Medi-Cal Policy Institute

Medi-Cal Managed Care

What Is Medi-Cal Managed Care?

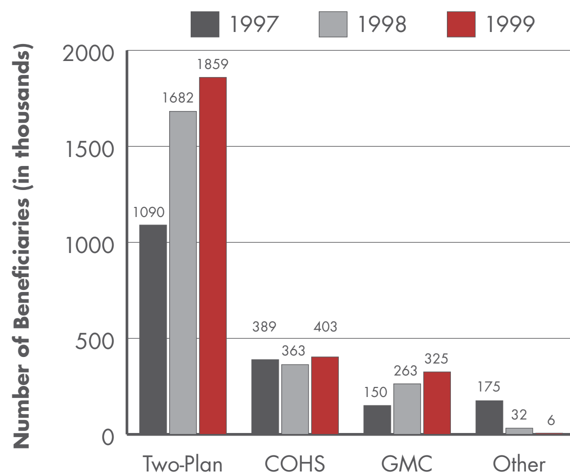
Providing health care for Medi-Cal beneficiaries via a managed care model is not a new concept. California began enrolling Medi-Cal recipients in managed care more than two decades ago. Legislation enacted in 1972 and 1975 authorized the state to license health maintenance organizations (HMOs) or prepaid health plans (PHPs) for enrollment of Medi-Cal beneficiaries. HMO licenses still bear the name of the 1975 legislation: the Knox-Keene Health Care Service Plan Act.

Not until the early 1990s, however, did California focus on shifting large numbers of beneficiaries into managed care. The state's expansion of Medi-Cal managed care was precipitated by many of the same factors that led to increased managed care penetration in commercial health care markets: concern about rapidly increasing health care costs and lack of access to primary health care services. This shift to managed care represents a significant change in the financing and delivery of health care in the Medi-Cal program. Today, approximately 52% of Medi-Cal beneficiaries are enrolled in some form of managed care.

There are three main Medi-Cal managed care models in California: County Organized Health Systems, Geographic Managed Care, and the Two-Plan Model. There are also a limited number of prepaid health plans and primary care case management programs that enroll Medi-Cal recipients on a voluntary basis. A small number of state-approved special managed care projects also exist primarily to serve seniors and individuals with AIDS.

Medi-Cal beneficiaries are enrolled in managed care according to the model of managed care in their given county. With the exception of those beneficiaries living in areas with a County Organized Health System, enrollment in a managed care plan is a process independent from general enrollment into the Medi-Cal program. A state subcontractor, Maximus, is responsible for both informing Medi-Cal beneficiaries about the managed care process and administering enrollment.

Figure 1: Medi-Cal Managed Care Enrollment by Model for 1997–1999



Source: California Department of Health Services, Fiscal Monitoring Unit, Monthly Enrollment Report, 10/97, 10/98, 10/99.

Primary Care Case Management Programs

Primary care case management (PCCM) contracts were first authorized by the state legislature in 1981. PCCM was created as a transitional model to a fully managed health care system. Under PCCM, primary care providers contract with the state's Department of Health Services (DHS) to manage or coordinate health care services for Medi-Cal beneficiaries. Membership in PCCM is voluntary and has been limited by DHS as other models have been phased in.

County Organized Health Systems

In 1982, state legislation was enacted to create three county organized health systems (COHSs) in California. Such a system allows a county to operate a managed care program. Enrollment in a COHS is mandatory for almost the entire Medi-Cal population, and occurs concurrently with enrollment in the

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Highlights

- **52% of Medi-Cal beneficiaries are enrolled in some form of managed care.**
- **26 counties enroll some or all Medi-Cal recipients in managed care programs.**
- **The number of Medi-Cal beneficiaries enrolled in managed care has more than doubled since 1996.**

Medi-Cal program. Santa Barbara, Monterey, and San Mateo Counties were the first selected to design and implement COHSs. The Monterey COHS ultimately was not viable. In 1990 Congress authorized three additional COHSs in California: Santa Cruz, Solano, and Orange Counties were selected. Under both laws, a COHS must be an independent public entity that meets Knox-Keene requirements (the state requirements for managed care organizations to obtain HMO licensure, such as proof of financial solvency), but does not need a Knox-Keene license. Counties contract with the California Medical Assistance Commission (CMAC) and are paid a set amount per member each month, known as a capitated rate. Most services covered under traditional Medi-Cal fee-for-service (FFS) are covered in the COHS. It is possible for a county to make a special arrangement with DHS for some services, such as nursing home care, to remain FFS.

The Solano County COHS recently expanded to include Napa County within its system, and the Santa Cruz County COHS is currently expanding to include Monterey County. Both expansions are allowed under the current cap on the number of Medi-Cal recipients permitted statewide. Additional counties in the state are interested in developing a COHS, however, this would require federal action to expand the number of COHSs from the current limit of five and to increase the cap on total COHS enrollment to more than 10% of total Medi-Cal beneficiaries in the state.

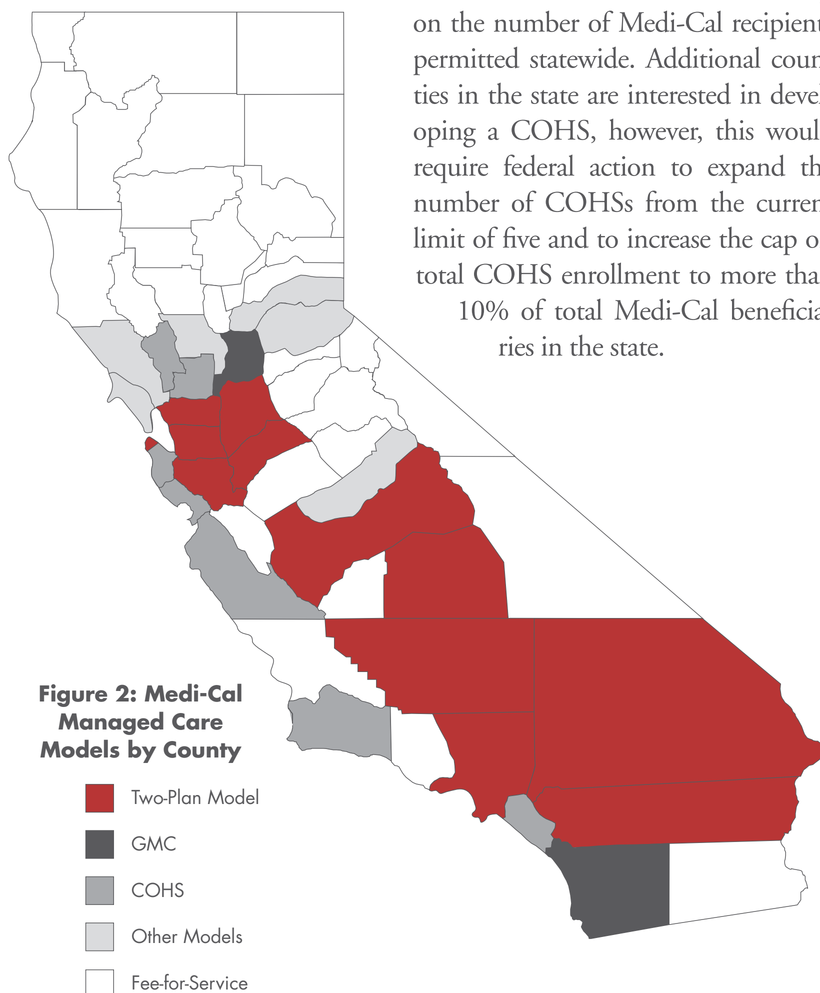

Figure 2: Medi-Cal Managed Care Models by County

Geographic Managed Care

In 1992, Sacramento County was selected by DHS to develop a managed care model referred to as Geographic Managed Care (GMC). The GMC model allows many plans to operate within a designated region. Currently there are six plans operating in Sacramento. San Diego has been designated as a GMC county and began operations as the Healthy San Diego program in the fall of 1998; it now has seven plans that serve Medi-Cal recipients.

Under GMC, the state contracts with a number of commercial managed care plans and pays for services on a capitated basis. Beneficiary enrollment in a plan is mandatory for the CalWORKs-linked Medi-Cal population. Other categories of Medi-Cal beneficiaries may voluntarily join these plans.

The Two-Plan Model

In 1993, amidst considerable public debate, DHS issued a strategic plan detailing the state's expansion of Medi-Cal managed care. A central component of the expansion is the Two-Plan Model, selected to be implemented in counties with the largest Medi-Cal populations. In 1995, twelve counties in California were designated to participate in the Two-Plan Model of managed care (see map). Under this model DHS contracts with one county-developed plan with Knox-Keene licensure, called a Local Initiative, and one Knox-Keene-licensed commercial plan. The design of the Local Initiative, a public entity, was intended to shift large segments of the Medi-Cal population into managed care while preserving the role of traditional health care providers serving Medi-Cal beneficiaries, including disproportionate share hospitals and county facilities.

L.A. Care Health Plan, the Local Initiative established in Los Angeles County, is the largest Medicaid-only plan in the country, with almost 620,000 members as of August 1999. L.A. Care sub-contracts for the delivery of services with seven HMOs and competes for members with Health Net, the commercial plan in Los Angeles.

Enrollment in the Two-Plan Model is mandatory for the CalWORKs-linked population. Voluntary enrollment of other Medi-Cal beneficiaries is permitted. Covered services include primary care, specialty care, inpatient care, and pharmaceuticals. Dental and specialty mental health services are largely provided via separate plans that manage only those services or are offered on a fee-for-service basis.

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