The Landscape for Improving Medi-Cal Managed Care Beneficiary Care in Sacramento County

Center for Healthcare Policy and Research
University of California, Davis
Joy Melnikow MD, MPH
Patrick S. Romano MD, MPH
Dominique Ritley MPH
January 2019

Acknowledgements

The authors appreciate the valuable and timely assistance from Shauna Durbin, MPH and Meghan Weyrich, MPH of the UC Davis Center for Healthcare Policy and Research and Bruce Abbott, UC Davis medical librarian, in conducting the literature review.

Report cover map of the California managed care county models obtained from Bindman A. A prescription for performance assessment and accountability in Medi-Cal. California Health Care Foundation. May 8, 2018 blog. Available at: https://www.chcf.org/blog/a-prescription-for-performance-assessment-and-accountability-in-medi-cal/.

The Landscape for Improving Medi-Cal Managed Care Beneficiary Care in Sacramento County

Executive Summary

In 1991, AB 337 established the California Managed Care Initiative, the route by which the state and counties developed several distinct Medi-Cal managed care plan models. Of the six managed care models in California today, the Geographic Managed Care (GMC) Pilot Project was the second model developed as an experiment in building a competitive public health insurance marketplace similar to the private insurance market. Sacramento and San Diego County are the only two counties that use this model. Other models (Two-Plan, County Organized Health System, Regional, etc.) limit competition to one or two plans as compared with the GMC model, which provides four to seven plans.

Sacramento County is home to more than 425,000 Medi-Cal beneficiaries. According to the Sacramento County Medi-Cal Managed Care Advisory Committee (composed of advocates, providers, plans) as well as researchers, county beneficiaries and providers face significant challenges due to a complex, confusing system with access problems and performance concerns. Most Sacramento MCMC plans rank near the bottom on quality metrics. Work by CHPR investigators suggests that access to primary care for beneficiaries is significantly worse in Sacramento County than in seven other regional counties. These challenges are compounded by pervasive instability among GMC health plans, independent practice associations and contracted providers, which has impacted beneficiaries' access to care.

This brief provides an overview of the Medi-Cal managed care (MCMC) models and current MCMC landscape in Sacramento, a rapid evidence review of comparative effectiveness studies on model performance and quality of care outcomes, and an overview of the political and administrative context to inform a robust discussion about the need and options for Medi-Cal managed care policy changes in Sacramento County.

Research evaluating access, quality, and outcomes of health care services by the six types of Medi-Cal models is sparse. We found little relevant peer-reviewed literature evaluating the effectiveness of models despite the growth of the MCMC delivery system over 30 years. There is some evidence of better MCMC plan performance in counties with little or no plan competition. The California Health Care Foundation is sponsoring two studies (due March 2019) analyzing the quality of care across MCMC plans and the effectiveness of the GMC model.

Current circumstances offer an opportunity for change in MCMC in Sacramento County, but the political and administrative landscape for changing MCMC administrative models is complex. The most feasible model may be unique to Sacramento County, a "hybrid" model with fewer plans adapted to local conditions. Strategies to address care of higher risk beneficiaries through risk adjustment or regulatory oversight will be a key component. Advocates and beneficiaries would need to be engaged in the conversation. To implement successful change, a coalition of key stakeholders (i.e., the Sacramento County Department of Health, the County Board of Supervisors, Mayor Steinberg, state legislators, health systems, FQHCs, other providers, advocates, and health plans) will need to work with the leadership in the Department of Health Care Services.

Part 1: Landscape of California Medi-Cal Managed Care Model Design and Performance

Medi-Cal Managed Care Model Descriptions

After piloting managed care programs for Medicaid beneficiaries in selected counties in the 1970s and 1980s, California established the California Managed Care Initiative through Assembly Bill 337 (1991). Since that time, California's Medi-Cal Managed Care (MCMC) program has grown from two counties (Sacramento and San Diego) to all 58 counties.[1,2] Each of the 58 counties in California now operates under one of six Medi-Cal managed care delivery models (see Table 1) covering about 10.5 million (81%) beneficiaries (Figure 2).[3,4] Commercial managed care and local initiative plans serving Medi-Cal beneficiaries are required to contract with the Department of Health Care Services (DHCS). In some counties (e.g., Los Angeles and Orange counties), the approved plan(s) or counties subcontract with other plans and many plans delegate risk to physician groups, independent practice associations, FQHC's and hospitals.[5] Each of these models is described below.

County Organized Health Systems (COHS)

Initiated in the 1980s and expanded in the 1990s and 2000s through state legislation and later Congressional action, the County Organized Health Systems model (COHS) enables counties to assume financial risk and negotiate capitation rates. COHS plans are developed by County Boards of Supervisors and administered by an independent commission.[1,6] Plan design incorporates input from local government, health care providers, community groups, and Medi-Cal beneficiaries. Federal law limits the number of COHS and percent of total Medi-Cal enrollment (five COHS plans), although the Medi-Cal 2020 waiver from the federal Centers for Medicare & Medicaid Services (CMS) permitted an expansion to six COHS plans.[7] Some COHS plans are in a single county while others operate in multiple counties. Each COHS plan covers all Medi-Cal beneficiaries within its geographic area. COHS plans operate differently across the state: Santa Barbara Regional Health Authority uses a single plan for its beneficiaries, whereas CalOptima-Orange County operates its own plan while also subcontracting to commercial plans.[8] COHS plans do not require Knox-Keene Act licensure, but do generally follow the law's consumer protection, coverage, and network adequacy requirements.[6] (The Knox-Keene Act is the set of state laws regulating health care service plans, including Health Maintenance Organizations (HMOs), in California).[9] Currently, six plans operate in 22 counties, covering about 20% of all Medi-Cal managed care beneficiaries.[4]

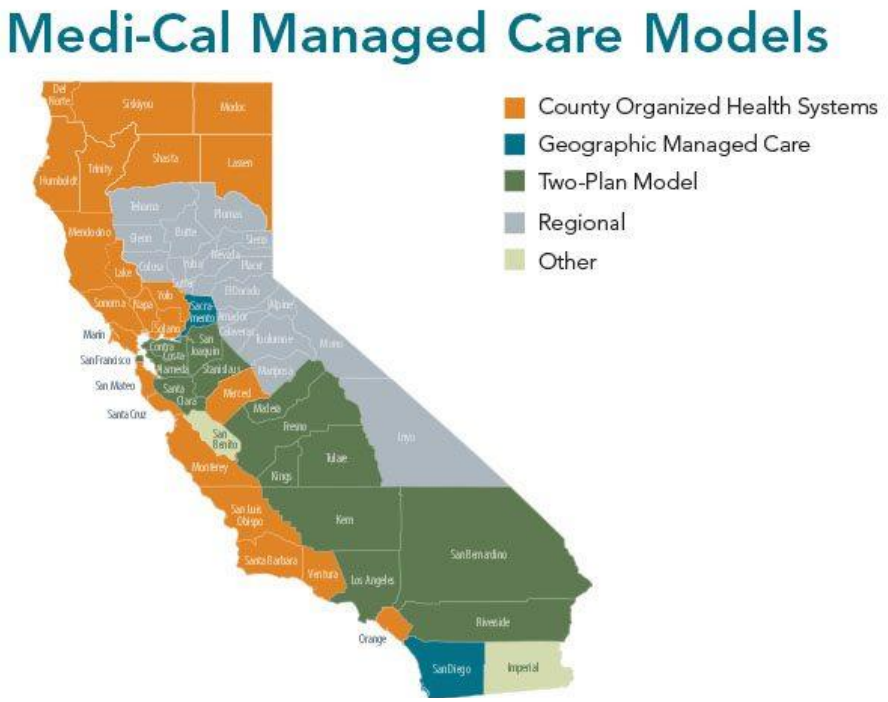
SIX COHS IN 22 COUNTIES

CalOptima (Orange County); • **CenCal Health** (Santa Barbara and San Luis Obispo Counties); • **Central California Alliance for Health** (Santa Cruz, Monterey, and Merced Counties); • **Gold Coast Health Plan** (Ventura County); • **Health Plan of San Mateo** (San Mateo County); • **Partnership HealthPlan of California** (Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Shasta, Siskiyou, Solano, Sonoma, Trinity, and Yolo Counties)

Geographic Managed Care (GMC)

Two counties in California use the Geographic Managed Care (GMC) model, in which multiple commercial Medi-Cal managed care plans are authorized to operate in the same county. The GMC model was established in 1994 in Sacramento County followed by San Diego in 1998.[1] These two counties include approximately 11% of all Medi-Cal managed care beneficiaries.[4] The number of plans contracted to cover these beneficiaries has fluctuated over the years. Currently, five plans provide services in Sacramento and seven plans provide services in San Diego. Enrollees may switch plans at any time (starting in the subsequent month), subject to enrollment caps established by the plans. If no selection is made by the beneficiary within a defined period, he or she is assigned randomly to a plan that is under its cap. Auto assignment is an incentive program sponsored by DHCS that offers plans meeting certain quality standards a greater percentage of non-selecting enrollees.

Figure 1. California Medi-Cal Managed Care Models by County



Source: Bindman A. A Prescription for Performance Assessment and Accountability in Medi-Cal. California Health Care Foundation. May 8, 2018.

Two-Plan

Fourteen counties, generally with the largest Medi-Cal populations, operate under the Two-Plan model. This model, which currently covers about 65% of Medi-Cal beneficiaries, requires one "local initiative" plan, developed by the county, and one Knox-Keene licensed commercial plan. Of the 6,823,513 beneficiaries in these MCMC plans, about 25% are enrolled in commercial plans and 75% are enrolled in county plans.[4] This design preserves the role of traditional safety net providers (including disproportionate share hospitals and county facilities). Los Angeles County is the largest county using this model, offering Health Net (commercial plan) and LA Care (county plan). LA Care subcontracts with Kaiser, Anthem Blue Cross, and Blue Shield to help it manage Los Angeles County's exceptionally large number of beneficiaries.

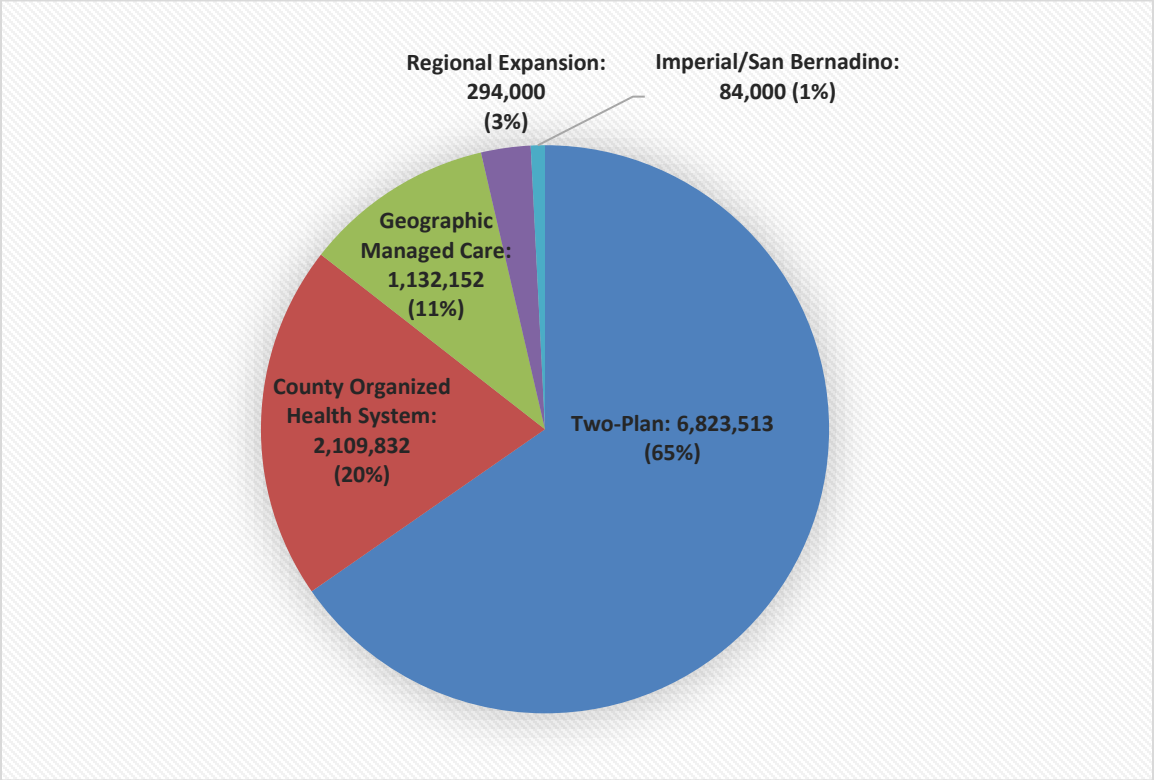
Regional Expansion

The Regional Expansion (now including Imperial and San Benito Counties) is the most recent addition to the MCMC program. This model, started in late 2013, covers 18 rural counties on the eastern side of California and serves about 300,000 Medi-Cal beneficiaries (3%). The California

Department of Health Care Services (DHCS) contracts with two commercial plans over this large geographic region, with the exception of Amador, El Dorado, and Yuba counties. These three counties and DHCS grandfathered in coverage from a third plan, Kaiser Permanente Healthy Families, to ensure continuity of care for children enrolled in that program.[10]

Imperial and **San Benito** counties, the most recent additions to managed care, operate unique Medi-Cal managed care systems that do not follow the requirements of the four models described above: Imperial offers two commercial managed care plans to its 76,000 beneficiaries and San Benito offers its 8,000 beneficiaries[4] a choice between a commercial managed care plan and Medi-Cal fee-for service.[11]

Figure 2. Medi-Cal Managed Care Enrollment by Model Type, December 2018



Source: California Department of Health Care Services. Medi-Cal Managed Care Enrollment Report - December 2018

Table 1. Summary of Medi-Cal Managed Care Characteristics - 2018				
Model Type	**Year Implemented**	**Counties Covered**	**Number (%) of Medi-Cal Beneficiaries[a]**	**Commercial Health Plans**
County Organized Health Systems *Single independent health plan created by County Board of Supervisors and operated by the county. Six health plans cover 22 counties. Federal restrictions exist on number of enrollees in the COHS model.*	1982 –CA statute 1990 – Congressional authorization	**6 COHS serving 22 counties** Monterey, Napa, Orange, San Mateo, Santa Barbara, Santa Cruz, Solano, and Yolo. (*2008 expansion*) Merced, San Luis Obispo, Sonoma (*2011 expansion*) Marin, Mendocino, Ventura *(2012 expansion)* Del Norte, Humboldt, Lake, Lassen, Modoc, Siskiyou, Shasta, Trinity	2,109,832 million (20%)	• None
Geographic Managed Care *Multiple commercial plans contract with DHCS.*	1994; 1998	**2 counties**: Sacramento, San Diego	1,132,152 million (11%)	• Anthem Blue Cross • Health Net • Molina • Aetna Better Health • Kaiser
Two-Plan *County-organized "local initiative" operates under the county and one commercial plan contracts with DHCS.*	1996	**14 counties** Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus and Tulare	6,823,513 million (65%)	• Anthem Blue Cross • Health Net • Molina
Regional *Two commercial plans contract with DHCS. Model exists in primarily rural counties.*	2013	**18 counties**: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba	294,386 (3%)	• Anthem Blue Cross • CA Health & Wellness • Kaiser*
Imperial *Two commercial plans contract with DHCS.*	2013	Imperial	*76,071 (<1%)*	• CA Health & Wellness • Molina
San Benito *One commercial plan contracts with DHCS; Medi-Cal beneficiaries choose between FFS and MC plan.*	2013	San Benito	*8,112 (<1%)*	• Anthem Blue Cross

Source: DHCS. Medi-Cal Managed Care Program Fact Sheet – Managed Care Models. https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf

[a] Data obtained from DHCS. Medi-Cal Managed Care Enrollment Report-December 2018; Tater M, Paradise J, and Garfield R. Medi-Cal Managed Care: An Overview and Key Issues. Kaiser Family Foundation. March 2016; Department of Health Care Services. County Organized Health Systems. Available at: https://www.dhcs.ca.gov/provgovpart/Pages/DR_COHS_Descr03.aspx

*Regional model exception: Kaiser is the third plan offered only in Amador, El Dorado, and Placer counties in addition to Anthem Blue Cross and California Health and Wellness.

Overview of Sacramento County Medi-Cal Managed Care

Sacramento GMC Plans and Providers

The number of contracted plans in Sacramento has fluctuated over time between 4 and 6 plans in any given year. In 2018, five commercial managed care plans covered almost 430,000 Sacramento County Medi-Cal managed care beneficiaries.[4,12] Table 2 shows the distribution of Medi-Cal beneficiaries among participating plans.

Table 2. Distribution of Sacramento County Beneficiaries Among Plans, December 2018

Sacramento County GMC Plans	Plan Enrollment
Aetna Better Health (first contracted in 2018)	4,247
Anthem Blue Cross (first contracted in 1994)	178,516
Health Net (first contracted in 1994)	105,494
Kaiser (first contracted in 1994)	85,651
Molina Healthcare (first contracted in 2000)	54,933

Source: Department of Health Services, Sacramento County. Medi-Cal Managed Care Sacramento Enrollment Data, 2018.

In recent years, Sacramento County's MCMC beneficiaries have experienced significant change in coverage and service provision from contracted plans and providers. To some extent, these changes are a result of the fact that all of the Sacramento County GMC plans, except Kaiser, contract with risk-bearing medical groups or Independent Practice Associations (IPAs), which in turn subcontract with primary care providers and specialists to provide patient care. For example, as of August 2018, River City Medical Group had risk-bearing contracts covering 2,091 enrollees from Aetna, 102,821 from Anthem, 78,508 from HealthNet, and 15,729 from Molina. Nivano Health had contracts covering 429 enrollees from Aetna and 13,627 from Anthem. Hill Physicians Medical Group had contracts covering 318 enrollees from HealthNet, 14,596 from Anthem, and 24,330 from HealthNet. Imperial Health Holdings had one contract covering 13,627 Anthem enrollees, while Golden Shore Medical Group had one contract covering 41,167 Molina enrollees. These arrangements lead to instability and risk shifting at both the plan and IPA/provider group levels with adverse impacts on Sacramento County's MCMC beneficiaries. Unequal distribution of risk is illustrated by the proportion of high-utilizers (top 3%) with 3 or more chronic conditions, which varied in 2017 from 23% in HealthNet and 32% in Kaiser to 56% in Molina, 59% in Anthem, and 84% in United.[13]

Both UC Davis Health and Sutter Health have had unstable relationships with MCMC plans.[14] In 2015, UC Davis Health terminated its Medi-Cal primary care contract with Health Net, though specialty care contracts continued. UC Davis Health contracted with United Healthcare to provide Medi-Cal primary care in 2018, but United Healthcare withdrew from GMC after just 10 months (citing financial concerns), disrupting care for about 4,400 enrollees.[15] In late 2018, UC Davis Health contracted with Health Net to provide full-risk capitated primary care to 5,000 Medi-Cal enrollees. Aetna Better Health replaced United Healthcare as an MCMC plan. Sutter Health terminated its Medi-Cal primary care contract with Anthem Blue Cross in 2017, forcing about 10,000 GMC enrollees to transfer care.[16] In February 2019, Anthem and Sutter

terminated their contract for Med-Cal and Medicare patients enrolled with Anthem, potentially forcing 12,000-20,000 enrollees around northern California to seek new physicians.[17]

Similar turmoil has affected several IPAs serving as intermediaries between plans and providers for Sacramento County Medi-Cal beneficiaries. For example, Nivano Physicians was placed on a corrective action plan by the Department of Managed Health Care (DMHC) due to its failure to meet financial solvency standards.[18] After the CEO, claiming to be the majority shareholder, dismissed all members of the board, appointed new board members, and reappointed himself as CEO,[19] Nivano faced lawsuits and lost contracts with both United HealthCare and Blue Shield. In 2018, Nivano reorganized and transferred its Sacramento County clinics to WellSpace Health.[20] In January 2019, Molina Healthcare's largest contracted provider group, Golden Shore Medical Group, proposed to sell its three local clinics to WellSpace Health as well, affecting about 19,000 patients.[21] This action may be motivated by financial difficulties, according to records at the Department of Managed Health Care, where regulators said Golden Shore was not compliant with solvency criteria and was on a corrective action plan.

Seven FQHCs contract with IPAs and MCMC plans to serve Medi-Cal managed care beneficiaries in the county: One Community Health; ELICA Health Centers; Peach Tree; Sacramento County Health Center; Sacramento Community Clinic (HALO); Sacramento Native American Health Center; and WellSpace Health.[22] As part of a federal demonstration program, MCMC plans are required to contract with willing FQHCs, which are paid at a higher rate than federal Medicaid reimbursement rates. The FQHC payment method links health center payments to the cost of providing covered services to Medicaid patients. [23] If the FQHC is paid less than the cost of care through the MCMC plan, the state must make up the difference. As a result, FQHC's role in providing primary care to GMC enrollees, outside Kaiser, has progressively expanded over the past five years.

Beneficiary Access to Care

Access to primary and specialty care for Medi-Cal patients has been a problem statewide, but seems to be worse in Sacramento than in other counties. According to the 2017 California Health Interview Survey, about 9% of Medi-Cal beneficiaries across California reported difficulty obtaining primary care as compared with 13% of Sacramento beneficiaries. About 30% of Sacramento County Medi-Cal beneficiaries reported difficulty finding specialist care in the last year, which is higher than the state average of 20%.[24] County level statistics are unstable, but statewide, Coffman and Fix reported that the ratio of primary care and specialty care physicians to Medi-Cal beneficiaries in the Sacramento region was about 20%-35% below state and national recommendations (39/100,000 and 63,100,000, respectively).[25] Additionally, physicians reported more difficulty obtaining specialty referrals for Medi-Cal patients (39%) than for privately-insured patients (6%). The most frequently cited reasons for physicians' limiting Medi-Cal patients in a practice were low reimbursement rates, administrative hassles, and delays in payment.

Research by Melnikow et al, using a simulated caller method in 2015, found that in an 8-county region (Solano, Yolo, Yuba, Sutter, Placer, El Dorado, San Joaquin and Sacramento),

Sacramento County had the worst access to new primary care appointments for MCMC beneficiaries in non-Kaiser plans.[26] Only 19% of primary care providers in Sacramento County had an appointment available with any provider within the state-mandated 10-business day requirement for primary care appointments. Accounting for the number of Medi-Cal enrollees needing a primary care provider, Sacramento access to primary care was significantly worse than the regional average. In the same region, emergency room utilization by Medi-Cal enrollees, adjusted for age and gender, was highest in Sacramento County.

MCMC Quality Performance and Patient Experience Metrics

An External Quality Review Organization (Health Services Advisory Group) submits an annual detailed report to DHCS on Medi-Cal managed care plan performance as measured by enrollee access and 18 quality of care measures for each of the MCMC plans contracted with DHCS.[12] These reports do not compare performance on quality measures by model type. However, the 2018 report clearly documents the wide variety of metrics on which GMC plan performance in Sacramento falls below state and national benchmarks. Managed care plans are contractually required to perform at or above the Minimum Performance Levels (MPLs), and to submit corrective action plans when they fall below. Yet in 2017, the most recent reporting year, the Anthem, Health Net, and Molina Sacramento GMC plans fell below the MPL on 7, 11, and 7 HEDIS measures, respectively. All three of these plans fell below the MPL on all age-stratified metrics of children and adolescents' access to primary care practitioners.

The DHCS Medi-Cal Managed Care Performance Monitoring Dashboard reports summary metrics quarterly on beneficiary enrollment, health care utilization, network adequacy, grievances, and health plan quality performance. Figure 3 shows a broad distribution in the *aggregate* quality factor score (a composite of the 18 DHCS-chosen HEDIS measures) among the plans offered in Sacramento. Kaiser (Northern California) met the NCQA (National Committee for Quality Assurance) High Performance Level (100%) while Anthem, Health Net and Molina all fell between 40% (the state's MPL) and 60%, well below the state average of 68%.[27] The December 2017 release of this dashboard further compared grievance rates across plan models.[28] Overall, GMC counties reported 0.9 grievances per 1,000 member months, versus 0.7 for Two-Plan counties, 0.5 for Regional counties, and 0.5 for COHS counties. Grievances were classified as related to quality of care (38%), benefits (13%), access (11%), referrals (9%), and other (29%).

DHCS also publishes the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Medicaid Managed Care Survey Summary Report, which includes survey-based data on enrollee experience for all Medi-Cal Managed Care plans statewide). The most recent report, published in January 2018, presents data from surveys performed in 2016.[29] In the overall enrollee ratings of these plans for adults (Figure 4), one Sacramento GMC plan (Kaiser NorCal) received "top box" ratings from 67% of respondents (above the 90th percentile on NCQA National Benchmarks), whereas Sacramento's Health Net, Molina, and Anthem GMC plans received such ratings from only 37%, 33%, and 32% of respondents, respectively. The last three ratings were well below the 25th percentile National Benchmark, significantly below the Medi-Cal Managed Care statewide average, and among the six worst plan ratings in the entire

state. “Top box” enrollee ratings for children were slightly better at 82% for Kaiser, 56% for Anthem, 55% for Health Net, and 43% for Molina.
In April 2018, the county’s Medi-Cal Managed Care Advisory Committee (composed of advocates, providers, and plans) summarized the challenges to Sacramento County’s Medi-Cal delivery system as follows[30]:

- **COMPLEX**: “Sacramento has 6 health plans, 5 IPAs and 4 hospital systems which add to complexity… Providers must deal with multiple IPAs, health plans with direct contracts, fee-for-service Medi-Cal, MCOs, etc., each with different authorization procedures, different service providers, etc… It is cumbersome for providers and patients. Except for Kaiser, Medi-Cal patients lack integrated care. Medi-Cal patients have unequal treatment vs. commercial patients.”

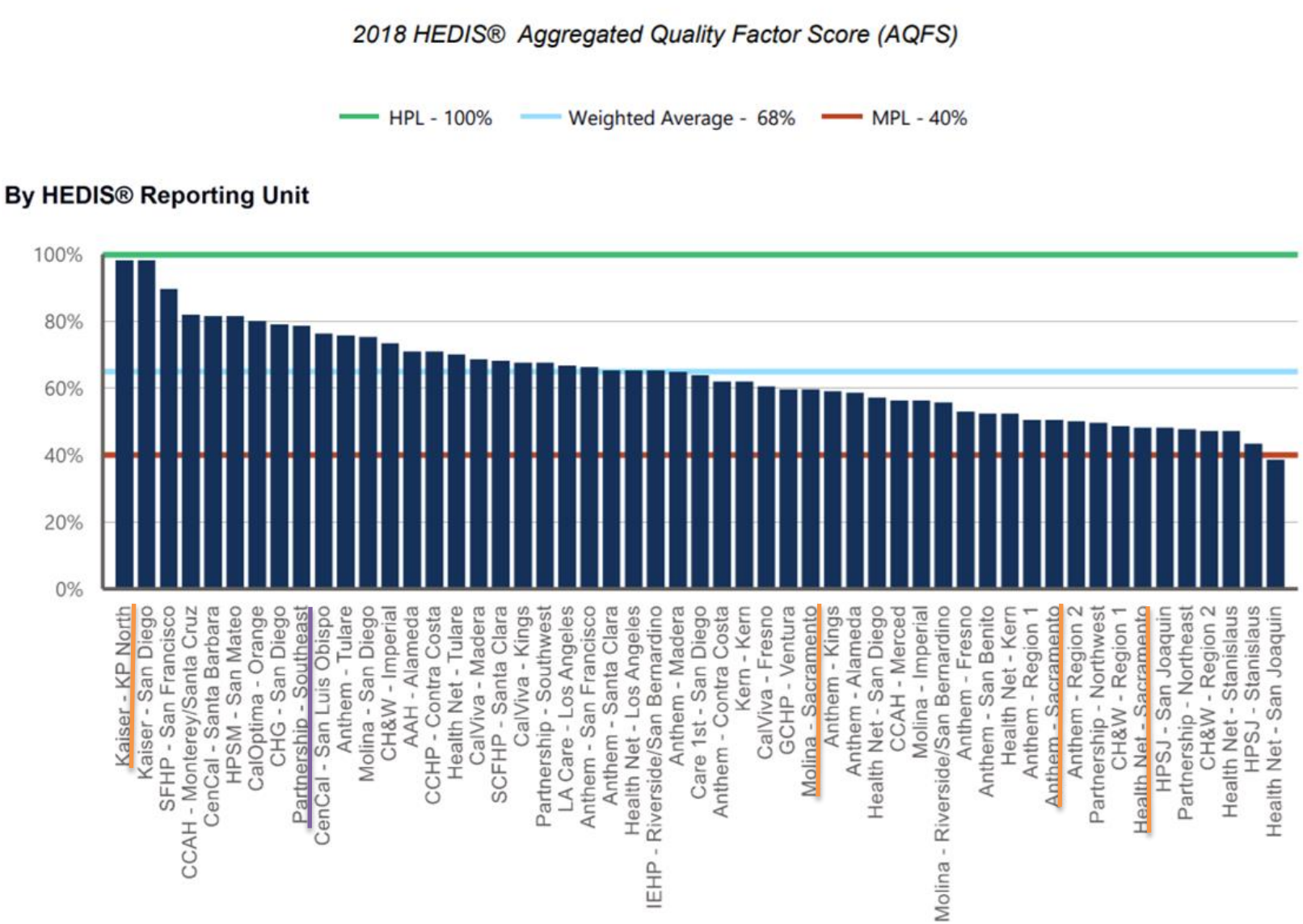
- **CONFUSING**: “Patients don’t know where to go. Typical member who has trouble getting care will turn to the ED… Most Sacramento FQHCs entered the market in the last ten years. The infrastructure was (previously) lacking… Choice is not real… you cannot figure out where to go that will take you… The system is confusing for providers. Time spent on claims payment, navigation (including calls escalated to management to resolve problems), etc. has a cost and takes away from care.”

- **ACCESS ISSUES**: “Specialists unwilling to contract. Many physicians stopped taking Medi-Cal… Private practices (non-FQHC) in Sacramento are becoming system foundation models and do not increase access… State pays each plan differently… Members are unable to get care where they live… Primary care is being provided in the ED. High cost primary care.”

- **LACK OF STANDARDIZATION**: “Multiple ways of doing things based on 6 plans plus 5 IPAs… Difficult for consumers and providers due to multiple access points, services, etc. Unclear how to access services, how to coordinate, and what are the criteria for approval… Labs do not always verify who the patient is enrolled with… Lack of data sharing.”

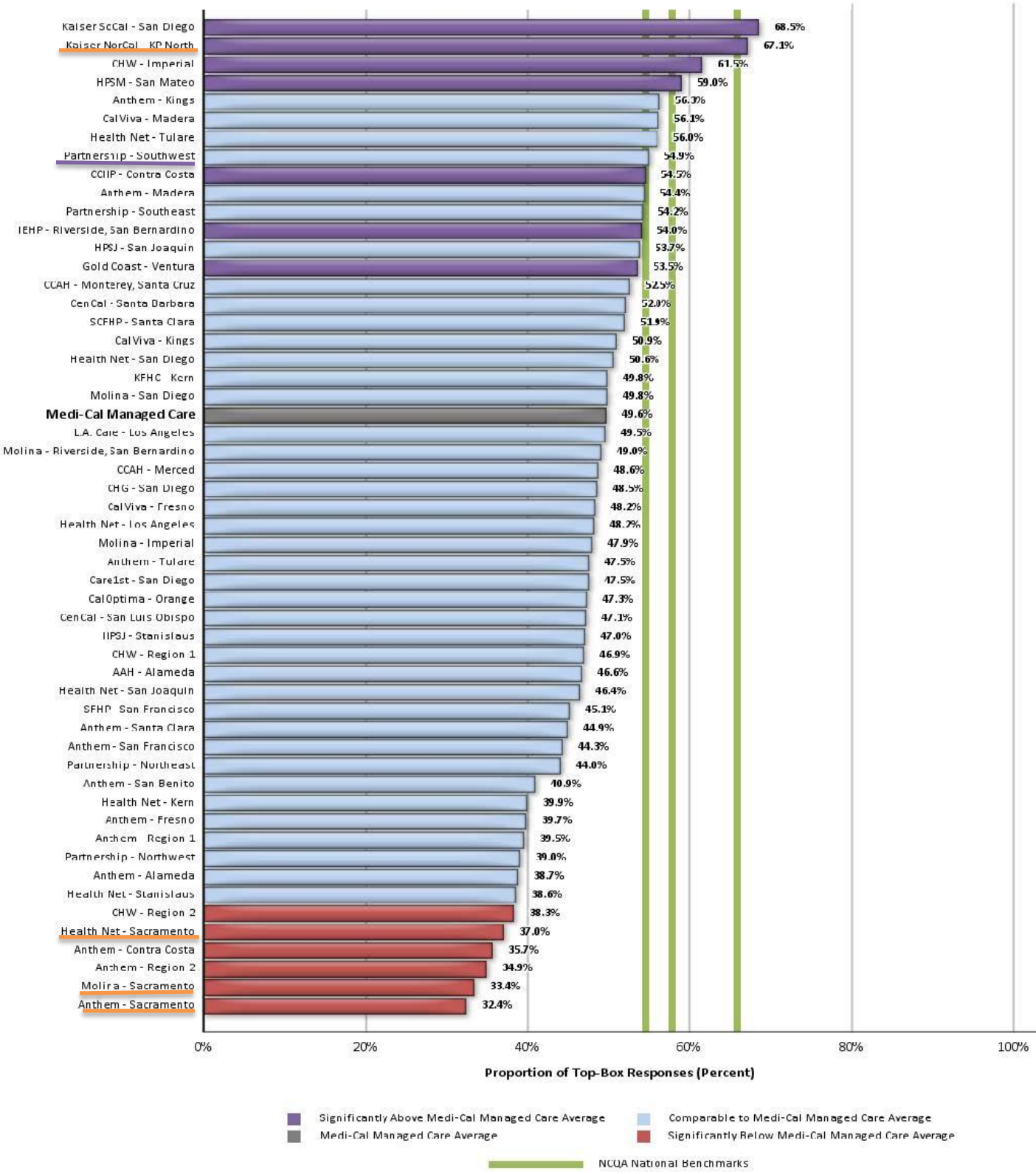
- **PERFORMANCE CONCERNS**: “Sacramento has relatively low quality / HEDIS scores.”

Figure 3. Managed Care Performance Monitoring Dashboard Report Released December 19, 2018



Source: California Department of Health Care Services. Managed Care Performance Monitoring Dashboard Report. December 19, 2018.

Figure 4. Adult Enrollee Experience Ratings of Health Plans, Top-Box Ratings



Source: California Department of Health Care Services. 2016 CAHPS Medicaid Managed Care Survey Summary Report. January 2018.

Literature Review

We searched both peer-reviewed and grey literature to identify studies that compared Medi-Cal models by relevant outcomes, including patient health outcomes, access, and health care quality.[a] Our search yielded 80 unique peer-reviewed references published between 1985 and 2018; however, none reported on the relevant outcomes noted above. Most studies compared the aggregate Medi-Cal Managed Care to the Fee-For-Service Model, or compared specific Medi-Cal managed care plans (e.g., Blue Cross vs. Molina vs. Health Net). Many of these managed care plans provide coverage in multiple counties with different models; thus, the data could not be aggregated to the model or county level. Other studies presented statewide-, regional-, or county-based analyses of all Medi-Cal enrollees, without specific inclusion criteria or stratification based on model type or type of enrollee (FFS or managed care).

The California Health Care Foundation commissioned several studies, due March 2019, to evaluate performance differences by MCMC models and plans. Specifically, *Experience with Geographic Managed Care* will examine the experience of Medi-Cal managed care in Sacramento and San Diego counties based on data from HEDIS, CAHPS, network adequacy and the California Health Interview Survey -- these metrics will be compared with results for similarly-sized urban counties with other models of managed care. *Trends in Quality and Patient Experience in Medi-Cal Managed Care* will examine HEDIS and CAHPS scores since 2008 to examine trends over time and variation among Medi-Cal models and plans.

We identified a single peer-reviewed study by McCue comparing Medi-Cal managed models on financial performance.[8] This study concluded that financial performance (operating margin, administrative cost ratio, medical loss ratio) from 1996 to 1998 was better than that of other state Medicaid programs. And, within California, the Two-Plan and COHS models experienced improved operating margins while the GMC model saw a slight decrease in operating margin. In the third year of comparison, the administrative cost ratio was highest for GMC, at 0.119, 0.101, and 0.074 for GMC, Two-Plan, and COHS, respectively. The medical loss ratio ranged from 0.849 to 0.908. The authors speculated that more concentrated markets in COHS and Two-Plan models decreased plan marketing costs. However, these results are dated and may not reflect the current fiscal health of models or their plans.

A cross-sectional analysis by Millet, Chattopadhyay, and Bindman examined rates of continuous enrollment in 2002 for California counties with a single Medi-Cal health plan (COHS) compared to counties with competing plans. They reported better rates of continuous enrollment in single plan counties, and found that hospital admissions for ambulatory-care sensitive conditions were lower in these counties.[31] Although numerous policy changes have been enacted since 2002, (i.e., increased use of auto-assignment and HEDIS measures, and a maturing pay-for-performance program) coverage from a comprehensive health system, whether Kaiser or a COHS plan, continues to have generally better quality ratings.

[a] The literature search was conducted through PubMed with no date restrictions using terms related to Medi-Cal managed care plans and models; the search for grey literature sources focused on eight federal and state government agencies and foundations.

Our search of the grey literature yielded one publication that compared the effectiveness of Medi-Cal managed care county models on health care quality and outcomes. The California Health Care Foundation supported a comparative analysis of 2012 HEDIS metrics and hospital/ED utilization and readmission rates among commercial plans, COHS plans, and local initiative plans from the Two-Plan model. The results showed greater variation *within* plans than variation (in average performance) *across* plan types, suggesting that plan type may have less impact on quality than individual health plan approaches to care delivery, demographics, or other county-specific characteristics.[32] As with the peer-reviewed literature, most grey literature reports and analyses compared Medicaid managed care to fee-for-service, compared Medi-Cal versus other state Medicaid models, or compared the performance of specific Medi-Cal managed care plans.

Part 2: The Political and Administrative Context of Sacramento County Medi-Cal Managed Care

Key decision makers and stakeholders who would be involved in changing the GMC model in Sacramento include local, state, and federal officials as well as representatives of health systems, health plans, providers, beneficiaries and their advocates.

Broadly speaking, the route to initiating change in Sacramento County MCMC requires engagement by the following groups:

- County Board of Supervisors
- County Department of Health Services
- Providers: Health systems and FQHCs
- Managed care plans
- Medi-Cal beneficiaries and advocates
- California Department of Health Care Services (DHCS)

Although the City of Sacramento does not have jurisdiction over local Medi-Cal decisions, Mayor Steinberg could be influential in considering options, given his state and local political experience and his interest in improving services to the homeless population. (The City of Sacramento's pilot program, Pathways to Health + Home, is a good example of the city administration's interest in improving access to care.[33]) Additionally, support from Sacramento-area representatives in the state legislature would round out a coalition for change. Identifying needed changes will be a key first step: improvements to quality metrics, access to care, and care coordination are obvious targets.

Local Entities

The **Sacramento County Board of Supervisors** is composed of five elected officials serving 4-year terms with no term limits. The positions are non-partisan, although Phil Serna (elected 2010), Patrick Kennedy (elected 2014), Don Nottoli (elected 1994) have been endorsed by the state Democratic Party while Susan Peters (elected 2004) and Sue Frost (elected 2016) have been endorsed by the state Republican Party. Due to the GMC model design, the county supervisors have a peripheral role in monitoring MCMC in Sacramento County (as compared

with their counterparts' obligations in managing COHS and Two-Plan models); DHCS handles plan contracting and oversight responsibilities. County involvement in serving Medi-Cal beneficiaries primarily revolves around enrollment assistance at the local county offices.

The **Sacramento Department of Health Services,** led by Director Peter Beilenson, is integral to improving MCMC in Sacramento County. The County Board of Supervisors appointed Dr. Beilenson in 2018. Currently, the department is responsible for appointing and overseeing the county's **Medi-Cal Managed Care Advisory Committee**.[34] The Committee, including representatives from an array of stakeholder groups, provides "input and recommendations to the California Department of Health Care Services (DHCS), Sacramento's Geographic Managed Care (GMC) health plans, the County Board of Supervisors, and designated County leadership regarding the delivery of Medi-Cal services in Sacramento County."[35] Their website provides data on GMC plans, including plan enrollment numbers, MCMC enrollment by zip code, ED utilization, data on high utilizers, and mental health plan data, as well as meeting minutes. A Care Coordination Work Group meets to discuss coordination among FQHCs, hospital systems, behavioral health providers, and the Department of Health Services. Sacramento County also operates an FQHC that provides primary care services to Medi-Cal and indigent patients.

There are currently **five active Medi-Cal managed care health plans** in Sacramento County: Aetna Better Health, Anthem Blue Cross, Health Net, Kaiser, and Molina. These health plans have been providing coverage in the Sacramento MCMC market for 18 to 25 years except Aetna Better Health, which joined the Sacramento GMC in 2018. These plans have a critical role to play in improving GMC or adopting an alternative MCMC model.

Local health system providers are important partners in exploring model change or improvements in GMC. UC Davis Health, Dignity Health, Kaiser Permanente, and Sutter Health are the primary health system stakeholders in Sacramento County. Most specialist physicians in Sacramento County are employed or affiliated with one of these systems, so effective integration and coordination of care for complex patients requires their involvement.

Additionally, the PRIME (demonstration) program requires designated public hospitals (including UC Davis) to partner with MCMC plans to adopt alternative payment methodologies (APMs). The intended shift of greater financial risk to hospitals by 2020 is motivated by the need for better integration, improved health outcomes, and increased access to care for beneficiaries. The CMS state waiver notes that incentive payments will move from pay-for-participation to pay-for-performance. CMS notes "To achieve such sustainability, 50 percent of all Medi-Cal managed care beneficiaries assigned to designated public hospital systems in the aggregate will receive all of or a portion of their care under a contracted alternative payment model by January 2018; 55 percent by January 2019; and 60 percent by the end of the waiver renewal period in 2020."[36,37]

Other key providers in the local health system include five or more risk-bearing **medical groups** and seven **FQHCs**. These FQHCs have expanded considerably in the last decade, and have

leveraged their direct Federal support to enhance primary care services for Medi-Cal beneficiaries (in some cases, taking over services that were previously provided by physicians affiliated with the IPAs and UC Davis Health).

Medi-Cal beneficiaries and advocates are also key groups with important input. Health Access, Legal Services of Northern California, and Disability Rights California are examples of organizations representing these stakeholders' interests.

State Entities

The **DHCS** must approve changes to county Medi-Cal managed care models. Over the next few months, recently elected Governor Newsom will make new gubernatorial appointments for the California Secretary of Health and Human Services and, possibly the director of DHCS (currently Jennifer Kent). Once appointments are completed, it will become clearer who could facilitate changes to improve Sacramento MCMC. The current Chief Deputy Director of Health Care Programs, Mari Cantwell, oversees waiver applications and the DHCS contracting office. For Sacramento County to change from GMC to an alternative MCMC model, the DHCS legal department would be involved in initial exploration of the necessary administrative process. Over the years, DHCS has initiated model changes at the county level, with county input, to boost managed care enrollment; however, to our knowledge, Sacramento would be the first county to initiate change from one MCMC model to another.

Additionally, the **Department of Managed Health Care (DMHC)** licenses and regulates 72 full service plans, some preferred provider organizations (PPOs), and dental and vision plans for the state of California. Their oversight includes those commercial plans with a Medi-Cal managed care product, but does *not* include COHS or Medi-Cal fee-for-service. Although DMHC does not have direct jurisdiction over changes to county models per se, it does play a role in enforcing regulations governing commercial plans in the GMC model. They offer health plan information that might inform alternative model choices including reports on health plan compliance, medical surveys, network adequacy, enrollment, financial solvency, grievances, and risk bearing organizations.[38,39]

The **Department of Finance** (DOF) (the fiscal arm of the governor's office rather than a formal department) would be involved in the change process. Ana Matosantos, recently appointed by Governor Newsom as cabinet secretary, was the DOF director under Governor Schwarzenegger and oversaw that former governor's health care reform effort.

Sacramento County's state representatives may also play an important role in negotiating improvements to Sacramento County MCMC. Depending on the chosen alternative, state legislation may be an effective path to change (e.g., through a budget trailer amendment). **Senator Richard Pan** has already expressed interest in improving systems of care for Medi-Cal beneficiaries in Sacramento County, and **Assembly Member Kevin McCarty** may also be supportive. Both serve on the Health committees of their respective houses. Assembly Members Ken Cooley, Jim Cooper, and Kevin Kiley also represent parts of Sacramento County.

CASE STUDY OF A COUNTY MODEL CHANGE

In 2005, DHCS created the Medi-Cal Redesign Plan to move counties from Medi-Cal fee-for-service into a managed care plan system. In response to this effort, the Sonoma County Department of Health Services received authorization from its County Board of Supervisors to convene a local planning group to provide input and make recommendations. Summary proceedings from the 2006 Sonoma County Planning Group on Medi-Cal Managed Care on adopting the COHS model may be instructive to Sacramento County policy makers. A key reason for Sonoma declining to adopt the Two-Plan or GMC model focused on their concern about the commercial plan for-profit focus and limited consumer and provider involvement in system governance. Sonoma County (with a smaller population than Sacramento County) ultimately joined an existing COHS (Partnership Health Plan of California) for the following reasons:

- Federal law limits the number of COHS plans to five and the percent of Medi-Cal enrollees. Although California identifies six COHS, CMS does not recognize Health Plan of San Mateo and cites waivers of federal code (for Merced and Ventura counties).
- Challenging and costly development of a new administrative system and the large financial risk this insurance system requires.
- Political will and financial interest could wane during the development period.

Part 3: Model Options and Future Exploration

Limited evidence shows that the GMC model, particularly in Sacramento County, has worse performance in terms of quality and access than the Two-Plan or COHS models. GMC plan payments are not explicitly adjusted for enrollee risk or prior utilization experience, unlike payments to Medicare Advantage (Part C) plans. As a result, plans attempting to optimize their operating margins in full-risk contracts may seek to enroll low-risk individuals and disenroll high-risk individuals. Beneficiary access to high-quality care, especially specialty care, may be compromised in an environment in which plans compete by avoiding complex or high-risk enrollees. Plan turnover and unstable provider contracts may result, especially in the absence of strong regulatory oversight.

Sacramento County could potentially adopt another Medi-Cal managed care model (Two-Plan, Regional, COHS or a “hybrid” model). There is precedent for modifying or adapting any of these models. Taking measures to improve GMC performance (perhaps based on a study of San Diego county plans and policies) could be an alternative. San Diego, despite also using the GMC model, has more plans grouped at the higher end of the performance scale, suggesting that greater regulatory oversight and closer relationships between FQHCs and regional health/hospital systems may enable the GMC model to be successful (Figure 3). Below we describe some of the pros and cons of adopting alternative models; these options are not exhaustive.

COHS Option

A single health plan designed by the Board of Supervisors and administered by an independent commission. Due to legal restrictions and requirements, joining an existing COHS would be more feasible than attempting to form a new plan.

Pros: COHS have been a successful model in other counties.

Cons: The primary barrier to adopting the COHS model is the federal law that limits the number of COHS and the total percentage of Medi-Cal enrollees in COHS. California added a few small counties to COHS over the past few years; however, adding the Sacramento Medi-Cal population would exceed the federal limit. Currently federal law limits California to five COHS plans, but the Medi-Cal 2020 wavier approved by CMS allowed California to expand to six COHS. This 1115 waiver is due for renewal. Ultimately, Congressional action would be required to adopt a COHS model in Sacramento County.

Additionally, Sacramento County lacks a public hospital and the administrative infrastructure for managing risk is undeveloped. The GMC model does not require Sacramento County to assume financial risk or administer managed care plans; therefore, elected officials and administrators are unfamiliar with the intricacies of the complex MCMC system. A COHS plan would require a high degree of county engagement with a substantial county role in implementation, administration, and oversight.

Two-Plan Option

Two plan types are offered: one commercial plan and a county-organized "local initiative" designed by the county board of supervisors and overseen by a county board.

Pros: Two-Plan local initiatives tend to score well on HEDIS performance measures, although the competing commercial plans vary geographically on their HEDIS scores. The Contra Costa County local initiative is very successful in the quality of care delivered and may offer a useful case study for Sacramento County. Narrowing Sacramento County's MCMC market to fewer plans could enable more effective county oversight of plans with a history of poor performance.

For example, Kaiser Permanente MCMC is highly rated on both quality indicators and user experience. Kaiser is building facilities in the Sacramento region to expand enrollment capacity. Hence, more Medi-Cal beneficiaries could benefit from enrolling in Kaiser. However, as noted earlier, Kaiser does not participate in the Medi-Cal auto-assignment program, and may not be interested in expanding care beyond the 85,000 Sacramento Medi-Cal beneficiaries it serves today.

Cons: If a Two-Plan model were proposed, the Sacramento County Board of Supervisors would need to adopt new local statute and appoint a local initiative board. Similar to the

administrative challenges posed by a COHS model, the lack of county infrastructure for establishing a local initiative plan may be the biggest challenge to this model option. As previously noted, the county has little experience with plan design and administration; therefore, gaining support and interest for a new local initiative may be difficult unless and until stakeholders are educated about the benefits/risks and reassured by the availability of financial and administrative support to initiate the change.

Regional Expansion Option

DHCS contracts with and oversees two commercial plans.

Pros: This is the model most similar to the GMC model in Sacramento County. but Adopting this model would require the least amount of administrative change at the local level.

Cons: This plan is used primarily in counties more rural than Sacramento. Gauging the interest and ability of two plans to properly serve 430,000 beneficiaries would be required. With the exception of Kaiser, the MCMC health plans currently serving Sacramento County demonstrate mediocre HEDIS performance scores and additional enrollment seems unlikely to improve their performance.

As with the Two-Plan model, several long-standing MCMC plans would be eliminated from serving Medi-Cal beneficiaries and existing MCMC plans not selected to continue in Sacramento County may raise concerns.

Hybrid Options

Many models have exceptions to their original design concept, and Sacramento County may want to pursue one of the existing hybrids or design its own version. A new hybrid might include the state selecting 1 or 2 commercial plans and the County creating a local initiative through an independent public authority to contract with health systems, ACOs, or an individual plan. There is also an opportunity to consider integrating health care carve-outs and wrap-around social services (e.g., housing, transportation, dental care, behavioral health, etc.) into the new county model.

Bindman recently published a commentary in JAMA on redesigning Medi-Cal managed care.[40] Based on the observational evidence available, he concluded that a single plan with payment models that incentivize quality will deliver greater value and accountability. Such a solution, while perhaps the best option, may not be feasible in Sacramento County under current conditions. However, limiting participation to two or three plans could stabilize the market by distributing risk more equitably, enabling closer monitoring of quality of care, and reducing the frequent turnover of plans and providers, which is disruptive to patient access and quality of care.

Summary and Recommendations

- There is an urgent need for change in GMC Medi-Cal in Sacramento County. Current conditions have led to Medi-Cal beneficiaries outside of the Kaiser system to have limited access to primary and specialty care, relatively low quality of care, and recurrent instability in plans and contracting providers.
- Limited county infrastructure for health care delivery and administration and the need for federal legislation make the COHS model a less feasible option.
- To date, the regional model has been adopted by smaller, more rural counties and it is unclear if application of that model to the larger, more urban Sacramento County would be feasible.
- Realignment of financial incentives to reduce plan and provider efforts to minimize risk by avoiding high-risk beneficiaries would be very helpful. This goal could be accomplished by risk-adjusting premium contributions, as in Medicare Advantage, or by reducing the number of plans and monitoring them more carefully to balance risk.
- A hybrid option narrowing the number of plans available may enable greater oversight of the plans in Sacramento County, with a potential to improve access and quality of care.
- Plans, health systems, and providers will need to emphasize cooperation over competition to effectively care for the Medi-Cal population.
- Sacramento County engagement and oversight will be a critical element in initiating change and ensuring the success of any new MCMC model.
- Stakeholder engagement through “town hall” meetings, and conversations involving all interested parties, is a critical next step in creating momentum for change.

Current circumstances offer an opportunity for change in MCMC in Sacramento County. A new Governor and administration interested in health care; an experienced local mayor with aligned interests; interested state representatives; the DHCS renewal of the 2020 Medi-Cal waiver application; a new county health services director with Medicaid managed care experience; a strong economy; and relevant experience in nearby counties could lead to a new partnership among key stakeholders that would improve access and quality of care for Sacramento County Medi-Cal beneficiaries.

ENDNOTES

[1] California Health Care Foundation, Medi-Cal Policy Institute. Medi-Cal Managed Care. Medi-Cal Facts. Vol 8; March 2000. Available at: https://www.chcf.org/wp-content/uploads/2017/12/PDF-mmc2.pdf

[2] California Department of Health Care Services. Medi-Cal Managed Care Baseline Quality Report. April 2012. Available at: https://www.dhcs.ca.gov/dataandstats/reports/documents/mmcd_qual_rpts/studies_quality_strategy/qualityreport_april2012.pdf.

[3] Bindman A. A prescription for performance assessment and accountability in Medi-Cal. California Health Care Foundation. May 8, 2018. Available at: https://www.chcf.org/blog/a-prescription-for-performance-assessment-and-accountability-in-medi-cal/.

[4] California Department of Health Care Services. Medi-Cal Managed Care Enrollment Report, December 2018. Available at: https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Enrollment_Reports/MMCEnrollRptDec2018.pdf.

[5] Mann C, Newman N, Lam A, Nevitt K. Moving Medi-Cal Forward on the Path to Delivery System Transformation. California Health Care Foundation. June 2016. Available at: https://www.chcf.org/wp-content/uploads/2017/12/PDF-MovingMediCalForwardManattHealth.pdf.

[6] Coursolle A and Landauer R. County Organized Health System - Medi-Cal Plans Managed Care in California Series Issue No. 3. National Health Law Program. September 29, 2014. https://healthconsumer.org/wp/wp-content/uploads/2016/10/County-Organized-Health-System-Medi-Cal-Plans.pdf.

[7] Report of the Planning Group on Medi-Cal Managed Care to the Sonoma County Department of Health Services Director. November 2006. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/SPD%20Sonoma%20County-Report%20of%20the%20Planning%20Group%20on%20Medi-Cal%20Managed-Care.pdf.

[8] McCue MJ, McCall N, Hurley RE, Wyttenbach M, White M. Financial Performance and Participation in Medicaid and Medi-Cal Managed Care. *Health Care Finance Review*. 2001;23(2):69-81.

[9] California Department of Managed Health Care. Laws and Regulations. Available at: https://www.dmhc.ca.gov/AbouttheDMHC/LawsRegulations.aspx.

[10] Tater M, Paradise J, Garfield R. Medi-Cal Managed Care: An Overview and Key Issues. The Kaiser Commission on Medicaid and the Uninsured. The Henry J. Kaiser Family Foundation. Issue Brief, March 2016. Available at: http://files.kff.org/attachment/issue-brief-medi-cal-managed-care-an-overview-and-key-issues.

[11] California Department of Health Care Services. Medi-Cal Managed Care Program Fact Sheet – Managed Care Models. February 2018. Available at: https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf.

[12] California Department of Health Care Services. Medi-Cal Managed Care External Quality Review Technical Report July 1, 2016–June 30, 2017. Available at: https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/TechRpt/CA2016-17_EQR_Technical_Report_F1.pdf.

[13] Sacramento County Department of Health Services. Data Summary Report, Highest Utilization: Top 3% of Adult Members-Non-primary care encounters. Report Date: June 25, 2018. Available at: http://www.dhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Care%20Coordination%20Work%20Group/Meeting%20Materials/2018/20180625/Data%20Summary_All%20Plans_Jan-Dec%202017.pdf.

[14] Henderson M, Kizer K, Kravitz R. Academic Health Centers and Medicaid: Advance or Retreat? *Academic Medicine*. 2018;93(10):1450-1453.

[15] Waters R. Getting slapped in the face – twice. Low income patients losing UC Davis coverage again. *Sacramento Bee*, Health & Medicine. September 27, 2018. Available at: https://www.sacbee.com/news/local/health-and-medicine/article219095945.html.

[16] McCoy D. Medi-Cal patient transfer seen as a boon for Native American health clinic. *Sacramento Business Journal*. August 22, 2017. Available at: https://www.bizjournals.com/sacramento/news/2017/08/22/medi-cal-patient-transfer-seen-as-a-boon-for.html.

[17] Alvarez, F. Update: Anthem Blue Cross cuts ties with Sutter Health on HMO, Medi-Cal plans. *Sacramento Business Journal*. February 1, 2019. Available at: https://www.bizjournals.com/sacramento/news/2019/02/01/anthem-blue-cross-ends-medi-cal-contracts-with.html.

[18] California Medical Association. Anthem Blue Cross cuts ties with Nivano Physicians Medical Group. December 14, 2017. Available at: https://www.cmadocs.org/newsroom/news/view/ArticleId/21194/Anthem-Blue-Cross-cuts-ties-with-Nivano-Physicians-Medical-Group.

[19] Rodd S. UnitedHealthcare, Blue Shield terminate contracts with Nivano Physicians. *Sacramento Business Journal*. August 8, 2017. Available at: https://www.bizjournals.com/sacramento/news/2017/08/08/unitedhealthcare-blue-shield-terminate-contracts.html.

[20] Rodd S. Two Nivano companies consolidate, transition clinics to WellSpace. *Sacramento Business Journal*. February 13, 2018. Available at: https://www.bizjournals.com/sacramento/news/2018/02/13/two-nivano-companies-consolidate-transition.html

[21] Anderson K. WellSpace Health Will Buy 3 Clinics, Gain 19,000 Patients in Sacramento. *Sacramento Bee*. January 19, 2019. Available at: https://www.sacbee.com/news/local/health-and-medicine/article224248905.html.

[22] Sacramento County Department of Health and Human Services, Primary Health Services Division. Federally Qualified Health Centers. February 2018. http://www.dhs.saccounty.net/PRI/Documents/Healthcare%20Resources/GI-FQHC-List.pdf.

[23] Shin P, Sharac J, Barber Z, and Rosenbaum SJ. Community Health Centers and Medicaid Payment Reform: Emerging Lessons from Medicaid Expansion States". *Geiger Gibson/RCHN Community Health Foundation Research Collaborative.* Paper 55. 2016. Available at: http://hsrc.himmelfarb.gwu.edu/sphhs_policy_ggrchn/55.

[24] UCLA Center for Health Policy Research. *Ask*CHIS 2017. Access and Utilization, Doctor & Other Visits. (Sacramento County). Available at: Exported February 2, 2019. Available at: http://ask.chis.ucla.edu/AskCHIS/tools/_layouts/AskChisTool/home.aspx#/geography.

[25] Coffman J and Fix M. Physician Participation in Medi-Cal: Is Supply Meeting Demand? California Health Care Foundation. June 2017. Available at: https://www.chcf.org/wp-content/uploads/2017/12/PDF-PhysicianParticipationMediCal2017.pdf.

[26] Melnikow J, Evans E, Ritley, D, Durban S. Geographic Differences in Access to Primary Care Providers for Medi-Cal Patients: A Mystery Shopper Study. Presented at the North American Primary Care Research Group Annual Meeting 2017, Montreal, Quebec. https://www.napcrg.org/conferences/annualpastmeetingarchives/.

[27] California Department of Health Care Services. Managed Care Performance Monitoring Dashboard Report. December 19, 2018. https://www.dhcs.ca.gov/services/Documents/MMCD/December192018Release.pdf.

[28] California Department of Health Care Services. Medi-Cal Managed Care Performance Dashboard. Released December 14, 2017. Available at: https://www.dhcs.ca.gov/services/Documents/MMCD/December2017Release.pdf.

[29] California Department of Health Care Services. 2016 Medicaid Managed Care CAHPS Survey Summary Report January 2018. Available at: https://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/CAHPS_Reports/CAHPS_2015-2016.pdf.

[30] Sacramento Department of Health Services. Medi-Cal Managed Care Stakeholder Advisory Committee. GMC Issues and Possible Solutions. April 23, 2018. Available at: http://www.dhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Care%20Coordination%20Work%20Group/Meeting%20Materials/2018/20180423/GMC%20Issues%20and%20Possible%20Solutions%2004%2023%2018.pdf.

[31] Millet C, Chattopadhyay A, and Bindman A. Unhealthy Competition: Consequences of Health Plan Choice in California Medicaid. *American Journal of Public Health*. 2010;100:11 p.2235-2240.

[32] California Health Care Foundation. Monitoring Performance: Locally Sponsored Versus Commercial Medi-Cal Plans. Issue Brief. July 2014. Available at: https://www.chcf.org/wp-content/uploads/2017/12/PDF-MonitoringPerformanceLocalVersusCommericalMediCalPlans.pdf.

[33] Sacramento Pathways to Health + Home. Available at: http://www.p2hh.com/.

[34] Sacramento County Department of Health Services. Medi-Cal Managed Care Advisory Committee Membership Roster. http://www.dhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/Rosters/RS-MCMC-Members-Roster.pdf.
[35] Sacramento Department of Health Services. Medi-Cal Managed Care Stakeholder Advisory Committee Charter. http://www.dhs.saccounty.net/PRI/Documents/Sacramento-Medi-Cal-Managed-Care-Stakeholder-Advisory-Committee/MA-MCMC-Charter.pdf.
[36] Centers for Medicare and Medicaid. CMS communication with DHCS Chief Deputy Director Mari Cantwell dated October 31, 2015. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/CMS_1115_Waiver_Renewal_Letter_103115.pdf.
[37] California Department of Health Care Services. California Medi-Cal 2020 Demonstration: Centers for Medicare & Medicaid Services Special Terms And Conditions Number: 11-W-00193/9; Amended April 15, 2018. Available at: https://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCsAmended060718.pdf.
[37] Department of Managed Health Care. Financial Summary of Medi-Cal Managed Care Health Plans. September 25, 2017. Available at: http://www.dmhc.ca.gov/Portals/0/Docs/DO/Agenda%20Item%206_Report%20Financial%20Summary%20of%20Medi-Cal%20Managed%20Care%20Plans%20FINAL.pdf?ver=2017-10-17-124609-830.
[37] Department of Managed Health Care. 2017 Annual Report. Available at: https://dmhc.ca.gov/Portals/0/Docs/DO/2017-Annual-Report-web.pdf.
[38] Department of Managed Health Care. Financial Summary of Medi-Cal Managed Care Health Plans. September 25, 2017. Available at: http://www.dmhc.ca.gov/Portals/0/Docs/DO/Agenda%20Item%206_Report%20Financial%20Summary%20of%20Medi-Cal%20Managed%20Care%20Plans%20FINAL.pdf?ver=2017-10-17-124609-830.
[39] Department of Managed Health Care. 2017 Annual Report. Available at: https://dmhc.ca.gov/Portals/0/Docs/DO/2017-Annual-Report-web.pdf.
[40] Bindman A. Redesigning Medicaid Managed Care. *JAMA*. 2018 Apr 17;319(15):1537-1538.