



A Close Look at Medi-Cal Managed Care: Statewide Quality Trends from the Last Decade

In the 1970s, California was the first state to introduce Medicaid managed care.¹ It is now mandatory in 57 of 58 counties for most Medi-Cal enrollees. In 2018, approximately 10.4 million (80%) of Medi-Cal enrollees received services through one of 22 insurers who provided managed care plans (MCPs) specific to the counties in which they operated.

This report examines the performance of Medi-Cal MCPs over the past decade in quality of care provided to members. In addition to reporting on overall trends in performance, this report also examines differences by type of MCP ownership (public, nonprofit, for-profit) and model of managed care (County Organized Health System, Two-Plan Model, and a few different models of competing commercial MCPs). These are described below in greater detail.

This analysis comes at an important time. First, California's newly elected governor has expressed interest in the quality of care for Medi-Cal enrollees, particularly after the state's auditor found that millions of children enrolled in Medi-Cal aren't receiving the basic preventive health checkups required by the program. Second, the California Department of Health Care Services (DHCS), which runs the Medi-Cal program and oversees quality of care for Medi-Cal enrollees, is preparing to launch a competitive procurement process to determine which for-profit and nonprofit commercial MCPs the state will contract with in the future to deliver Medi-Cal managed care services. Third, the federal government recently updated regulations requiring states to improve how Medicaid programs hold MCPs accountable for their performance.

Data sources. This report draws primarily from two sources of public information provided by DHCS on the quality of care provided to its members: the Healthcare Effectiveness Data and Information Set (HEDIS), a set of standardized quality measures established by the National Committee for Quality Assurance, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), a survey designed to capture patients' satisfaction with their health care. This report examines 41 quality measure: 35 from HEDIS and 6 from CAHPS.

Key Findings

- ▶ **From 2009 to 2018, quality of care in Medi-Cal managed care was stagnant at best on most measures.** Among 41 quality measures collected in two or more years, more than half (59%) remained unchanged or declined. The picture looks only slightly better when limited to the 31 quality measures still collected by DHCS. Of those, 52% remained unchanged or declined. Specifically, quality of care significantly declined for Medi-Cal enrollees on 4 measures and was unchanged on 12 measures. There was significant quality improvement on 15 measures.
- ▶ **While declines in quality in some cases were relatively small on a percentage basis, the clinical significance in all cases could be interpreted as substantial, given the size of the impacted population.** The same is true for observed improvements in quality.
- ▶ **Three of the four current measures that declined over time were related to the care of children.** Six of the nine quality measures currently in use that are

1. Margaret Tatar, Julia Paradise, and Rachel Garfield, "Medi-Cal Managed Care: An Overview and Key Issues," KFF (Kaiser Family Foundation), March 2, 2016, www.kff.org.

related to children declined or stayed the same; there was improvement in only three of these measures.

- ▶ **Medi-Cal enrollees' rating of their experiences with their MCP were consistently below the 50th percentile nationally.** The only CAHPS measure that improved significantly over time was the one that asked enrollees to rate how well doctors communicate.
- ▶ **Medi-Cal MCPs' quality scores varied markedly within and across MCPs by ownership during the past decade.** Most striking was the substantially lower quality scores of the for-profit MCPs, on average, relative to the nonprofit and public MCPs. These differences in quality scores by MCP ownership were not explained by observed demographic differences or the physician supply in the counties in which they were operating.
- ▶ **While there was variation of MCP performance within each of the Medi-Cal managed care models, counties that rely on a single public MCP (County Organized Health Systems) had on average better quality scores than counties that furnish Medi-Cal services through either a Two-Plan or competing commercial model.** This remained the case after adjusting county demographics and physician supply, and was even true for the quality measures used as the basis for the enrollment-based "auto-assignment" incentive in counties with competing MCPs.

Opportunities for Improvement

The collection and reporting of data by DHCS has been helpful for monitoring access and quality but has been insufficient for ensuring accountability and driving consistent improvements over time. With this in mind, California lawmakers and DHCS should consider the following actions:

- ▶ **Establish specific, measurable, and time-bound quality-improvement targets for each MCP and for the Medi-Cal managed care program as a whole.**
- ▶ **Establish meaningful financial incentives that are relevant for all its MCPs.** One possibility is the use

of direct financial rewards for achieving improvement targets and direct financial penalties for consistently scoring below specified targets on quality metrics.

- ▶ **Support the capacity of MCPs to make improvements through a collaborative learning process guided by robust comparative data and analysis.**
- ▶ **Incorporate each MCP's performance and improvement over time into contracting decisions, and establish a process for replacing MCPs that don't meet expectations.**
- ▶ **Reconsider the role of for-profit MCPs in furnishing Medi-Cal services, given that their quality for the most part lags behind public and/or nonprofit MCPs.**
- ▶ **Reconsider the role of MCP competition, with input from counties and Medi-Cal enrollees.**

Although offering enrollees a choice of MCPs may be seen as a way to promote value, it is worth considering whether the administrative complexity is justified, given these models for delivering Medi-Cal services achieve lower quality on average than reliance upon a single MCP. Competition among MCPs can also undermine collaboration among MCPs for shared learning.

State officials must take bold steps to further invest in building California's health care delivery system to help ensure that all Medi-Cal enrollees, regardless of where they live, receive timely access to high-quality care. MCPs can be an important part of the solution, but they require additional guidance and support. DHCS could contribute to building MCP capacity to improve quality by working with MCPs to better understand the underlying factors that contribute to high-quality care and by creating a programmatic structure that fosters cooperation rather than competition among its contracted MCPs.

The complete report is available at www.chcf.org/medi-cal-quality.