A California Health Analyst
On Medicaid Managed Cure

An up-to-the-minute look at managed care in California’s Medicaid (Medi-Cal) program.

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ALTHOUGH WE APPLAUD and learn from the achievements of other states, what works well in one state is not necessarily transferable to another state. For example, the size and diversity of California’s population present unique challenges and opportunities for MediCal (California’s Medicaid program). To understand the scope, depth, and complexity of the state’s Medicaid managed care program, one must know that Medi-Cal serves 5.5 million persons, a number that exceeds the total overall population of three of the four other states studied by Marsha Gold, Michael Sparer, and Karyen Chu. In addition, the more than forty different languages spoken by Medi-Cal beneficiaries magnify issues regarding culturally and linguistically sensitive services. We believe that the paper by Gold and colleagues does not accurately convey the importance of the above-mentioned factors in the development of Medicaid managed care in California.

RECENT DEVELOPMENTS, Significant events in the provision of Medicaid managed care in California have transpired since Gold and colleagues did their research in late 1994 and early 1995. On 22 January 1996 the Health Care Financing Administration (HCFA) approved the two-plan-model waiver, the largest waiver of its kind, affecting two million Medi-Cal beneficiaries. Beneficiaries in twelve counties will be given a choice between two health maintenance organizations (HMOs): a county-operated or locally developed HMO and a commercial HMO. Both plans will provide or arrange for all covered health care services for the majority of Medi-Cal beneficiaries in a region on a capitated, full-risk basis.

At the same time, California is committed to protecting and preserving both traditional and safety-net providers. Each county had the opportunity to fine-tune the basic definition of traditional providers—any provider that has delivered service to Medi-Cal beneficiaries within the past six months—to establish participation standards and reflect the needs of its community. State regulation defines safety-net providers as hospitals or comprehensive primary care clinics that provide care for both Medi-Cal beneficiaries and the medically indigent. Also included are hospitals that have a high charity factor (the top one-third in the county). California requires that county-operated or locally developed two-plan-model HMOs offer subcontracts to all safety-net providers. These providers must agree to provide services on the same terms and conditions as other similar providers do, with some specific reimbursement criteria for federally qualified health care centers and rural health clinics. California requires all two-plan-model contractors to maintain the percentage of traditional and safety-net provider capacity specified in their approved contract applications.

California also has expanded its Health Care Options program, which enabled the

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statewide elimination of all forms of door-to-door marketing by Medi-Cal contractors as of 1 May 1996. Health Care Options provides Medi-Cal applicants and beneficiaries with information on Medi-Cal benefits and processes enrollments and disenrollments. Information typically is mailed to beneficiaries’ homes. In addition, beneficiaries may call a toll-free telephone number to get answers to questions concerning health care options. Aid to Families with Dependent Children (AFDC) and AFDC-linked beneficiaries in California’s eighteen largest counties are required to enroll in a Medi-Cal managed care plan. For those mandatory beneficiaries who do not select a plan, the Health Care Options program will assign them to a plan with a primary care site that serves the area where they reside. In counties using the two-plan model, Health Care Options serves as the central point for Medi-Cal beneficiaries to receive information, as well as to enroll and dis-enroll.

We disagree with the information displayed in the paper’s exhibits concerning California’s Medicaid managed care program. Exhibit 1 reports that California’s prior experience with Medicaid managed care is limited. California has been involved in Medicaid managed care for more than two decades and has had extensive experience in managed care. For example, in 1993 California had 600,000 Medicaid beneficiaries enrolled in managed care plans in twenty counties. Exhibit 1 also reports that California has mandatory programs in only some counties. Although this is factually correct, this statement can be misleading without qualification. California now has mandatory programs in six counties, with enrollment exceeding 550,000. Furthermore, by 1 January 1997 the two-plan model should be operational in twelve counties, with a mandatory enrollment feature that will increase enrollment by an additional two million beneficiaries.

Gold and colleagues fail to explain that the geographic managed care model that was implemented in Sacramento County in April 1994 was the first of its kind and now exists in only one county. In this model the state contracted with seven managed care plans for mandatory enrollment of the entire AFDC and AFDC-linked populations. Although the initial enrollment process for the Sacramento geographic managed care model resulted in some confusion, the confusion has now abated. In 1995 a beneficiary satisfaction survey was sent to 5,000 geographic managed care enrollees (with a 30 percent response rate). Of those who responded, 85 percent indicated that they were satisfied with their health plan.

Exhibit 2 reports that central beneficiary education was limited and that door-to-door marketing varied by county. When the authors conducted their research, those statements were correct. Since then, however, California has expanded its Health Care Options program; as of 1 July 1996 this program serves as a central point for education in eighteen counties.

Exhibit 3 purports to represent the statewide focus of the Medicaid managed care program of each of the states studied. It is perplexing that for California the authors focus primarily on the Sacramento geographic managed care model, which is now used in only one county. Three of the five countywide county-organized health system (COHS) models were operational at the time of the study, as were numerous prepaid health plans, primary care case management plans, and special project contracts throughout the state.

In response to growth in Medi-Cal managed care enrollment, the California legislature added eighty-three new positions to administer and monitor the Medi-Cal managed care program. The majority of these positions are dedicated to program monitoring, including quality assurance.

Through use of a variety of Medi-Cal managed care models, California has demonstrated that it is firmly committed to ensuring that its diverse beneficiary population has adequate access to high-quality medical care.