From the CEO

Understanding Medi-Cal Managed Care Plans and Payments

By Barbara Baldwin, M.P.H.

Many CSA members have expressed confusion when they try to understand the characteristics of Medi-Cal Managed Care plans and their rights to negotiate and to receive payments greater than those under the Medi-Cal fee schedule. Because the federal government has determined that cost containment in health care delivery is best achieved through managed care, the Medi-Cal program has developed an expanding array of managed care systems. Currently, about half of the estimated 6.6 million Medi-Cal beneficiaries receive their health care under a Medi-Cal Managed Care (MMC) plan and processes are in play to expand to 13 additional counties.

California has a unique system in that counties may choose one of three types of plans that provide flexibility to meet the local needs of the 22 counties currently participating in MMC. The existing models are County Organized Health Systems (COHS), Geographic Managed Care (GMC), and Two Plan models, each with its own features and requirements. The characteristics, requirements and differences among the plans can be confusing and are made more complex by the practice of some commercial health plans to subcontract for certain services. A summary of significant features of each model follows.

County Organized Health System

Beneficiaries: 565,027. Enrollment is mandatory for nearly all who are eligible for Medi-Cal, including aged, blind, and disabled.
Characteristics: Unique to California; a single, publicly run plan. COHS counties negotiate contracts with the California Medical Assistance Commission (CMAC) and are paid a capitated rate, which is confidential.
Physician participation: Direct contracting with COHS. Primary care physicians receive capitation, specialists primarily paid on fee-for-service basis.
Knox-Keene: Plans not required to comply with Knox-Keene requirements, except for portions of business including Healthy Families (Health Plan of San Mateo voluntarily licensed under K-K).
Geographic coverage: Eight counties—Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano, Yolo.

Health care delivery system: Five plans—Partnership Health Plan of California (Napa, Solano and Yolo), Health Plan of San Mateo, Central Coast Alliance for Health (Santa Cruz, Monterey), Santa Barbara Health Initiative, Cal Optima (Orange).

Geographic Managed Care

Beneficiaries: 334,668. Enrollment mandatory for family eligibility category; aged, blind, and disabled can opt for fee-for-service coverage.
Characteristics: Most common model in other states. CMAC negotiates contracts with a number of commercial managed care plans in specific geographic regions. Capitation rates are negotiated by CMAC and are confidential.
Physician participation: Contract with commercial health plans separate from any contract they have with the payer for private patients.
Knox-Keene: Licensed Knox-Keene plans must comply with requirements.
Geographic coverage: Two counties—Sacramento and San Diego.
Health care delivery system: Seven commercial health plans—Sacramento and San Diego—Blue Cross of California Partnership Plan, Inc. (Blue Cross); Care1st Partner Plan, LLC (Care1st); Health Net Community Solutions, Inc. (Health Net); KP Cal, LLC (Kaiser); Molina Healthcare of California Partner Plan, Inc. (Molina). Sacramento—Western Health Advantage Community Health Plan (WHA); San Diego—Community Health Group Partnership Plan, Inc. (CHG).

Two Plan

Beneficiaries: 2.35 million. Enrollment mandatory for family eligibility category; aged, blind, and disabled may opt for fee-for-service coverage.
Characteristics: Two health plans in each county—one commercial and one local initiative. DHCS Medi-Cal Managed Care Division oversees program compliance and contracts on a competitive bid basis for the commercial plan in each county. The local initiative is determined by the County Board of Supervisors. Capitation rates for 2007 for the Two-plan counties are available on the Medi-Cal Web Site.
http://www.dhs.ca.gov/mcs/mcmcd/PDF/Reports/Rates/20070207_2Plan_Rate_Manual.pdf
Physician participation: Providers subcontract with the managed care plans to participate in their provider networks.
Knox-Keene: Local initiatives and licensed Knox-Keene plans must comply with requirements.
Geographic coverage: 12 counties—Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

Health Care delivery system: Each county has a commercial health plan and a local initiative (Medi-Cal managed care plan sponsored by county governments). 10 local initiatives—Alameda Alliance for Health, Contra Costa Health Plan, Health Plan of San Joaquin, Inland Empire Health Plan, Santa Clara Family Health Plan, Kern Family Health Care, LA Care Health Plan, San Francisco Health Plan. Stanislaus and Tulare designated Blue Cross as their local initiatives.
Three commercial health plans: Blue Cross of California Partnership Plan (Alameda, Contra Costa, San Francisco, San Joaquin, Santa Clara); Health Net Community Solutions (Fresno, Kern, L.A., Stanislaus, Tulare); Molina Healthcare of California Partner Plan, Inc. (Riverside and San Bernardino).

Rules governing physician payments

COHS MMC plans operate under federal waivers that grant substantial flexibility to the state and the plans to creatively design service delivery systems. GMC and Two-Plan MMC plans operate under a State Plan Amendment. Each plan has the responsibility of maintaining an adequate network of providers and is permitted to negotiate payment rates with providers for nonemergency services. Under the Federal Deficit Reduction Act of 2005, payment for emergency services provided by noncontracting physicians is limited to the amount that would be paid under Medi-Cal fee-for-service.

Under each MMC plan model, a health plan may have a variety of payment/compensation arrangements with the various providers in its network. Specialist services are treated just as all other nonemergency services. Physicians can negotiate with plans for higher rates for nonemergency services and some anesthesia groups have been successful in negotiating rates higher than standard Medi-Cal. Other plans pay Medi-Cal rates to anesthesiologists who have little bargaining power, except to refuse to accept Medi-Cal patients for nonemergency care. A decision to pursue that course has obvious pitfalls in terms of relationships with hospitals and the community.

Noncontracting anesthesiologists who want to negotiate specific claims with the MMC plans operating in their counties of practice must do so at the local level. However, because obstetrical care by definition is an emergency service paid at the fee-for-service rate, a large portion of services provided may not fall under any negotiated rates. For those who wish to contact their local MMC plans, a list of all plans, and contact information is on the DHCS Web Site at **http://www.dhs.ca.gov/mcs/mcmcd/htm/MedicalManagedCareHealthPlans.htm.**

Some members have contacted the CSA to learn whether the state or federal government can intervene to enable them to have more clout in negotiating for payments. The most common claim is that the plans in their counties are not complying with Knox-Keene requirements for a complete panel of physicians. Although all are required to maintain adequate access, the COHS and local initiatives are not bound by Knox-Keene regulations. The federal waivers grant broad discretion and the state has the authority to deem that access is adequate based on the plans' encounter reports.

Despite the strains on the state budget and the Medi-Cal system in California, on August 24 the governor approved an increase of $108 million to Medi-Cal Managed Care plans in the new fiscal year. This is a reduction of almost half of the original allocation. The amount was approved "to fund rate increases for plans to ensure adequate access to care for low-income Californians." What remained unspoken was the absence of an increase to physicians who treat the three-plus million Medi-Cal patients whose services are paid on a fee-for-service basis.

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Managed Care Models, by County