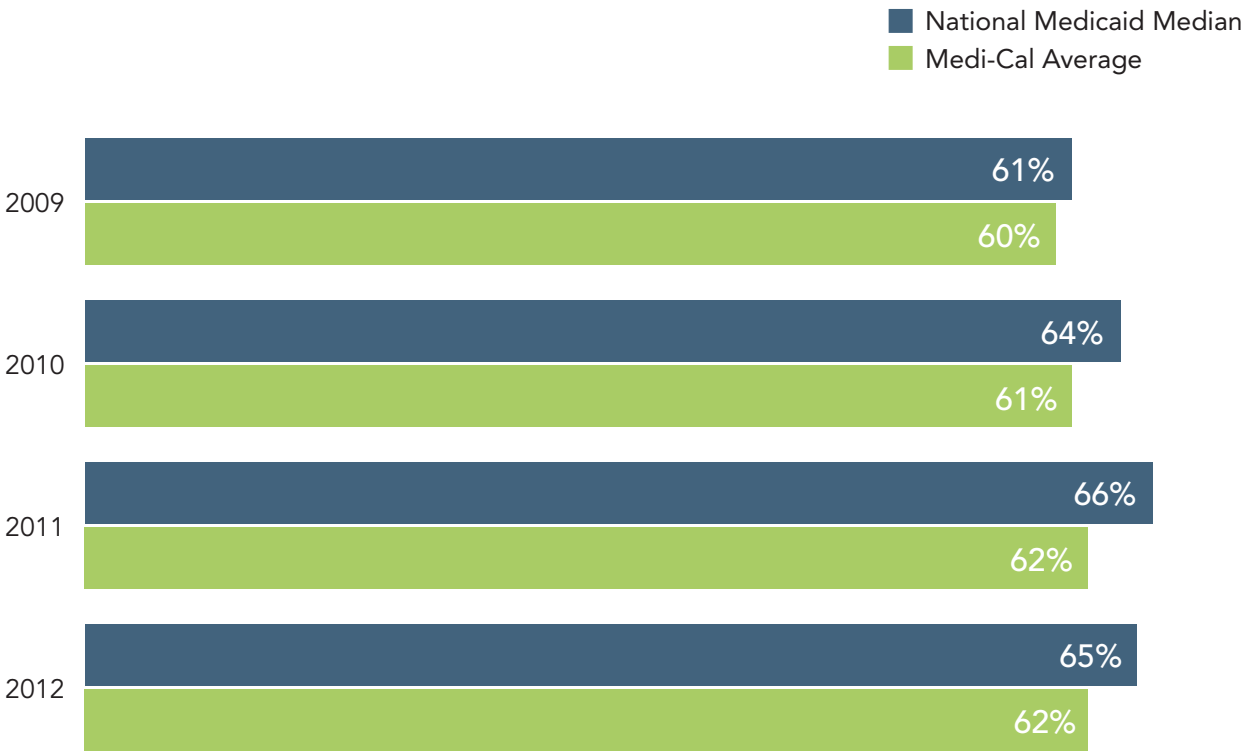
Sources: 2011 and 2012 HEDIS rates: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (provided on June 5, 2013). 2009 and 2010 HEDIS rates: DHCS, www.dhcs.ca.gov. National benchmarks provided by Health Services Advisory Group.

National Measures

From 2009 to 2012, Medi-Cal's performance on timeliness of prenatal care improved slightly, but still fell behind the national Medicaid median. This HEDIS measure is one of two for which the Medi-Cal statewide average has yet to reach the national Medicaid median.

Postpartum Care

California vs. US, 2009 to 2012



Notes: HEDIS is the Healthcare Effectiveness Data and Information Set. Years represents measurement over prior calendar year. For example, 2012 reflects HEDIS measurement period of January 1, 2011, to December 31, 2011. Postpartum care is a measure of the percentage of deliveries in which the mother had a visit on or between 21 and 56 days after delivery. National Medicaid Median reflects the 50th percentile for the previous HEDIS year. Medi-Cal Average is a weighted average based on plan enrollment.

Sources: 2011 and 2012 HEDIS rates: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (provided on June 5, 2013). 2009 and 2010 HEDIS rates: DHCS, www.dhcs.ca.gov. National benchmarks provided by Health Services Advisory Group.

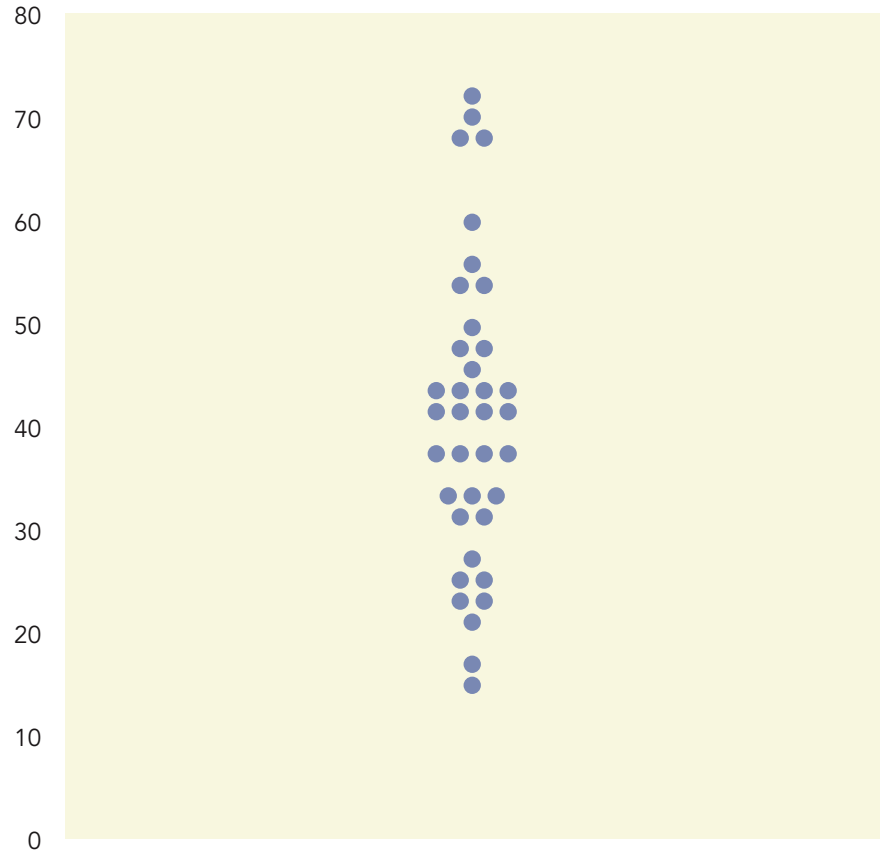
National Measures

Even though Medi-Cal's performance on providing postpartum care improved slightly between 2009 and 2012, it fell further behind the national Medicaid 50th percentile. This is one of two HEDIS measures for which the Medi-Cal statewide average has consistently fallen below the national Medicaid median.

Health Plan Quality Among Plans

Total HEDIS Scores, 2012

HIGHEST POSSIBLE SCORE: 76



Notes: HEDIS is the Healthcare Effectiveness Data and Information Set. Total HEDIS score reflects cumulative performance across all 19 HEDIS measures. Scoring method is based on DHCS Quality Award calculations. The score for individual HEDIS measures is calculated as follows: four points for 90th percentile and above among Medicaid plans, three for 75th to 89th percentile, two for 50th to 74th percentile, one for 25th to 49th percentile, and no points for a HEDIS score below the 25th percentile. Each dot represents one plan. Plan-specific scores are available at www.chcf.org/medical-dashboard.

Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (rates provided on June 14, 2013).

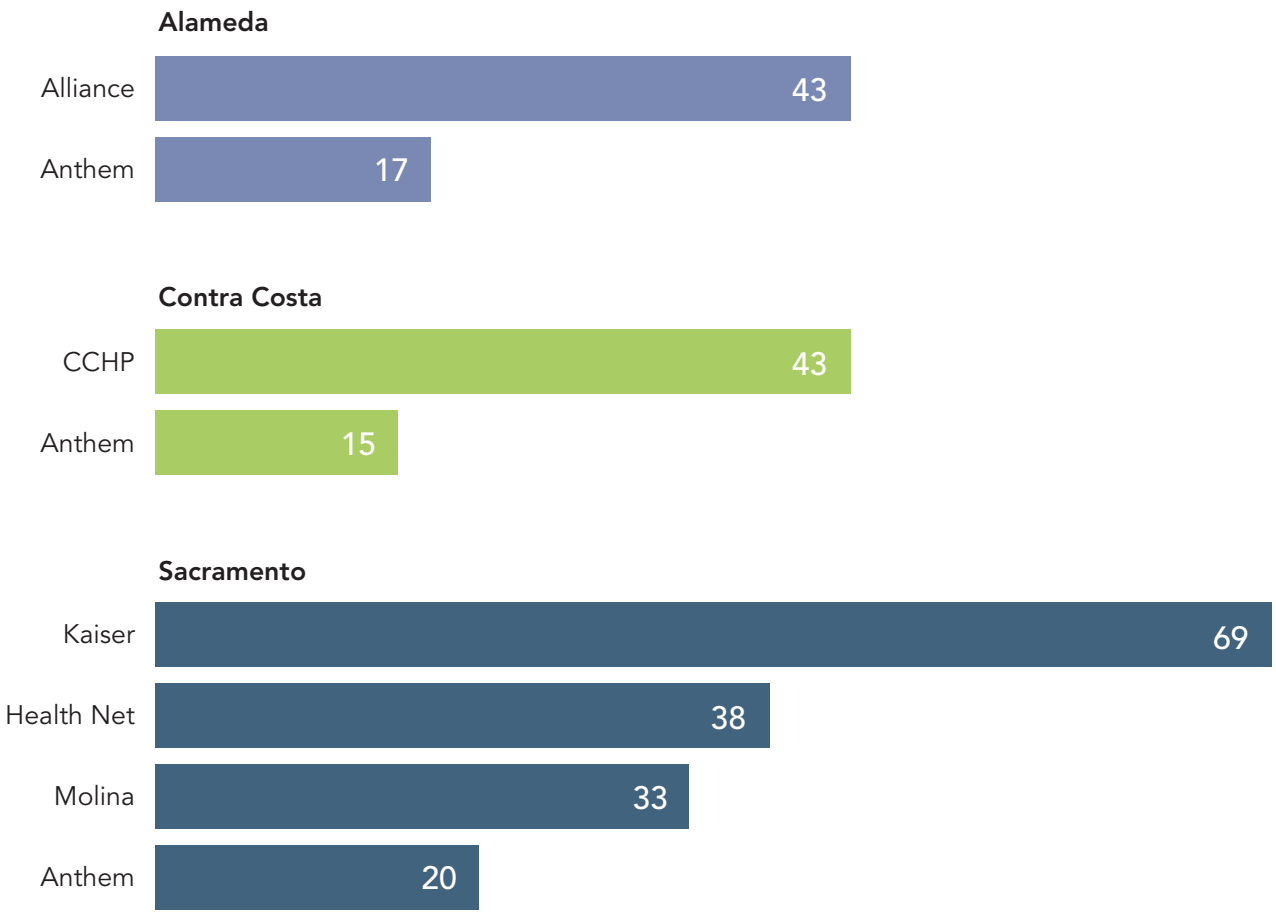
National Measures

California health plans' total HEDIS scores varied widely. The total HEDIS score of the highest scoring plan (73) is nearly five times greater than that of the lowest scoring plan (15).

Health Plan Quality, Selected Counties

Total HEDIS Scores, 2012

HIGHEST POSSIBLE SCORE: 76



Notes: HEDIS is the Healthcare Effectiveness Data and Information Set. Analysis excluded County Organized Health Systems counties, in which only one plan operates. Alliance is Alameda Alliance for Health, CCHP is Contra Costa Health Plan.

Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (provided on June 14, 2013).

National Measures

Although some variation of health plan HEDIS scores across counties is expected due to differences in population demographics and health care delivery system capacity, there were large differences in health plans' HEDIS scores within several counties. Anthem had the lowest score in the three counties with the greatest variance in total HEDIS scores among plans.

CAHPS Scores, by Population

California vs. US, 2010

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

Star Rating	Adult Percentiles	Child Percentiles
★★★★★	≥90th	≥80th
★★★★	75th to 89th	60th to 79th
★★★	50th to 74th	40th to 59th
★★	25th to 49th	20th to 39th
★	≤24th	≤19th

Notes: CAHPS is the Consumer Assessment of Healthcare Providers and Systems. Global ratings measure respondents' assessment of their health plan and the quality of care received in the last 12 months. Composite measures combine results for closely related items that have been grouped together. Adults are anyone 18 years or older, and children are 17 and younger. For measure definitions, see Medi-Cal Managed Care Program, "2010 CAHPS Summary Report" (www.dhcs.ca.gov).

Source: California Department of Health Care Services (DHCS), www.dhcs.ca.gov.

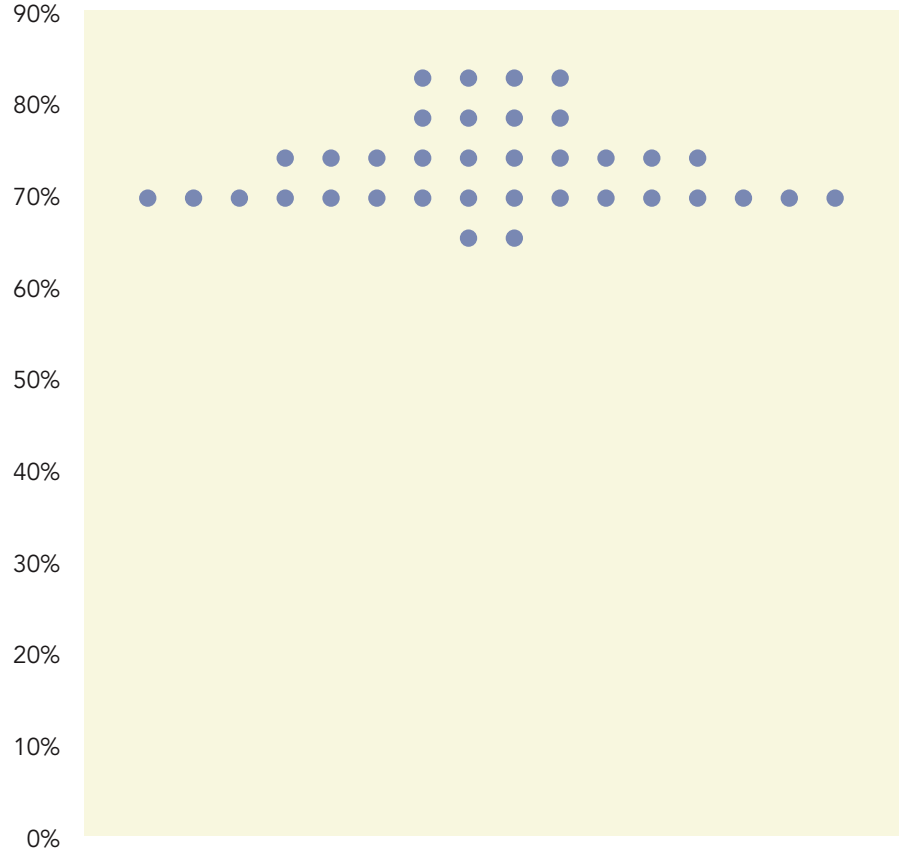
National Measures

Aggregated statewide CAHPS scores for Medi-Cal managed care plans fell below the national 50th percentile benchmark for all nine adult measures, and they fell below the national 40th percentile benchmark for eight of the nine child measures. For most measures, Medi-Cal managed care plans scored below the national Medicaid 25th percentile.

Health Plan Member Satisfaction, by Plan

CAHPS Scores, California, 2010

PERCENTAGE WHO RATE 8, 9, OR 10



Notes: CAHPS is the Consumer Assessment of Healthcare Providers and Systems. Percentages reflect unweighted average ratings by adults and children across the four global ratings measures: rating of health plan, rating of all health care, rating of personal doctor, rating of specialist. Members could rate a plan on a scale from 0 (lowest) to 10 (highest). Each dot represents one plan. Plan-specific scores are available at www.chcf.org/medical-dashboard.

Source: Medi-Cal Managed Care Program 2010 CAHPS Summary Report, www.dhcs.ca.gov.

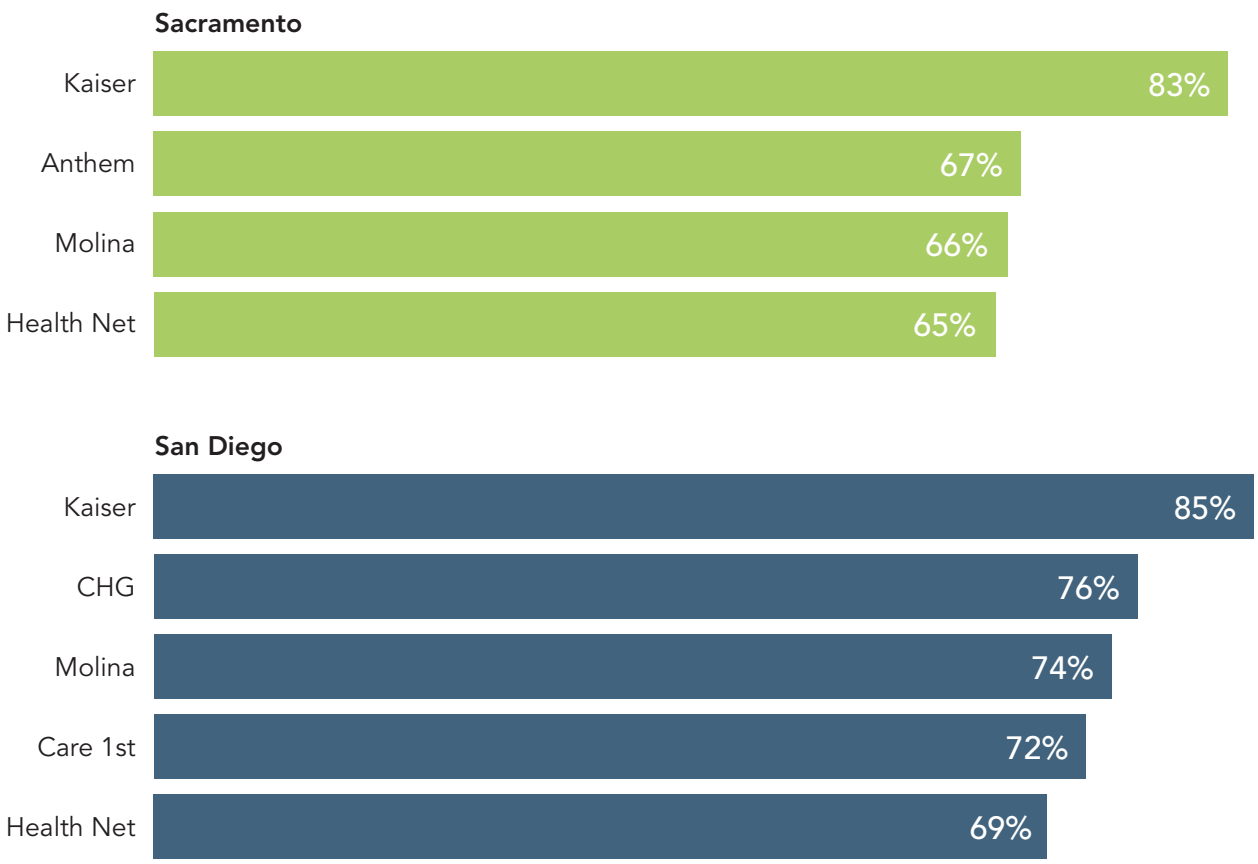
National Measures

Across all nine CAHPS measures for adults and children, the percentage of managed care enrollees who gave satisfaction ratings of 8, 9, or 10 ranged from a low of 65% to a high of 85%.

Member Satisfaction, Selected Counties

CAHPS Scores, California, 2010

PERCENTAGE WHO RATE 8, 9, OR 10



Notes: CAHPS is the Consumer Assessment of Healthcare Providers and Systems. Percentages reflect unweighted average ratings by adults and children across the four global ratings measures: rating of health plan, rating of all health care, rating of personal doctor, rating of specialist. Members could rate a plan on a scale from 0 (lowest) to 10 (highest). CHG is Community Health Group.

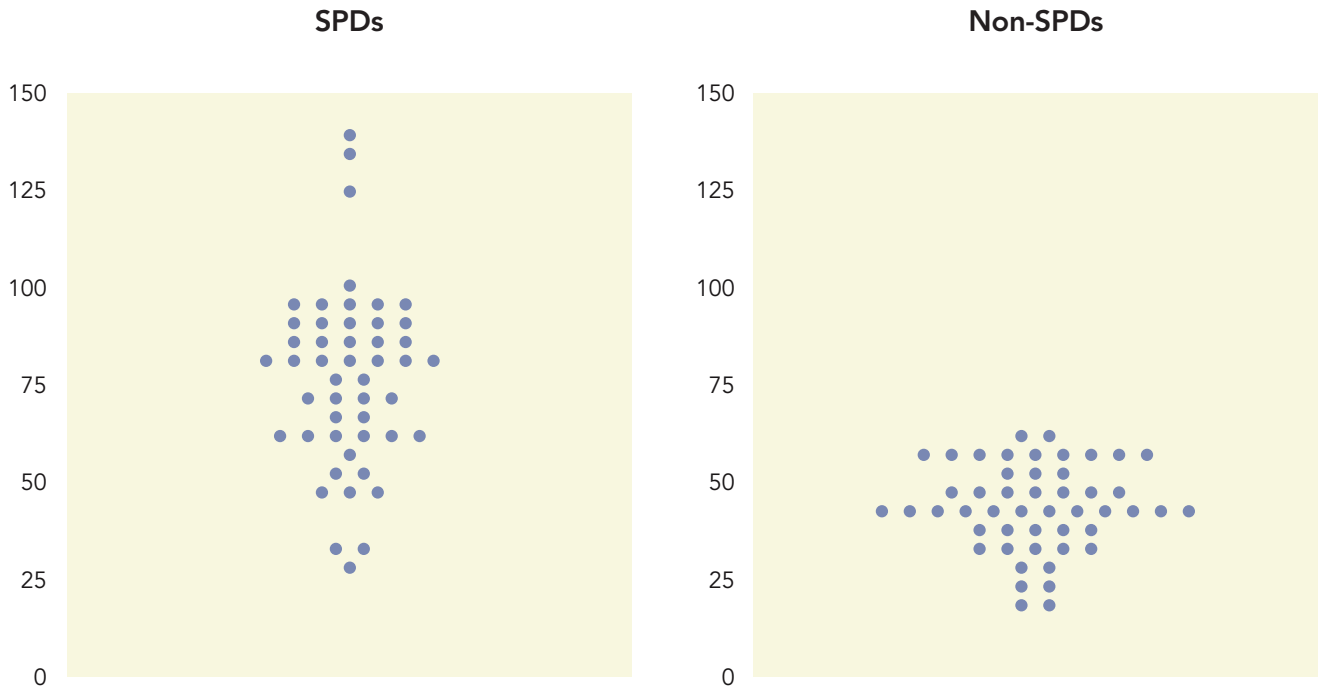
Source: Medi-Cal Managed Care Program 2010 CAHPS Summary Report, www.dhcs.ca.gov.

National Measures

In two counties, there was wide variation among health plans' member satisfaction scores. In both Sacramento and San Diego Counties, Kaiser had the highest satisfaction ratings.

Emergency Department Use Among Plans
by Population, 2012

VISITS PER 1,000 MEMBER MONTHS



Notes: Each dot represents one plan. Plan-specific scores are available at www.chcf.org/medical-dashboard.

Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division. Number of enrollees and ED visits by plan for January 2012 to March 2013 (created June 17, 2013).

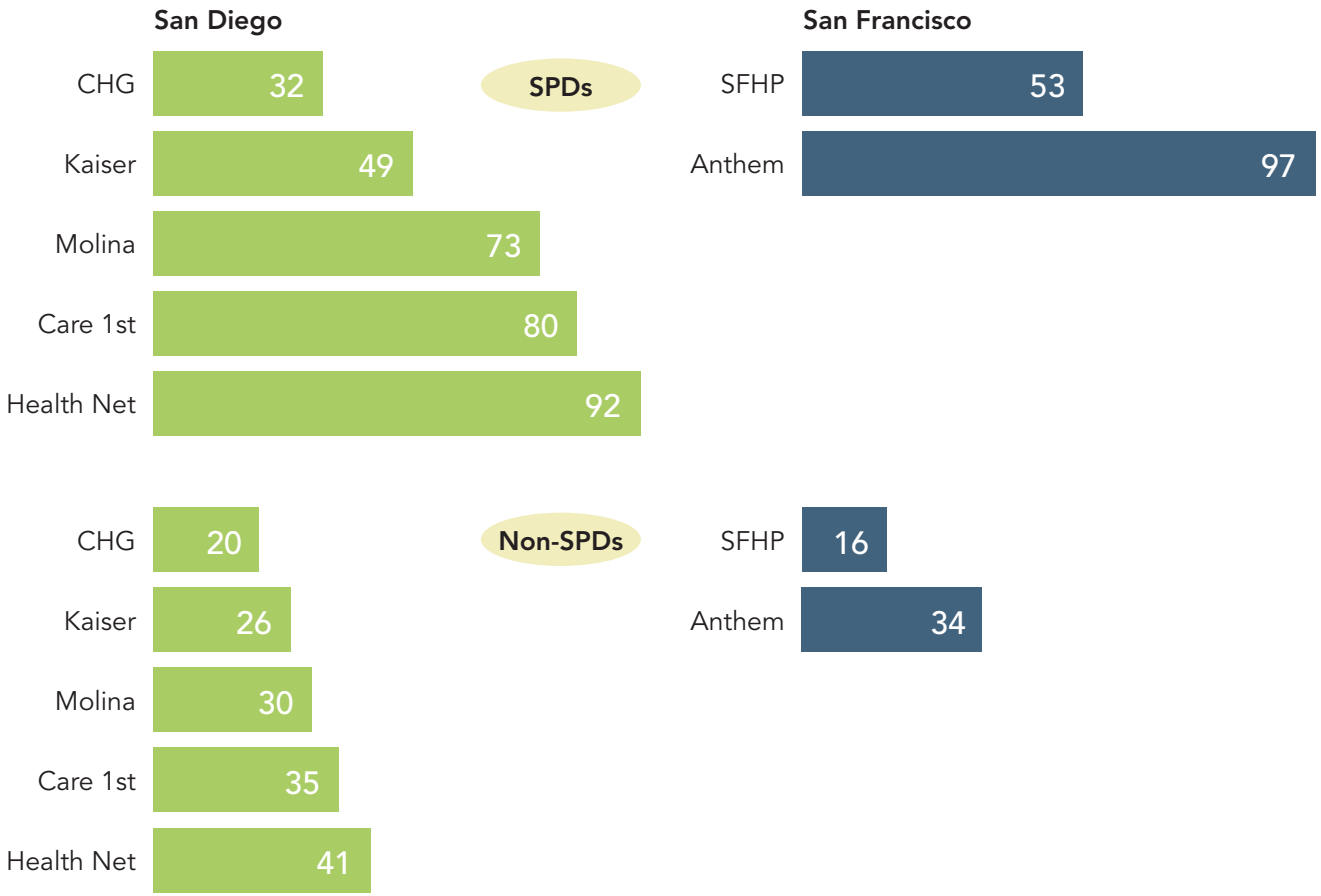
Service Use

Rates of emergency department (ED) use among plans varied nearly four-fold for children and adults without disabilities (non-SPDs), and nearly five-fold for seniors and persons with disabilities (SPDs). For both populations, ED use rates were among the highest for plans operating in Kings and Stanislaus Counties (not shown). High rates of ED use may be an indication of lack of access to ambulatory care or poor care quality, among other factors.

Emergency Department Use, by Population

Selected Counties, 2012

VISITS PER 1,000 MEMBER MONTHS



Notes: Analysis excluded County Organized Health System counties, in which only one plan operates. CHG is Community Health Group, SFHP is San Francisco Health Plan.

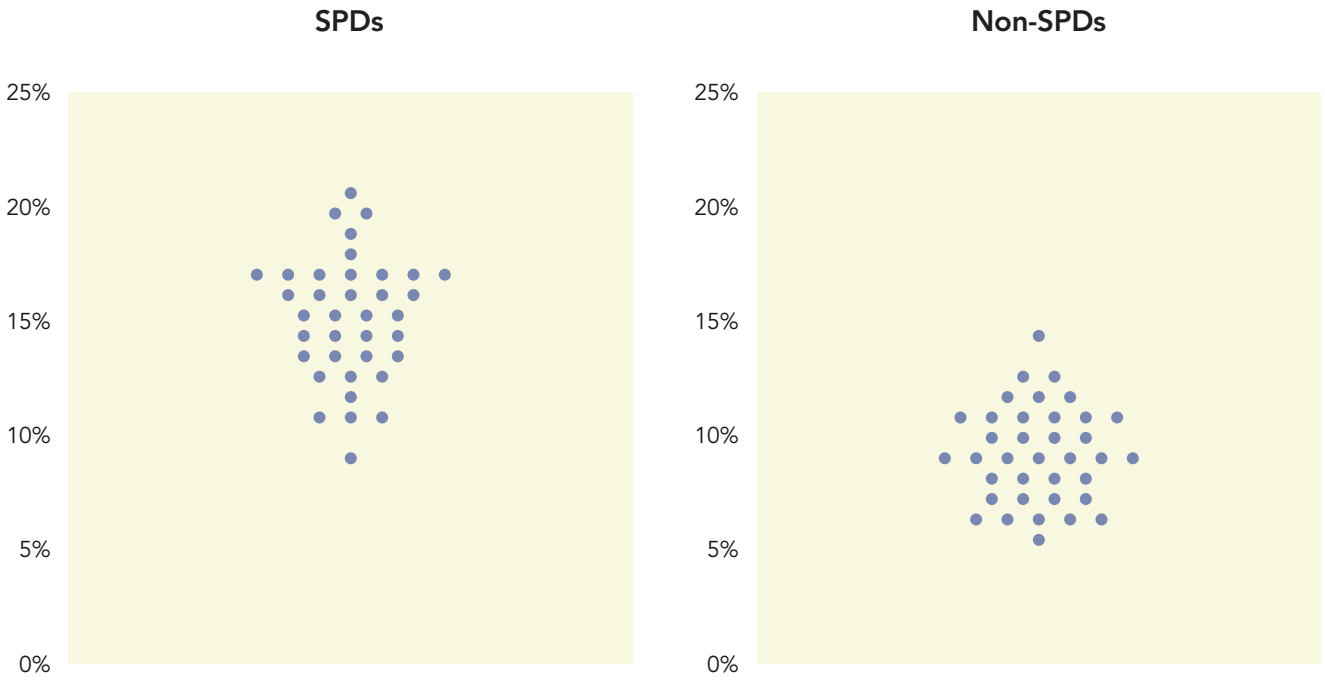
Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division. Number of enrollees and ED visits by plan for January 2012 to March 2013 (created June 17, 2013).

Service Use

In many California counties, there was substantial variation among plans in emergency department (ED) use. This variation was greatest in San Diego and San Francisco Counties for children and adults without disabilities (non-SPDs), and for seniors and persons with disabilities (SPDs). High rates of ED use may be related to poor access to ambulatory care or poor overall quality of care.

Hospital Readmission Rates Among Plans

Selected Populations, 2012



Notes: Each dot represents one plan. Plan-specific scores are available at www.chcf.org/medical-dashboard.

Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division. Hospital readmission rates (all causes) by plan for January 2012 to March 2013 (created June 17, 2013).

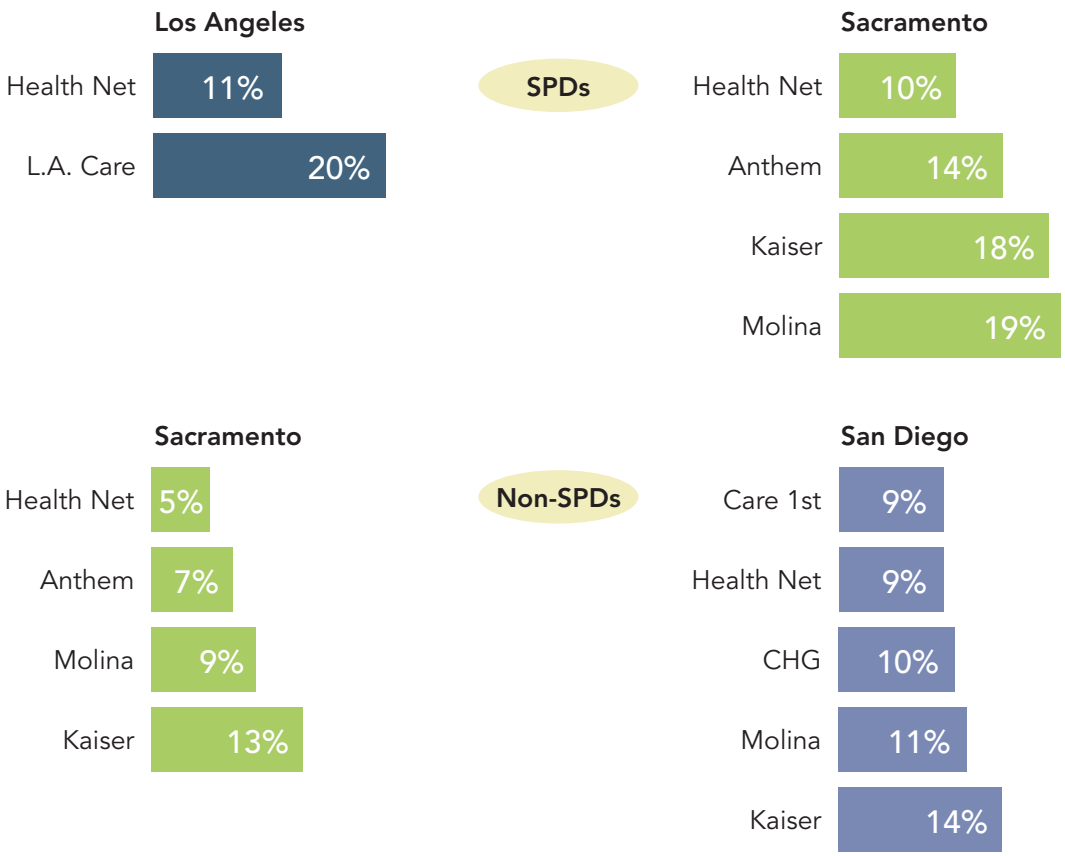
Service Use

A common measure of quality of care, readmission rates among plans varied nearly three-fold for children and adults without disabilities (non-SPDs), and two-fold for seniors and persons with disabilities (SPDs). Lower readmission rates are considered an indicator of better care quality.

Hospital Readmission Rates, by Population

Selected Counties, 2012

PERCENTAGE OF HOSPITALIZATIONS WITH A READMISSION WITHIN 30 DAYS OF DISCHARGE



Notes: Analysis excluded County Organized Health System counties, in which only one plan operates. CHG is Community Health Group. After the counties shown, San Diego County had the next greatest difference in readmission rates for SPD enrollees, and Los Angeles County the next greatest difference for other enrollees.

Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (report created June 4, 2013). All cause readmissions rates for 2012 (dates of service in CY 2011).

Service Use

Health plans' hospital readmission rates varied the most in Los Angeles, Sacramento, and San Diego Counties — for children and adults without disabilities (non-SPDs), and for seniors and persons with disabilities (SPDs). High readmission rates may indicate poor care quality.

Overview of Additional Plan Performance Measures

Member Grievances: Health plan members may submit a grievance with their health plan if they have a complaint about how benefits and services were handled or have had services denied or modified. A high grievance rate may indicate that members are not receiving appropriate access to needed services. An important limitation of this measure is that a plan's grievance rate is related to the ease or difficulty of filing a grievance and the processes that plan has to record and report this information. Therefore, a high rate may also be an indication that a health plan has a thorough process for documenting and reporting member grievances, and a low rate may show that members are encountering barriers to filing a grievance.

State Fair-Hearings Requests: Medi-Cal beneficiaries have the right to request a state fair hearing when they have a complaint about how their benefits and services were handled or when they have had services denied or modified. A large number of these requests from members may be an indicator of poor access to care or other problems within that plan. Analysis of data on state fair hearings should also include an analysis of those requests that were upheld or overturned. Such data, however, were unavailable at the time of this report. There is no comparable measure for individuals with private coverage.

Continuity-of-Care Requests: Medi-Cal beneficiaries who are required to transition from fee-for-service Medi-Cal to Medi-Cal managed care may request continued access to an out-of-network provider for 12 months. The volume of these requests is one measure of the health plan's provider network's ability to serve new managed care members who are transitioning from the fee-for-service program. There is no comparable measure for individuals with private coverage.

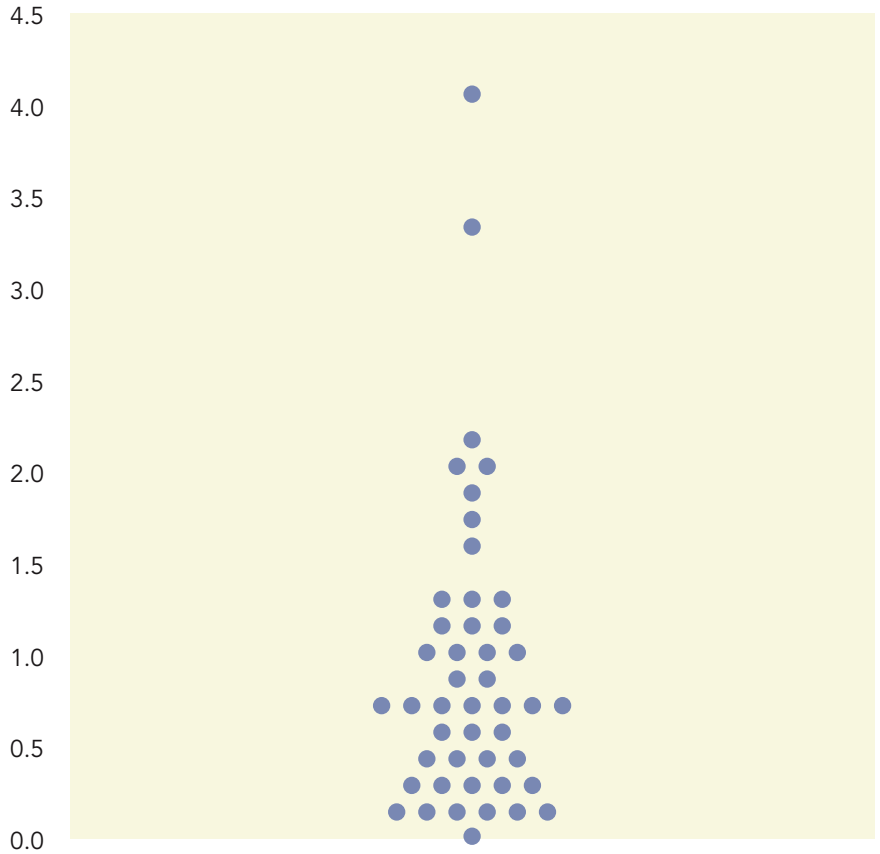
Sources: California Department of Health Care Services (DHCS), Medi-Cal Fair Hearing, www.dhcs.ca.gov. DHCS, Medi-Cal, "Extended Continuity of Care for SPDs Transitioning to Mandatory Managed Care," files.medi-cal.ca.gov.

Other Enrollee Measures

Health plan performance was compared using member grievances, state fair-hearing requests, and continuity-of-care requests. These measures provide additional context on how well a plan is meeting consumer needs.

Grievance Rate Among Plans
January to March 2013

GRIEVANCES PER 1,000 MEMBERS



Notes: Each dot represents one plan. Plan-specific scores are available at www.chcf.org/medical-dashboard. Period shown reflects most recent quarter for which data were available.

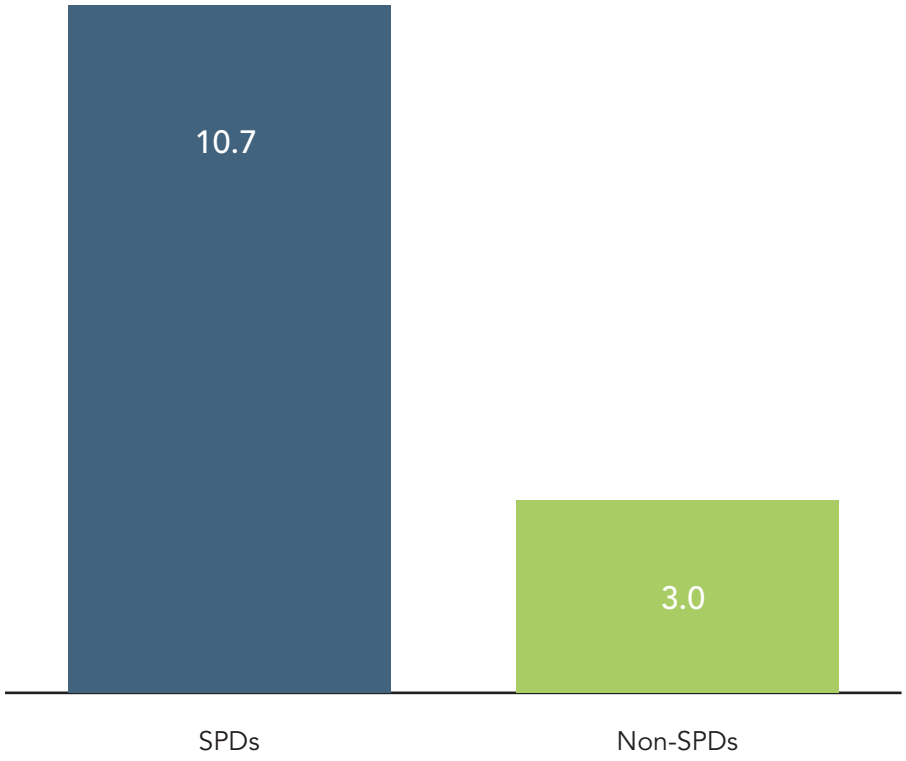
Source: Navigant calculations using data providing by California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (June 26, 2013), including the number of grievances and member months by plan.

Other Enrollee Measures

Member grievance rates varied considerably among plans. Some of this variation may be due to differences in processes for handling member complaints and grievances. Notably, the two plans with the highest grievance rates (Kaiser – Sacramento and Kaiser – San Diego) also had the highest scores for member satisfaction, whereas no grievances were recorded for the plan with the lowest rate (Community Health Group – San Diego).

Health Plan Grievance Rate
by Population, April 2012 to March 2013

GRIEVANCES PER 1,000 MEMBERS



Note: Includes Two-Plan and Geographic Managed Care counties only.

Source: Calculation based on data provided by California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (June 26, 2013), including the number of grievances and member months by plan.

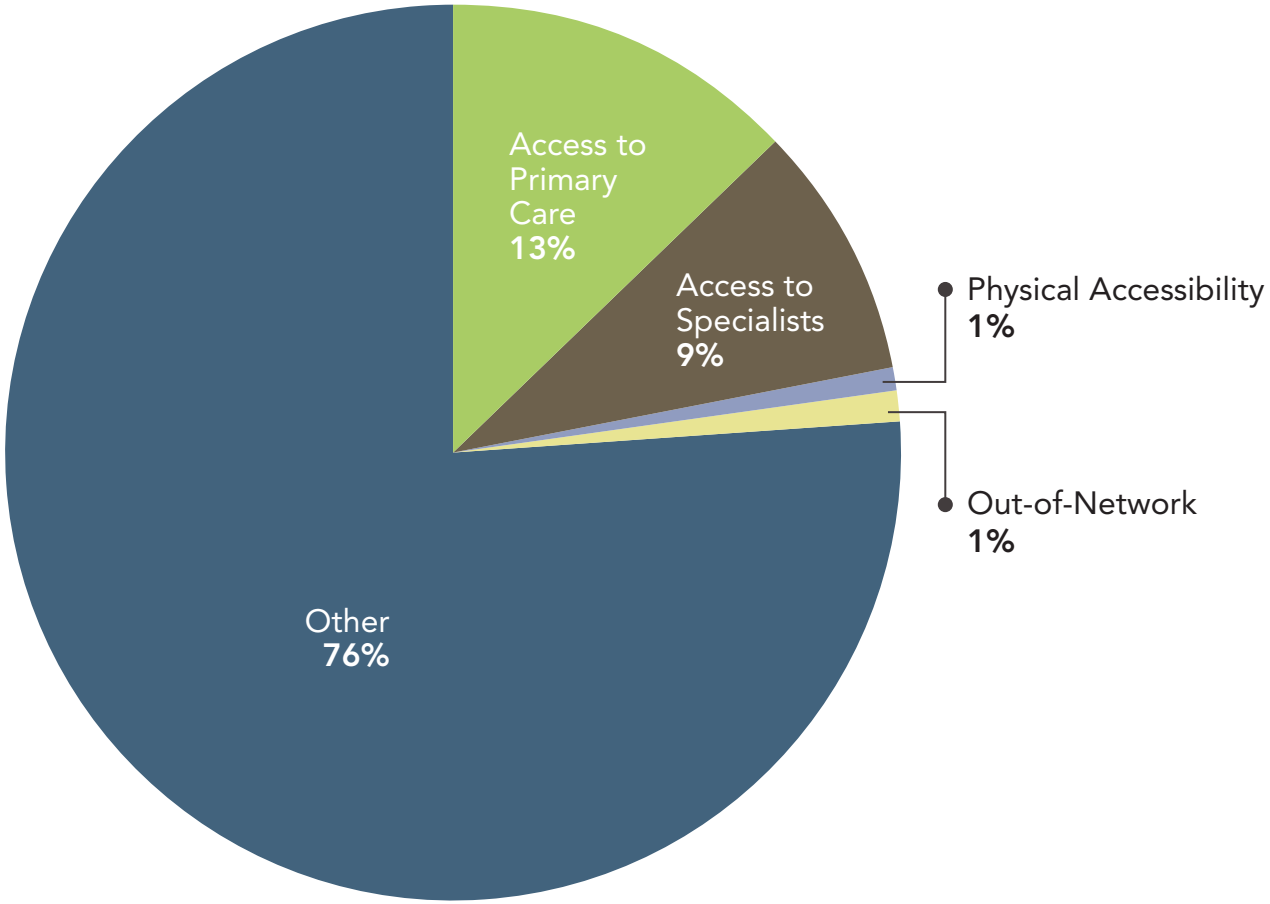
Other Enrollee Measures

The statewide grievance rate among seniors and persons with disabilities (SPDs) was more than three times greater than that of children and adults without disabilities (non-SPDs).

Reasons for Health Plan Grievances

SPDs, 2012

TOTAL: 6,216



Note: Includes Two-Plan and Geographic Managed Care counties only.

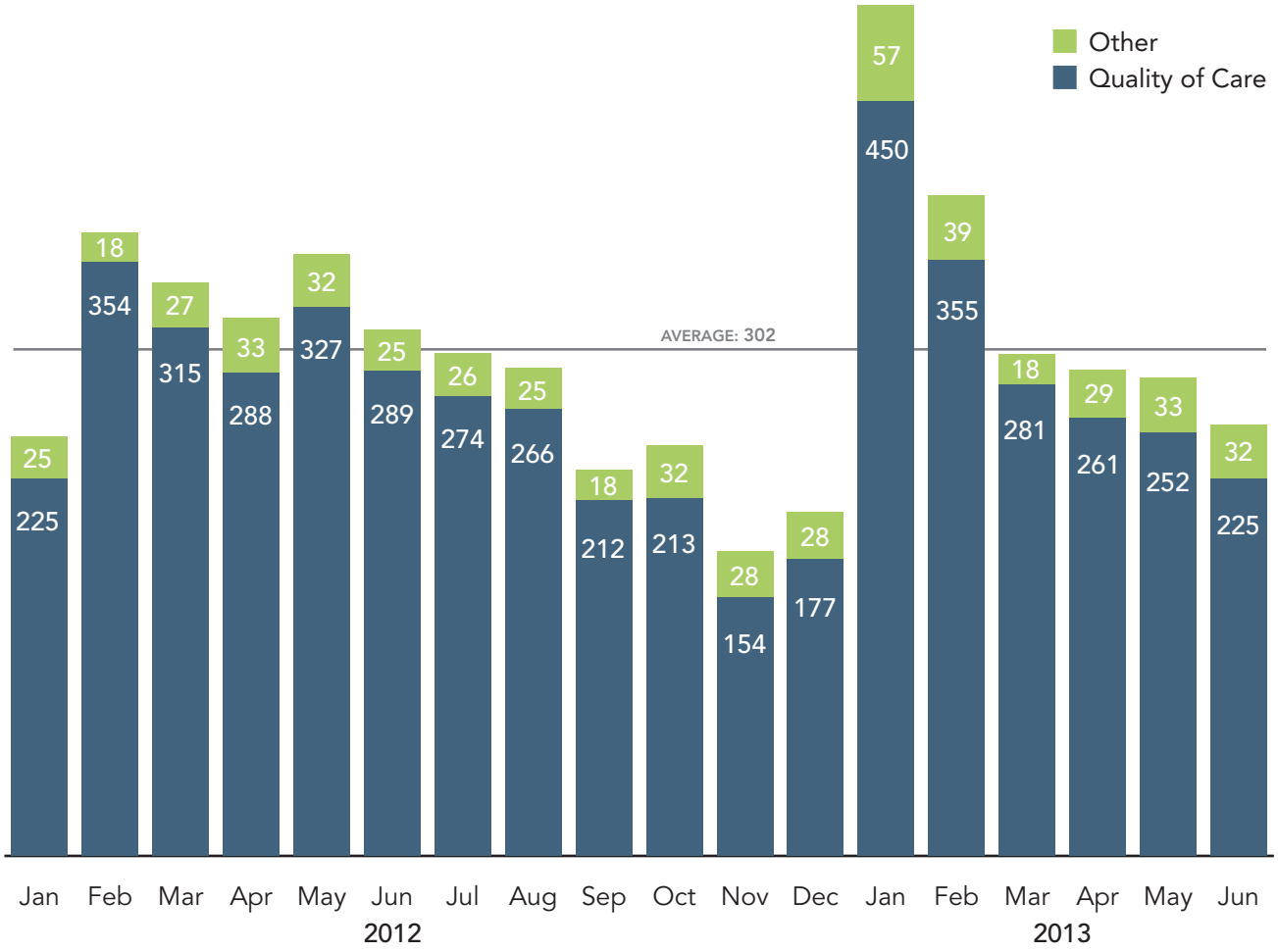
Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (June 12, 2013).

Other Enrollee Measures

Just over 6,200 health plan grievances were filed in 2012 by seniors and persons with disabilities (SPDs) with Medi-Cal. Of the grievances filed, 76% were categorized as "other," for which there is no additional explanation. To better understand generalizable or systemic causes of grievances, this categorization needs to be made more transparent.

State Fair-Hearing Requests, by Reason

January 2012 to June 2013



Notes: Other includes the following categories: health care plan issues, plan subcontractor/provider issues, continuity of care, eligibility, enrollment/disenrollment, other health coverage, and miscellaneous. Quality of Care encompasses complaints related to delays or denials of service, other service disputes, and the outcomes of medical exemption requests.

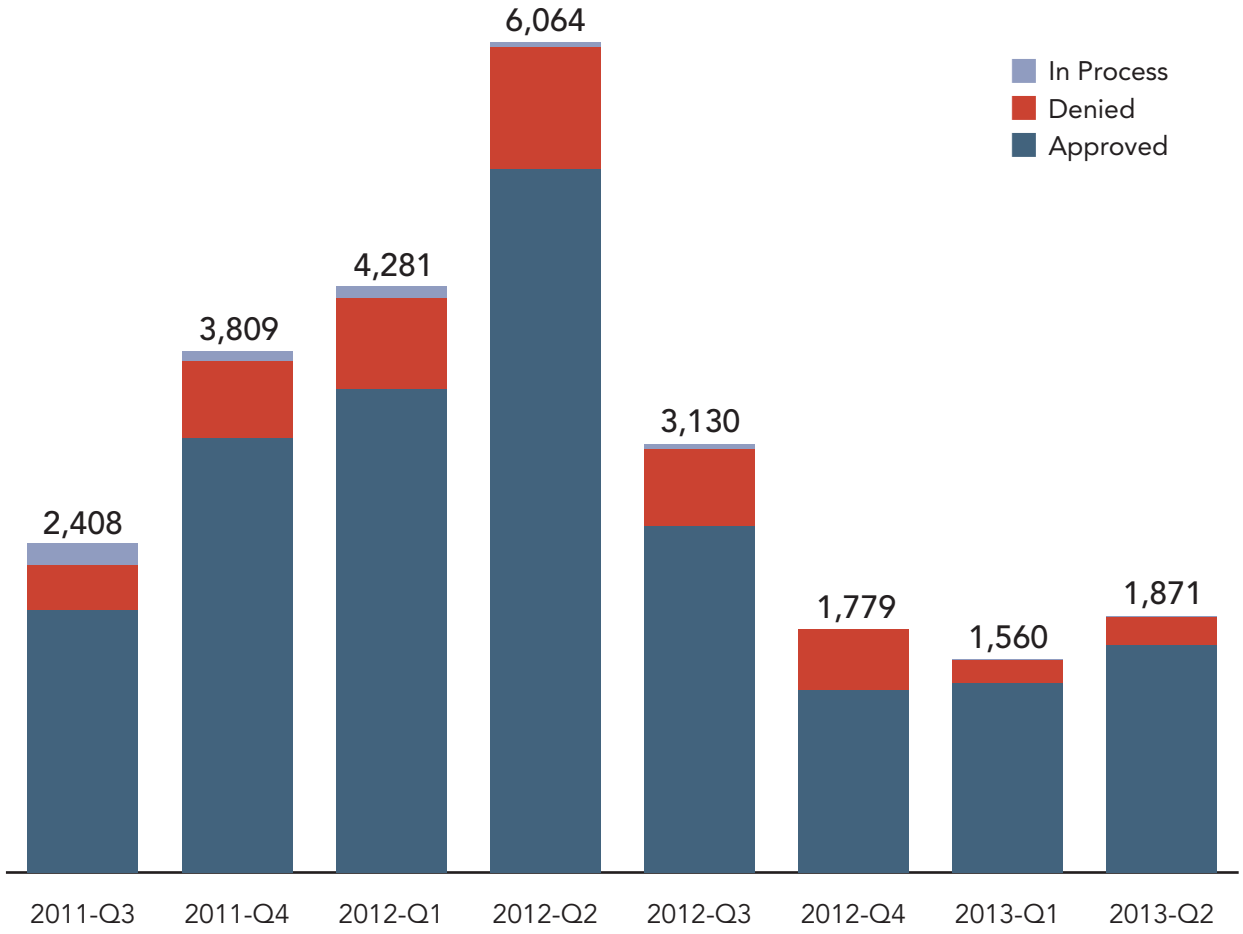
Source: California Department of Health Care Services (DHCS) Medi-Cal Managed Care Division (report created September 16, 2013), Ombudsman Fair Hearings by Reason Category, January 2012 to June 2013.

Other Enrollee Measures

Managed care enrollees may request a state fair hearing if they have a complaint about their health plan; these requests most commonly relate to care quality. The number of hearing requests spiked at the beginning of 2013 and declined in the months since then.

Continuity-of-Care Requests by SPDs

October 2011 to June 2013



Notes: Includes Two-Plan and Geographic Managed Care counties only. The volume of continuity-of-care requests is a measure of ability of the plan's provider network to serve this population of new managed care members.

Source: California Department of Health Care Services (DHCS), Managed Care Implementation for Seniors and Persons with Disabilities Monitoring Dashboard, September 2012 (2011-Q3 to 2012-Q2) and augmented November 2013 (2012-Q3 to 2013-Q2).

Other Enrollee Measures

Continuity-of-care requests from seniors and persons with disabilities (SPDs) rose dramatically from July 2011 through June 2012, coinciding with the phase-in of mandatory managed care for this population from June 2011 to May 2012. The number of these requests declined considerably after the second quarter of 2012, and in the first half of 2013, nearly 90% of requests had been approved.

Overview of Financial Performance Measures

Knox Keene–licensed health plans are required to report specific financial measures to the Department of Managed Health Care. Since these financial data are reported across all lines of business, including Medi-Cal, Medicare, commercial, and others, they provide a picture of a health plan's overall financial condition. The measures included in this report are:

- **Net Income/Loss:** Health plans with cumulative net losses of income over the most recent eight quarters were identified.
- **Medical Loss Ratio (MLR):** MLR reflects the percentage of a health plan's premium revenue that is used to cover medical expenses. Health plans with MLRs above 100% in four of the most recent eight quarters were identified, as were those with MLRs below 85%. A high MLR indicates that the plan is using a larger portion of its customer's premium dollar to cover medical care as opposed to overhead expenses.
- **Current Ratio:** The current ratio, which is calculated by dividing current assets by current liabilities, is a measure of a health plan's ability to pay back its short-term liabilities with its short-term assets. Health plans with current ratios below 1.0 in four of the most recent eight quarters were identified.
- **Tangible Net Equity (TNE):** TNE is total assets less intangible assets and total liabilities. Licensed HMOs in California must comply with a formula-based TNE requirement. Health plans with a TNE below 100% in the most recent quarter were identified.

Note: A Knox-Keene license is granted by the California Department of Managed Health Care (DMHC) to health plans that meet certain minimum standards. This license is required by plans to conduct business in California.

Sources: Mercer Government Human Services Consulting, *The Impact of California's Fiscal Crisis on Medi-Cal Health Plans*, www.chcf.org. DMHC, Plan Tangible Net Equity Requirement, www.dmhc.ca.gov.

Financial Measures

Although a detailed assessment of the financial performance of health plans participating in Medi-Cal is beyond the scope of this study, the four measures included are useful indicators of plans' financial health.

Financial Performance Indicators

July 2011 to June 2013

Medi-Cal Health Plan	Net Income	MLR	Current Ratio	TNE
Alameda Alliance for Health	▼	●	●	▼
Anthem Blue Cross	●	●	●	●
CalOptima	●	●	▼	●
CalViva Health	●	●	●	●
Care 1st	●	●	●	●
CenCal	●	●	●	●
Central California Alliance for Health	●	●	●	●
Community Health Group	▼	●	●	●
Contra Costa Health Plan	●	▼	●	●
Health Net	●	●	●	●
Health Plan of San Joaquin	●	●	●	●
Health Plan of San Mateo	●	●	●	●
Inland Empire Health Plan	●	●	●	●
Kaiser Permanente	●	●	▼	●
Kern Health Systems	▼	▼	●	●
L.A. Care Health Plan	▼	●	●	●
Molina Healthcare of California	▼	●	●	●
Partnership HealthPlan of California	●	●	●	●
San Francisco Health Plan	●	●	●	●
Santa Clara Family Health Plan	●	●	●	●

▼ Fell below indicators
● Met or exceeded indicators

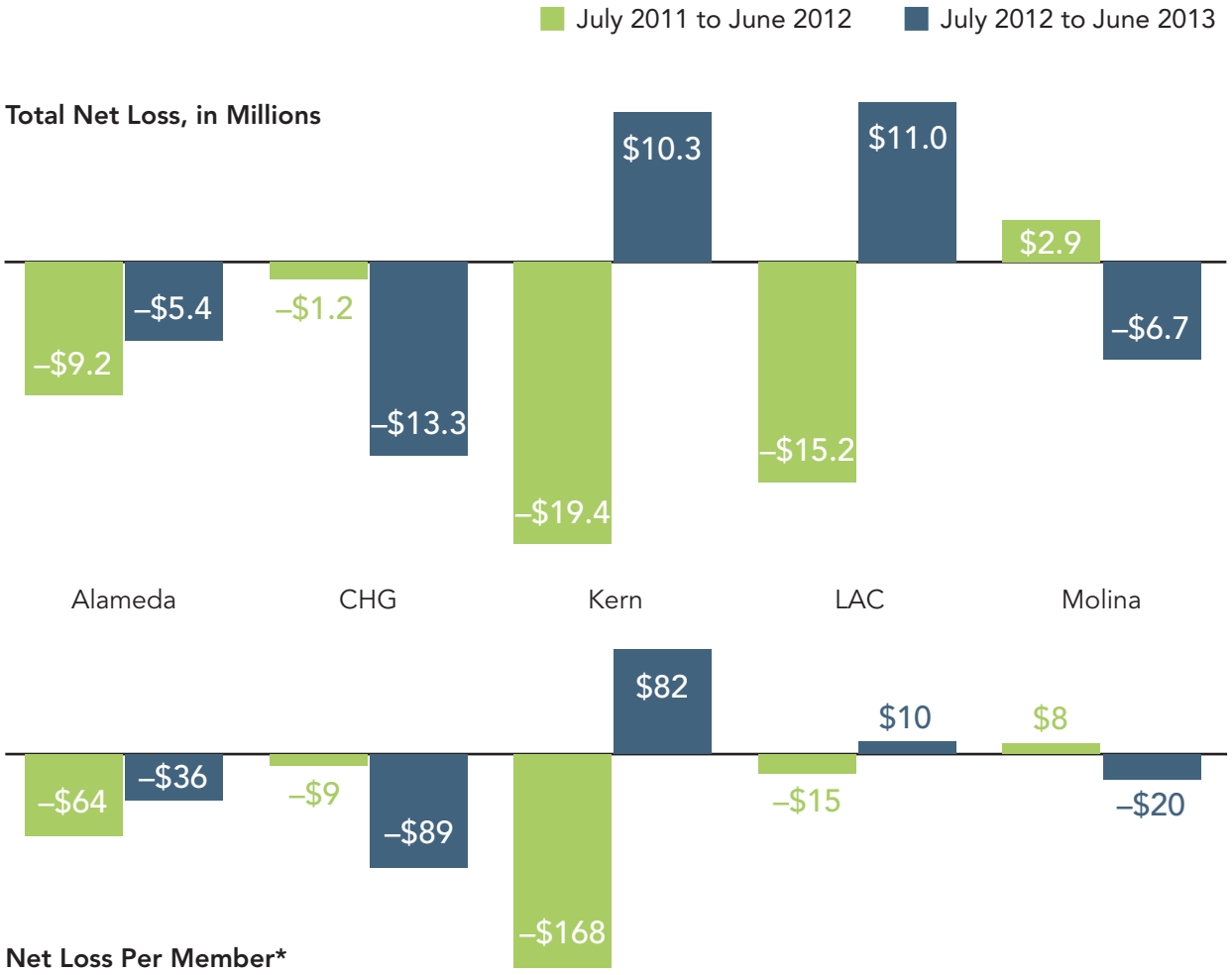
Notes: Net income, medical loss ratio (MLR), and current ratio were examined over eight quarters. Tangible net equity (TNE) was examined over the most recent quarter reported to DMHC, April to June 2013. Red represents a cumulative net loss for the period or a net loss in four of the eight quarters, an MLR below 85% or above 100%, a current ratio less than 1.0 in four of the eight quarters, or TNE below 100%. Gold Coast Health Plan did not report financial information to DMHC during the period examined.

Source: Navigant and California HealthCare Foundation analysis of financial data reported to the California Department of Managed Health Care, "Health Plan Financial Summary Report," wpso.dmhc.ca.gov/flash, accessed October 31, 2013.

Financial Measures

Criteria were established for this dashboard to flag measures of health plan financial performance that warrant further examination. Eight of the 20 health plans with which Medi-Cal contracts met those criteria.

Plans with Net Income Loss
July 2011 to June 2013



*Based on reported enrollment in Q1 (January to March) of 2012 and 2013, respectively.

Note: Alameda is Alameda Alliance for Health, CHG is Community Health Group, and LAC is L.A. Care.

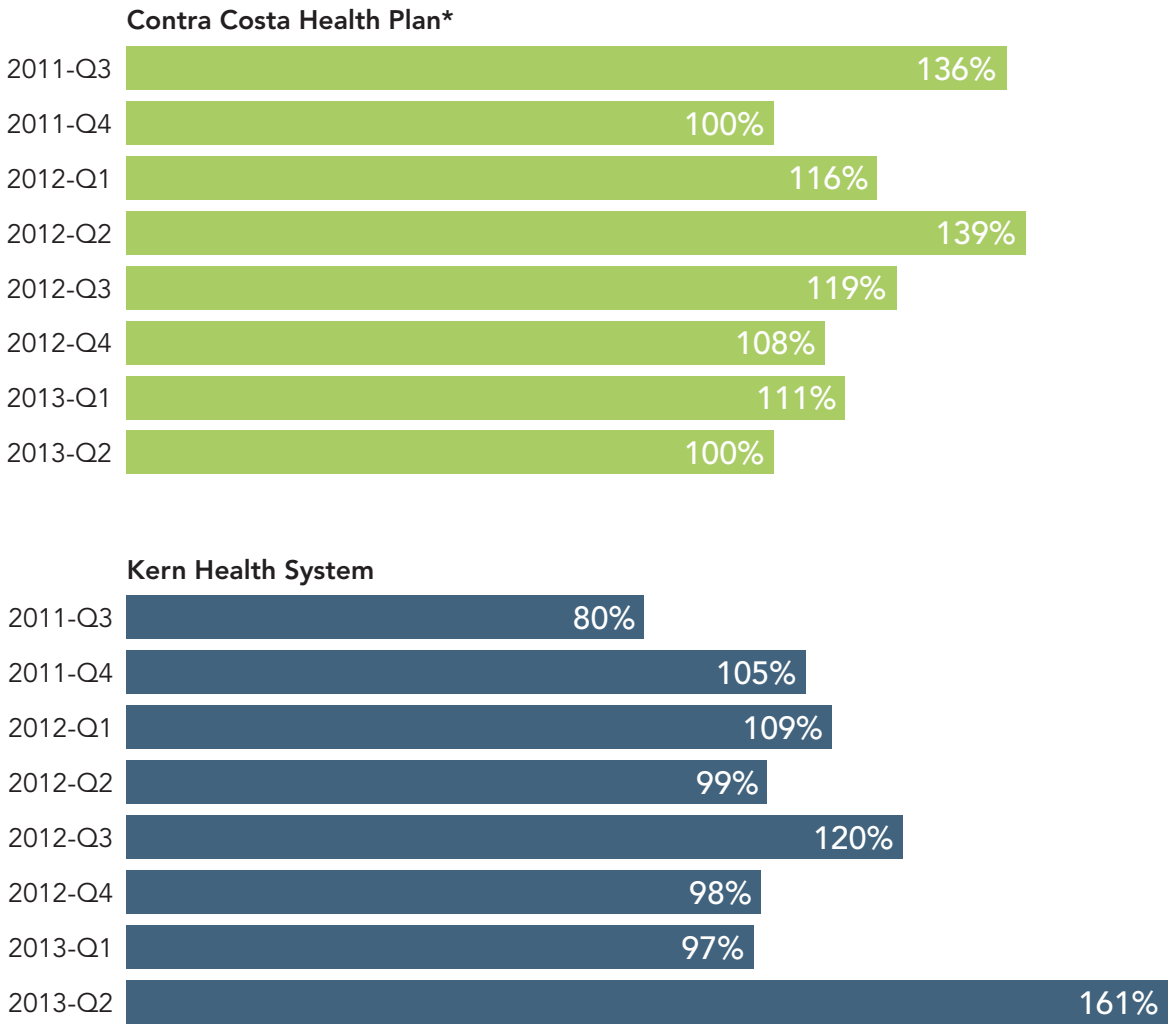
Source: California Department of Managed Health Care, "Health Plan Financial Summary Report," wpso.dmhc.ca.gov/flash, accessed October 31, 2013.

Financial Measures

Five of the 20 plans with which Medi-Cal contracts had a cumulative net loss of income over the past two years. Among these plans, losses on a per-member basis varied significantly.

Plans with High Medical Loss Ratios

July 2011 to June 2013



*Contra Costa Health Plan reports that DMHC has incorrectly excluded certain revenues and that its Medical Loss Ratios were below 100% during period shown.

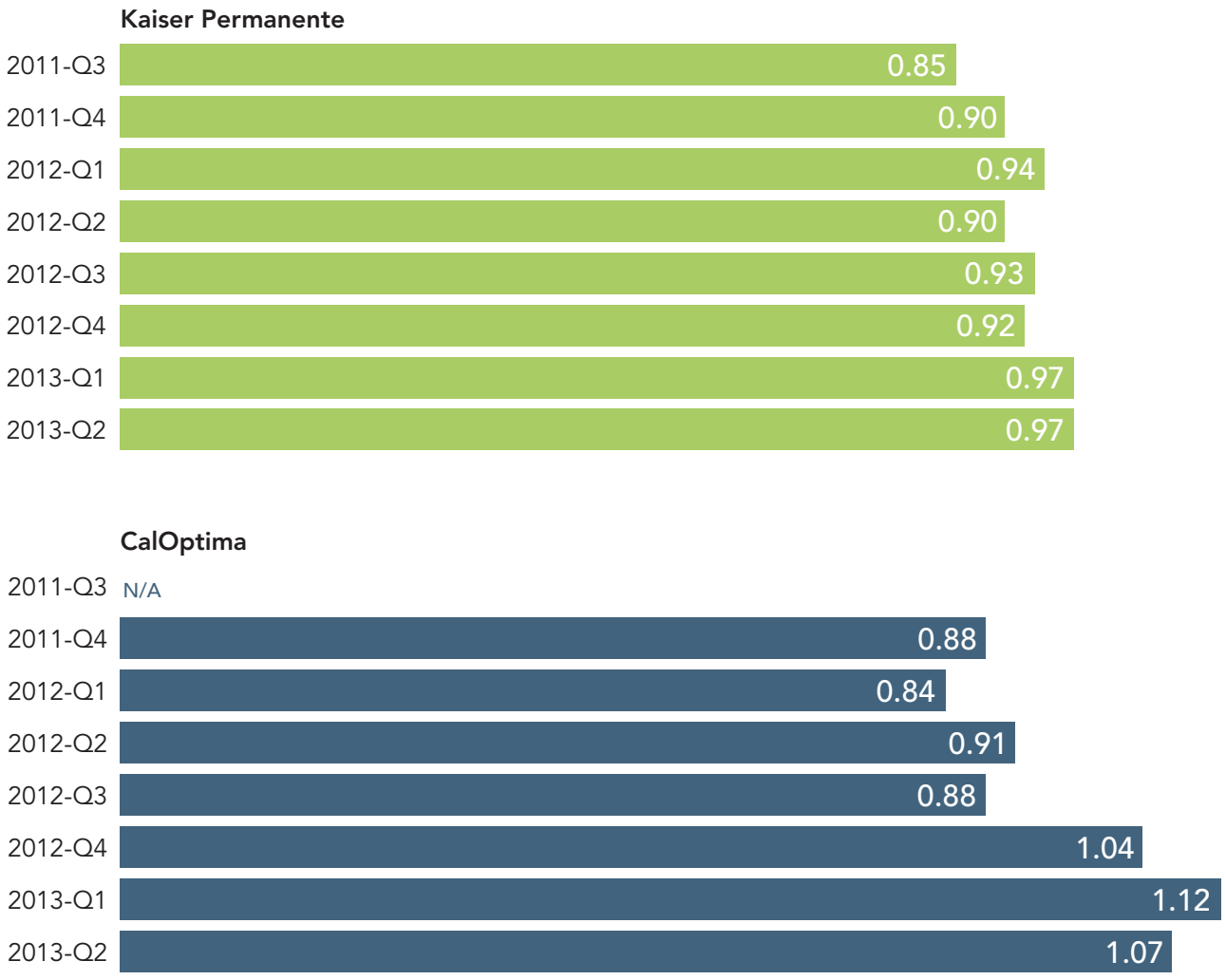
Source: California Department of Managed Health Care, "Health Plan Financial Summary Report," wpso.dmhc.ca.gov/flash, accessed October 31, 2013.

Financial Measures

Two health plans that contract with Medi-Cal had medical loss ratios exceeding 100% for four or more of the eight quarters in the study period. An MLR that exceeds 100% is not sustainable.

Plans with Low Current Ratios

July 2011 to June 2013



Note: Current ratio was not available for CalOptima for Q3 of 2011.

Source: California Department of Managed Health Care, "Health Plan Financial Summary Report," wpso.dmhc.ca.gov/flash, accessed October 31, 2013.

Financial Measures

Two of the health plans that contract with Medi-Cal had current ratios below 1.0 in four or more of the eight quarters of the study period. Both plans, however, performed well on other measures of financial health (not shown). The current ratio is a measure of a health plan's ability to pay back its short-term liabilities with its short-term assets.

Recommendations

This Medi-Cal managed care performance dashboard is a tool for quickly assessing the overall strengths and weaknesses of the program and pointing to areas for further inquiry and monitoring.

To improve the usefulness of this dashboard, the California Department of Health Care Services would need to:

- Establish desired values for each measure so that users can readily determine whether performance meets, exceeds, or falls below expectations.
- Revise data collection and measure reporting methods so that results can be stratified by race/ethnicity and other population subgroups at the plan level (or at the program level, when plan-level stratification is not feasible).
- Administer a consumer experience survey annually.
- Standardize data collection and reporting of self-reported measures across plans, such as member grievances and timely access to care.
- Report results for nationally accepted measures using data the state already has, such as potentially avoidable hospitalizations for ambulatory sensitive conditions, on an annual, or more frequent, basis.
- Add new measures as they are developed and validated, so that the dashboard represents the full range of populations and services covered through Medi-Cal managed care.

Resources

California HealthCare Foundation, *Medi-Cal Facts and Figures: A Program Transforms,* www.chcf.org.

California Department of Health Care Services, Medi-Cal Managed Care — Quality Improvement and Performance Measurement Reports, www.dhcs.ca.gov.

California Department of Managed Health Care, Health Plan Financial Summary Report, www.dmhc.ca.gov

About the Author

This report was prepared with support from Navigant Consulting. Navigant's health care practice assists state Medicaid agencies, health plans, and health systems in the design, implementation, and evaluation of integrated solutions that create high-performing health care organizations.

About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit www.chcf.org.

Appendix A: Medi-Cal Managed Care Enrollment, by Plan, November 2013

Alameda Alliance for Health	152,579
Anthem Blue Cross	458,140
California Health and Wellness	90,204
CalOptima	474,254
CalViva Health	220,566
Care 1st	32,910
CenCal	110,298
Central California Alliance for Health	220,155
Community Health Group	154,499
Contra Costa Health Plan	93,329
Gold Coast Health Plan	121,355
Health Net	887,454
Health Plan of San Mateo	75,540
Heath Plan of San Joaquin	190,368
Inland Empire Health Plan	648,667
Kaiser Permanente	71,767
Kern Health Systems	133,368
L.A. Care Health Plan	1,168,192
Molina Healthcare of California	255,858
Partnership Health Plan	340,054
San Francisco Health Plan	69,031
Santa Clara Family Health Plan	152,293
Total	**6,120,881**

Source: California Department of Health Care Services, Medi-Cal Managed Care Enrollment Reports (November 2013), www.dhcs.ca.gov.

Appendix B: Additional HEDIS Measures

For 2012, health plans reported 11 measures which were not measured against national Medicaid benchmarks.

These include:

- Outpatient visits
- Emergency department visits
- Monitoring of patients on persistent medications: ACE Inhibitors or ARBs
- Monitoring of patients on persistent medications: Digoxin
- Monitoring of patients on persistent medications: diuretics
- Children 12 to 24 months who had a visit with a PCP
- Children 25 months to 6 years who had a visit with a PCP
- Children 7 to 11 years who had a visit with a PCP during the measurement year or the year prior to the measurement year
- Adolescent 12 to 19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year
- Immunizations for adolescents — combination 1
- All-cause readmissions