



CALIFORNIA HEALTHCARE FOUNDATION

Medi-Cal Managed Care Plans and Safety-Net Clinics Under the ACA

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About the Foundation

The California HealthCare Foundation (CHCF) is leading the way to better health care for all Californians, particularly those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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Introduction

The Affordable Care Act (ACA) expanded Medi-Cal eligibility and benefits in 2014, swelling the rolls of California beneficiaries from 7.5 million in 2010 to 12.4 million by early 2015¹ and driving new focus on quality, performance, and system integration. Complementary policy initiatives, through the Bridge to Reform 1115 Medicaid Waiver in California, have expanded mandatory Medi-Cal managed care enrollment to additional populations and geographies, resulting in new relationships, opportunities, and pressures for Medi-Cal managed care plans and safety-net clinics.

This issue brief is funded by the California HealthCare Foundation and examines the following questions:

- ▶ How has enrollment in Medi-Cal managed care plans changed over this tumultuous period?
- ▶ How are commercial and public Medi-Cal managed care health plans investing in safety-net clinics?
- ▶ What are the issues facing Medi-Cal managed care and its relationship to the safety net?

Findings are based on self-reported health plan and Department of Health Care Services (DHCS) data of enrollment and investments in their provider networks. Consultants conducted interviews with health plan leaders from commercial and public plans to gather their insights and to highlight trends, as well as with health advocates and the DHCS.

Background

Six models of Medi-Cal managed care operate in California's 58 counties (see Figure 1, page 4).

- ▶ County Organized Health System (COHS)² model (22 counties in six single-health plans); all Medi-Cal members in the county enrolled in one plan
- ▶ Geographic Managed Care Model (two counties with multiple commercial plans)
- ▶ Two Plan Model: a publicly run Local Initiative³ and a commercial plan (14 counties); two plans for Medi-Cal members to choose from

Definitions

Safety-net clinics. Include county primary and specialty services and community clinics and health centers (CCHCs).

Community clinics and health centers (CCHCs). Include licensed community clinics, Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes, Rural Health Centers (RHC), and Indian clinics.

Public plans. Local Initiative and County Organized Health Systems (COHS) are referred to as public plans.

- ▶ Imperial Model (one county with two commercial health plans, one designated by the county)
- ▶ Regional Expansion Model (18 counties with two commercial health plans)
- ▶ San Benito Model (one county with a single commercial plan and option to stay in fee-for-service)

The safety-net system of public and nonprofit organizations operates under an "open door" philosophy and policy to provide care for the homeless, severely mentally ill, uninsured, and other vulnerable populations as well as maintaining access to important community services. The need for essential community clinics providing culturally competent services to traditionally low-income community residents, regardless of ability to pay, is a core rationale for policy efforts to support the safety-net system.

California has a long history of strengthening the clinic safety-net system for uninsured and low-income Californians through its Medi-Cal managed care program. From its inception, Medi-Cal managed care policy and implementation included specific initiatives and protections for the safety net. When Medi-Cal managed care expanded in the mid-1990s to include commercial health plans, these health plans and their provider networks did not generally include safety-net clinics. One implementation concern at the time focused on the risk to the safety net if commercial health plans were the primary contracted entities for Medi-Cal managed care. If

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



Source: California Department of Health Care Services (DHCS).

safety-net institutions were locked out of managed care contracting, access to care for Medi-Cal patients would be disrupted. Safety-net clinics were the primary system of care for the uninsured, therefore destabilizing this system could worsen access to care and overall capacity across low-income populations. Another concern was that sicker, higher-cost patients may be disproportionately enrolled in county systems while commercial health plans could capture lower-cost, healthy patients. The safety net relied on a mix of patients and high Medi-Cal volume for its precarious solvency, and there were fears that a change in this financial mix could cause a collapse in the backstop system of care for multiple vulnerable populations.

The Two Plan Model was developed to include Local Initiative public health plans, created by county boards of supervisors with the expressed purpose of serving a public interest and protecting the viability of the local safety net. Both Local Initiative and COHS public plans have safety-net representation on their governing boards, and they share missions to serve vulnerable populations. Safety-net clinics rely on the public plan models to maintain solvency, promote a solid community reputation, and retain historically high member enrollment. The state incentivizes contracts with safety-net clinics by awarding an increase in the percentage of assigned lives through a default algorithm to plans that have a higher participation of safety-net clinics, taking into account quality scores. Historically, commercial plans did not have

statutory or policy requirements to protect and support the safety net until recent legislative change (see explanation of AB 85 below).⁴

The New Landscape

Implementation of the Affordable Care Act (ACA) is changing the landscape of health care. There are many positive consequences for safety-net clinics. For example, the ACA funded \$11 billion nationally over a five-year period for the operation, expansion, and construction of health centers through the Community Health Center Fund,⁵ and California received \$1.4 billion, or 13% of this funding, targeted specifically to federally qualified health centers. In addition, safety-net clinics received federal and foundation support for outreach, enrollment, and care integration to successfully implement the ACA.

California's 2010 Bridge to Reform 1115 Waiver included a number of initiatives to implement the ACA, such as phasing in coverage for the adult expansion population through the Low Income Health Program. The 1115 waiver also signaled increasing reliance on "accountable, coordinated systems of care"⁶ through mandatory enrollment in managed care for new populations and new geographies. Seniors and Persons with Disabilities (SPDs) were mandated into managed care in all counties;⁷ Healthy Families transitioned into Medi-Cal managed care; 28 new counties were brought into Medi-Cal managed care, expanding the program to every county in the state; the Adult Day Health Care benefit transitioned into managed care; and the Coordinated Care Initiative demonstration for Medicare/Medi-Cal beneficiaries began.⁸ See Appendix A for a description of Medi-Cal managed care expansion efforts. Health plans and providers alike are challenged to integrate new populations as well as new services. Services such as Home and Community Based Services and Mental Health-Substance Use Disorder are straining resources as plans and providers implement new systems and respond to new needs.

The population enrolled in managed care has also changed considerably, requiring an unprecedented increase in primary care and significantly more chronic care management. In 2009, 71% of Medi-Cal managed care enrollees were under age 21 — primarily mothers and children. Today, only 55% of the population is under age 21, reflecting the increase in managed care enrollment of SPDs and new adult ACA expansion

beneficiaries. As a result, provider staffing, referral networks, and overall operations of safety-net clinics have had to change.

As part of implementation of the ACA, California enacted legislation (AB 85) to ensure the stability of the safety net, requiring that 75% of new ACA Adult Expansion members in all Medi-Cal managed care plans who did not make an affirmative provider choice be enrolled in county health facilities.⁹

The dramatic increase in new patients assigned to safety-net clinics, many of them with complex medical and behavioral health conditions, strained clinics' ability to provide timely access to primary care in an increasingly monitored and regulated environment. While some initiatives did not expand the size of a clinic's patient population, the mandatory enrollment into managed care meant new expectations of clinics for many more of their patients (management of all care as opposed to episodic care, and expectations of access without appointment delays), despite limited capital and infrastructure to make improvements in efficiency, throughput, and customer service.

Managed care expansion accompanies a concurrent increase in purchaser and regulator expectations of quality, value, and improved health outcomes. There is heightened scrutiny by the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC), the Centers for Medicare & Medicaid Services (CMS), the state legislature, and consumer advocates about timely access requirements and quality performance measures, as well as requiring new levels of accountability and transparency. This dramatic shift adds to the pressure of ensuring sufficient availability and accessibility of primary care providers in the safety net.

The ACA-created California Health Benefit Exchange (Covered California) is also a player in the pressure to gain sufficient primary care for newly covered populations. In the near term, more covered lives and a requirement for every consumer to be assigned a primary care provider, with no corresponding boost in the supply of new providers, spell significant competition for the provider slots available across California. In general, the health plans participating in Covered California use different provider networks than Medi-Cal, and at this point Covered California has had little to no impact on Medi-Cal access. However, there is significant movement

of lower-income enrollees between Covered California and Medi-Cal,¹⁰ and some speculate that providers will want to maintain their relationships with their former Covered California patients and begin contracting for Medi-Cal as well. The competing challenge is that over time, as Covered California enrollment grows, the Medi-Cal plans may face difficulty maintaining their networks as current Medi-Cal providers seek to participate more in Covered California with better rates. On the other hand, particularly in certain regions, even this competitive pressure may not impact demand on safety-net clinics, either because commercial networks cap their total Medi-Cal enrollment, individual doctors in commercial independent practice associations (IPA) close their panels to new Medi-Cal patients, or growing retirements of one- and two-doctor offices lead to loss of a group of high-volume private Medi-Cal providers.

Various policy approaches have been employed to increase primary care providers' participation in Medi-Cal, with mixed success. The ACA required primary care providers to be paid at least Medicare rates for two years, from 2013 through 2014. This increase was fully funded by the federal government and raised fee-for-service and managed care Medicaid fees for primary care services. The Legislative Analyst Office estimates that a \$5.3 billion payout¹¹ was paid over two years with the intention of increasing primary care provider participation in the Medi-Cal program. However, there is little supporting information and tremendous skepticism about the impact of this policy in California for several reasons: delays in federal policy guidance meant the funds were not distributed in California until early 2014, and complex CMS requirements for the plans (related to how to identify which providers were eligible for payments and how to account for capitation payments when allocating the funding), meant that many providers did not receive payments until the program was almost over. Given the fact that payments were retrospective, and providers knew they would not continue past 2014, most health plans believe that the increased rates had little to no effect on the number of physicians accepting Medi-Cal or the number of patients that physicians were willing to see. Finally, county and community-based FQHC clinics with large numbers of Medi-Cal patients were not eligible for increased payments because their payment is based on a prospective payment system (PPS) methodology.

Another approach to assist health plans in increasing provider participation is through the rate-setting

methodology for the Medicaid expansion population. Given the lack of cost and utilization experience with the expansion population, which had historically been uninsured childless adults, the state worked collaboratively with health plans to set the most appropriate rate. The rates were set assuming the population was a blended mix of families and SPD populations. With rates viewed as historically low by managed care plans, and given that the rates were fully funded by the federal government, the state was willing to take a less aggressive approach to rate setting, and assumed pent-up demand as well as other cost pressures on the plans. All these factors allowed the plans to receive what is widely viewed as very adequate rates for the expansion population. In most instances, these increased rates were passed onto provider groups, increasing their financial viability — at least for the short term. Although the delayed, ACA-mandated primary care increase was not viewed as successful in expanding capacity, some plans believe the ongoing rate increase associated with expansion did bring new physicians into their networks.

The period from 2010 to 2015, with expanding numbers of beneficiaries, greater enrollment into managed care, and complementary efforts to expand primary care capacity and improve safety-net provider systems, illustrates the early impact of the ACA in California. The next section takes a closer look at changes in Medi-Cal enrollment data between 2013 and 2015 and its impact on the safety net.

Medi-Cal Enrollment Data: Trends in the Safety Net

Data were collected from Medi-Cal managed care plans to examine their relationship with the safety net prior to implementation of the ACA (2013) and afterward (2015). The data below show that the safety net has always been an important provider in Medi-Cal managed care and that it provided the majority of access required to meet the explosive growth in Medi-Cal during the implementation of the ACA. Enrollment data listed include 22 Medi-Cal managed care plans. See Appendix B for a list of health plans.

Commercial and public plans were asked to report total enrollment, and enrollment affiliated with safety-net

primary care providers. The safety-net primary care providers were divided into county clinics and CCHCs. (Non-safety net primary care providers can be identified by subtracting the SN numbers from the total). The enrollment data were separated into three Medi-Cal aid groups: SPDs, ACA Adult Expansion, and all others. All of the health plan data discussed in this section is self-reported from the health plans.

Major findings include:

- ▶ Public plans and safety-net clinics are major players in Medi-Cal managed care. Almost 70% of beneficiaries were enrolled with public plans in 2015. Safety-net clinics now have 41% of beneficiaries enrolled in Medi-Cal plans, including 30.3% in CCHCs and another 10.3% in county clinics.
- ▶ The safety-net clinics became even more important with the ACA expansion, after which they accounted for 54% of new managed care members. Safety-net clinics' share of overall enrollment rose from 33% in 2013 to 41% in 2015. Although the commercial plans also moved new members into these clinics, the public plans depended on them much more heavily, assigning almost 1.3 million new members to safety-net clinics in response to the expansion.
- ▶ There is wide variation in safety-net clinics' market share across type of clinic (county vs. CCHCs), type of health plan (commercial, Local Initiative, and COHS), geographic location (north vs. south), and Medi-Cal aid category (Adult Expansion, SPD, and other aid categories).¹² The COHSs have the highest safety-net clinic enrollment, followed by the Local Initiatives, and then the commercial plans. The CCHCs have a larger share of enrollment than do the county clinics in general, including all aid categories, while county enrollment is heavily concentrated in the Adult Expansion aid category. The safety net has a higher percentage of enrollment in Northern California than in Southern California.
- ▶ The high levels of Medi-Cal enrollment in public plans heightens the importance of quality data comparisons between commercial plans and public health plans. HEDIS¹³ data from the DHCS 2015 Aggregated Quality Factor Score ranks Medi-Cal managed care plans. The 11 highest-scoring Medi-Cal plans (excluding Kaiser) are all public plans.¹⁴

March 2015 Medi-Cal Managed Care Enrollment Data (Post-ACA)

According to enrollment data provided by DHCS, Medi-Cal enrollment as of March 2015 was 12.4 million. Three million beneficiaries were in Medi-Cal's Fee-For-Service (FFS) program, and 9.4 million got some or all of their care through Medi-Cal managed care plans (Table 1).

Table 1. Medi-Cal Enrollment for 2015

Total Medi-Cal Enrollment*	12,419,720
Fee-For-Service*	3,025,392
Medi-Cal Managed Care*	9,394,328
Medi-Cal Managed Care Enrollment in Report [†]	9,341,860
% of Actual DHCS Reported MCMC Enrollment	99.4%

*Special data run provided by DHCS Research & Analytics Division.

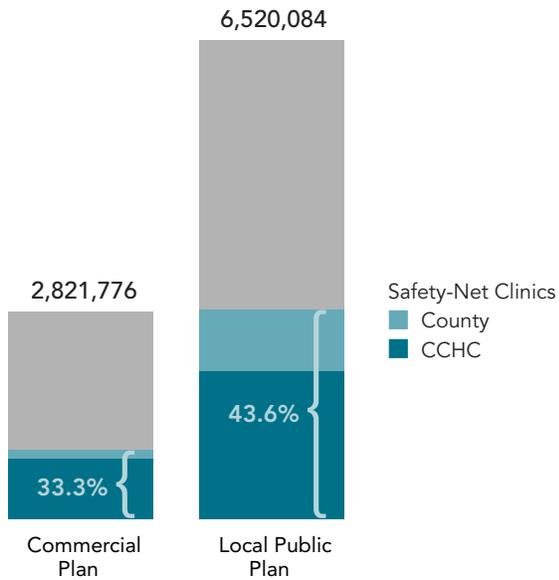
[†]Data self-reported by plans, DHCS data noted above, & DHCS Year 9 & 10 Default Algorithm Reports.

The enrollment numbers reported by the 22 health plans show 9.3 million Medi-Cal members enrolled in Medi-Cal managed care in March 2015. This represents 99% of the total Medi-Cal managed care enrollment reported by DHCS.

Almost two-thirds (65%) of CCHC enrollment was in the public plans, and over 83% of county clinic enrollment was in the public plans. Overall, 41% of beneficiaries were enrolled with safety-net primary care providers, including 30.3% in CCHCs and another 10.3% in county clinics. See Figure 2 on page 8.

The CY 2015 (post-ACA) enrollment is significantly higher than the CY 2013 reported numbers. The results of data collection show 3.2 million members added to Medi-Cal managed care enrollment during this three-year period. Almost 2.2 million (69%) of the members were added through the ACA Medicaid Adult Expansion. Fully 54% of new managed care members entering public and commercial plans enrolled with safety-net primary care providers (Figure 3, page 8). The safety net had 60% of enrollment growth with public plans and 42% of enrollment growth with commercial plans. The COHS plans had 73% of their growth enroll in safety-net clinics.

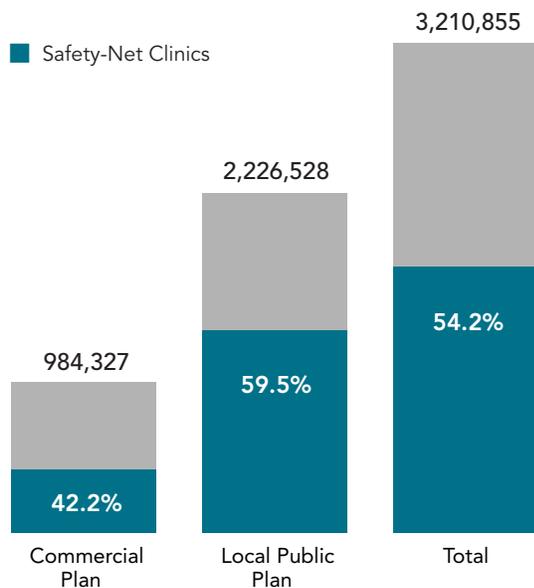
Figure 2. Total Medi-Cal Enrollment and Portion Attributed to Safety-Net Clinics, by Plan Type, 2015



Note: N = total enrollment.

Source: Data self-reported by plans; special data run provided by DHCS & Research Analytics Division; DHCS Year 9 & 10 Default Algorithm Reports.

Figure 3. Total Medi-Cal Enrollment Growth and Portion Attributed to Safety-Net Clinics, by Plan Type, September 2013 to April 2015

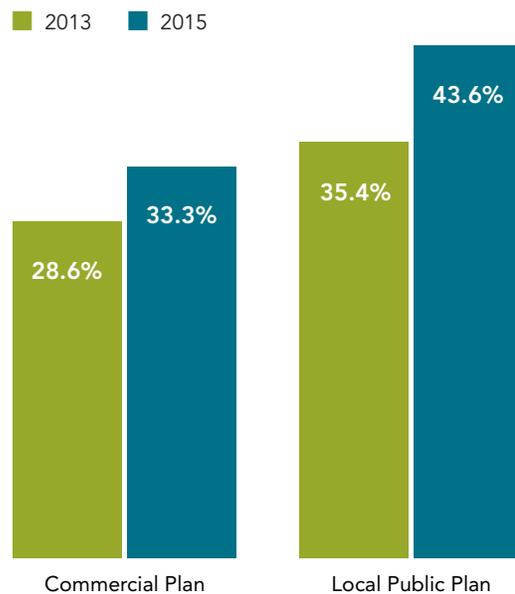


Note: N = total enrollment growth.

Source: Data self-reported by plans; special data run provided by DHCS & Research Analytics Division; DHCS Year 9 & 10 Default Algorithm Reports.

Growth resulted in the market share of the safety net growing from 33% to 41% between 2013 and 2015. The public plan percentage of members in safety-net clinics grew from 35% to 44% and commercial plans from 29% to 33% (Figure 4), while some COHS plans found safety-net clinics post-ACA to now represent 70% of their network.

Figure 4. Safety-Net Enrollment Market Share, by Plan Type, 2013 vs. 2015

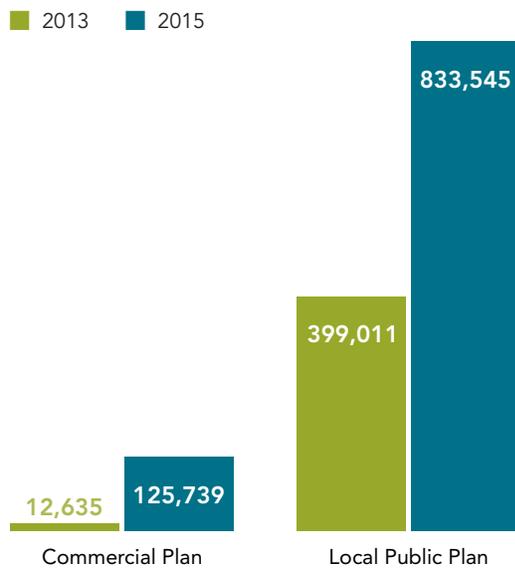


Source: Data self-reported by plans; special data run provided by DHCS & Research Analytics Division; DHCS Year 9 & 10 Default Algorithm Reports.

Both the commercial and public plans increased their reliance on the safety net. Although commercial and public plans have had roughly the same percentage of their network enrolled in CCHCs (29% commercial, 31% public plan), the market share for county clinics (5% commercial, 13% public plan) was almost three times as large in public plans. See Figure 2.

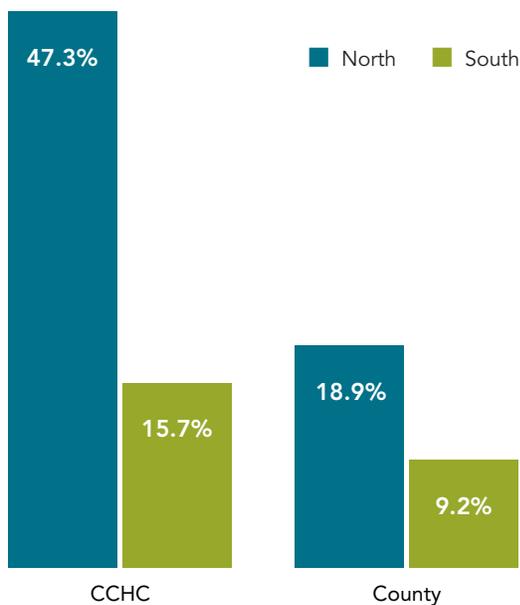
The most dramatic change in enrollment across the safety net and plans was the enrollment in county clinics through commercial plans (Figure 5, page 9). Prior to the ACA Adult Expansion, commercial health plans had almost no member enrollment with county clinics. Commercial plan enrollment with county providers grew to over 100,000 members with the Adult Expansion; however, total numbers remain small compared to enrollment

**Figure 5. County Clinic Enrollment, by Plan Type
2013 vs. 2015**



Source: Data self-reported by plans; special data run provided by DHCS & Research Analytics Division; DHCS Year 9 & 10 Default Algorithm Reports.

**Figure 6. Safety-Net Enrollment Market Share
by Geography and Clinic Type, 2015**



Source: Data self-reported by plans; special data run provided by DHCS & Research Analytics Division; DHCS Year 9 & 10 Default Algorithm Reports.

in public plans. The growth in county clinic enrollment in commercial plans was almost exclusively in one plan (97%) and most of that was in the Adult Expansion population (90%) in Los Angeles County. There may be no single explanation about this change in contracting strategy, but undoubtedly AB 85 was the important driver, and positive capitation rates paid by DHCS for specific Medi-Cal expansion population groups was an additional incentive for commercial plans to contract with county clinics.

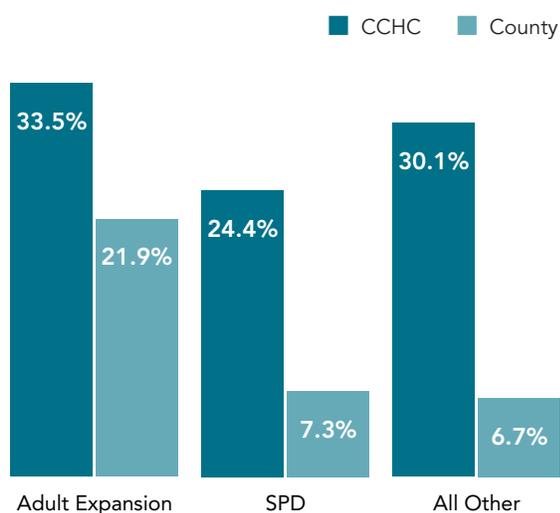
There was variation in market share, not only between the commercial and public plans, but also among the public plans. Local Initiatives had enrollment totaling 4.2 million members, with 40% of members enrolled with safety-net clinics. COHS plans had enrollment totaling 2 million members, with 49% enrolled with safety-net clinics. Excluding CalOptima from the COHS numbers, COHS plans assigned 72% of their members to safety-net clinics.¹⁵ The COHS plans varied significantly from a high of 83% enrolled in the safety net to a low of 7%.

Safety-net enrollment is higher in the north (66% safety-net market share) than in the south (25% safety-net market share) of California. See Figure 6. Although not all commercial plans provided county-by-county data, a review of health plans with over 60% of total enrollment documents clear geographic variation in safety-net market share. The south, as represented by Inland Empire Health Plan, Molina Healthcare, CalOptima, and LA Care, and the north, as represented by Central California Alliance for Health, Contra Costa Health Plan, Santa Clara Family Health Plan, Health Plan of San Mateo, San Francisco Health Plan, Alameda Alliance, and Partnership Health Plan, show significant differences.

Safety-net enrollment also varies significantly by aid category (Figure 7, page 10). The total safety-net market share by 2015 is 55% in Adult Expansion, 32% in SPD, and 37% in all other aid categories. The CCHC market share is 34% in Adult Expansion, 24% in SPD, and 30% in all other aid categories, while the percentages for county clinic sites are 22% for Adult Expansion, 7% for SPD, and 7% for all other.

The next section of this report examines health plan investments in the safety net to prepare for the ACA. Enrollment data offers interesting background to the reported health plan investments in the safety net. Prior to the ACA, commercial plans' Medi-Cal managed care

Figure 7. Safety-Net Enrollment Market Share, by Medi-Cal Aid Category and Clinic Type, 2015



Source: Data self-reported by plans; special data run provided by DHCS & Research Analytics Division; DHCS Year 9 & 10 Default Algorithm Reports.

enrollment totaled only 12,636 in county clinics, and the relationship of commercial plans with both county and CCHC safety-net provider networks was nascent. Therefore, there was a less clear business imperative and rationale for commercial health plans' financial investment in the safety net prior to 2015.

Health Plan Investments in the Safety Net

Interviews and self-reported data from both commercial and public plans documented a record of financial support and targeted payments for local safety-net organizations designed to support access and quality improvements during the reporting period (2013-2015). Public plans were far more likely than commercial plans to make investments in safety-net clinics and were more likely to pair payments with technical assistance. Commercial plans have lower enrollment, and their investments are spread over the state, while public plan investments are focused on a single county or region.

There are a variety of reasons for the higher level of investment: the public plan's mission to support safety-net viability, pressures to drive delivery system change

to meet new access and quality standards, and higher membership in safety-net clinics resulting in a greater need to invest. Public plan governing boards include safety-net leaders, bolstering support for redesigning delivery systems.

Interviewees from public plans emphasized that new expectations for safety-net clinics — including timely access, quality benchmarks, comprehensive assessments, and care management — could not be met without designing new ways to incentivize and drive change. Clinics often did not have the expertise or resources needed to transform how they delivered care, and plans needed flexible ways to drive improvements. The investments were cited as an innovative approach to help plans meet contractual requirements related to access, quality, and care coordination.

Data from public plans demonstrate a consistent history of support, significantly high levels of investment, and a wide variety of incentives and technical assistance to support change. Approaches included incentive bonuses for improved access, onsite consultants to support practice redesign and improved efficiency, and learning collaboratives focused on team care, panel management, and advanced access. Interviewees noted that these investments resulted in reduced appointment delays, increased capacity for new patients, and improved quality scores.

Public plans provided many examples of financial investment support throughout the study period (2013-2015). In addition, public plans increased investments in clinics during 2014-2015 as Medi-Cal enrollment expanded and California shifted more Medi-Cal populations into managed care. From 2013 to 2014, many public plans ramped up investments earmarked for expanded county and CCHC capacity in anticipation of expanded enrollment and populations. One public plan reports grant programs of \$116 million to address infrastructure, access, and provider capacity. Another public plan offered \$7 million to improve access across primary, specialty, and hospital safety-net providers. And yet another public plan increased its practice improvement incentive bonus from \$9 million in 2013 to \$22 million in 2014, with most of the improvement measures designed to address access and quality gaps. Although investments related to pay for performance (P4P) generally affected all plan network providers, public plans also designed measures and targeted investments to improve performance for the clinics.

Both commercial and public Medi-Cal managed care plans utilize a range of investment methods to target quality improvements, access expansion, and specific local needs. See Table 2. Most plans used investment payments tied to performance such as quality improvement incentive payments and pay for performance programs. Although most measures were tied to HEDIS benchmarks and targets set by DHCS, some incentive programs went far beyond to address advance care planning, chronic pain care improvements, and after-hours appointments. These programs, generally available to all participating providers in a public plan, were not specifically designed or targeted to support the safety net. Broad-based, all provider incentives and pay for performance programs were the primary vehicle for commercial plan support to the safety net.

In contrast to commercial plans, public plans report far larger and more varied investments in safety-net organizations. While they also utilize payment incentives, public plan investments more often include a menu of methods and strategies, and P4P programs designed to address specific issues in safety-net clinics such as appointment delays and long waiting times. Public plans are more likely to include grants, technical assistance programs, and favorable auto-assignment programs (which drive membership into safety-net clinics). Moreover, public plans provided far larger levels of support targeted to expand access and implement practice improvements within the safety-net clinics. For example, public plans provided grants to increase primary care capacity, recruit providers, conduct outreach and enrollment to the uninsured, and improve care coordination, as well as capital projects to expand clinic space, improve technology systems, and purchase equipment. Others offered support for Primary Care Medical Home certification, clinic management, or practice improvement. In addition, public plans used targeted financial investments such as provider incentives and technical assistance consultants (e.g., Coleman Associates' intensive, onsite redesign consultants) to support safety-net clinics. Public plans offered financial support across the range of safety-net clinics in their geography; however, larger investment levels targeted primary care settings such as community clinics and health centers (CCHCs). Grant investments were used by health plans irrespective of contracting model to both capitated and fee-for-service providers. Among public plans, Local Initiatives and County Organized Health Systems were equally likely to invest in safety-net improvements.

Table 2. Financial Investments Targeted to the Safety Net by Plan Type

Public
<ul style="list-style-type: none"> ▶ Favorable default algorithm into safety-net providers for members not selecting a primary care provider ▶ Rate increases targeted to safety net ▶ Program grants to develop new services, improve chronic care, improve patient experience, implement telemedicine, and reduce avoidable emergency department visits ▶ Capacity Expansion/Service Improvement Grants to purchase equipment and IT systems, recruit and retain providers, support loan repayment expenses, implement practice improvement strategies, and expand space ▶ Technical assistance: Coleman Associates' Performance Improvement, work flow redesign, team-based care implementation, and support for Patient Care Medical Home certification ▶ Pay for performance targeted to safety net with measures designed to drive clinic improvements ▶ Quality incentive payments targeted to meet HEDIS benchmarks in the safety net
Commercial
<ul style="list-style-type: none"> ▶ Grants for equipment, patient experience, health fairs, improvement in access and quality ▶ Contributions to capital campaigns, clinic state association, local fundraising events

Source: Data provided by health plans for 2013-2015 activities.

Views from the Field

Interviews were conducted with executives from 21 commercial and local public Medi-Cal managed care plans as well as four statewide stakeholder and consumer advocate organizations (see Appendix C for a list of interviewees). A number of insights and questions emerged about the new landscape, the issues facing Medi-Cal managed care, and how these trends may impact safety-net clinics over the next five years.

Public Medi-Cal managed care plans absorbed the largest percentage of new ACA members. There is significantly more money flowing through Medi-Cal managed care plans to safety-net clinics as coverage expands and the state shifts more populations from fee-for-service to managed care. It also means primary care safety-net clinics are caring for sicker patient populations who require more complex care and high levels of care coordination. And maintaining access to care for the residual

uninsured population to avoid care shifting to local emergency departments remains an important underlying fact of life for the safety net. This points to an even greater need for collaboration and alignment between health plans and safety-net clinics. A number of plan executives noted that there is inconsistent and insufficient capacity across safety-net clinics to meet new capacity and practice transformation expectations. This compromises their readiness to participate in shared risk pools and to meet quality reporting requirements that increasingly will be demanded in the future. Interviewees noted that small clinics have particular difficulty with the bandwidth and available investment required for transformation. Most public plans are using targeted financial investments to incentivize and directly support the new capacities and practice improvements required for long-term success. Moreover, public plan investments prioritize changes based on local challenges and drive change at the system level. Will safety-net clinic capacity expand to meet the need? Will access to primary care worsen for the remaining uninsured?

Safety-net clinics are at the center of ensuring access for both public and commercial Medi-Cal managed care plans. State policy now explicitly encourages all health plans to contract with safety-net clinics. At the same time, both public and commercial plans contract through a delegated and capitated contracting model for a significant number of enrolled lives. Under this model, the health plan delegates risk-based payments (per member per month) to an IPA, and the safety-net clinic receives primary care enrollment as part of the IPA. The IPA may include private practice physicians as well as safety-net clinics. In this case, the safety-net clinic does not have a direct contracting relationship with the health plan, and this complicates relationships between plans and safety-net clinics. The implications are significant if this trend leads to less defined, uniquely identified safety-net systems. Will incentives developed to sustain the safety-net transfer to the IPA? Will IPA involvement lead to more private physicians and medical groups participating? Will IPA contracting foster closer relationships between private practice providers and safety-net clinics that lead to improved access to specialists? Will safety-net IPAs be able to accept risk and meet other delegated requirements?

Value-based purchasing requires rapid reboot. Government payments to health plans and health plan payments to providers are moving to value-based

purchasing to align quality and care coordination, and to increase prevention. The increased focus on pay-for-quality methods along with related political pressures is leading to changing or ending the current cost-based reimbursement methods for safety-net clinics, especially FQHCs. Recent legislation authorizes a three-year alternative payment methodology pilot and evaluation of new capitation arrangements intended to transition away from PPS rates.¹⁶ This will require dramatic changes in the business and care models employed by clinics. As yet, new payment models that acknowledge the particular needs and strengths of safety-net clinics and identify unique safety-net value are nascent. Will care coordination for those with complex social and medical needs be reimbursed differently? Will language and cultural competency be valued? Will the value of open door services to the residually uninsured be included?

DHCS role as an active purchaser to uphold performance standards becomes more formal. The state's oversight role is increasing as a consequence of expanded reliance on organized systems of care and the significant size of the Medi-Cal program. DHCS lists multiple efforts it will rely upon to monitor and ensure quality.¹⁷ These efforts bring new reporting burdens and potential business consequences for health plans and providers alike. In most cases, health plans have targeted investments to prepare for new accountability and to improve reporting and performance — some targeted to safety-net clinics and others designed for all network providers. What is the likely impact on the safety net of the state's role as active purchaser? Will DHCS recognize safety-net clinic investments — aimed at reaching access and quality benchmarks — as legitimate medical expenses, reflected in future rates?

Increasing scrutiny follows from expanded reliance on managed care. The expansion of managed care is increasing scrutiny on performance standards such as timely access to care for new members.¹⁸ As safety-net clinics care for expanded rolls of managed care enrollees, new levels of transparency and accountability will follow.

Federal and state regulators have significantly increased oversight and monitoring of system performance. There is significant question as to whether safety-net clinics can meet or even adequately report on compliance measures. And failure to meet standards is tied to financial penalties. Have investments to expand the capacity and operation of safety-net clinics been

sufficient to meet the new demands? How will plans, public and commercial, respond if safety-net clinics do not perform as required? Will financial penalties fall disproportionately to the safety net? Will investment in safety-net clinics increase to meet requirements? How will state and federal regulators handle deficiencies that remain? How will this impact safety-net clinic and health plan relationships?

Concerns about competition for Medi-Cal enrollment remain top of mind. One new commercial plan is contracting with the state for Medi-Cal managed care members, and there is discussion of others joining in the future. Although public plan enrollment remains strong, there are longstanding concerns that public plan enrollment may decrease over time, which will in turn reduce plan stability and result in reductions in resources available for safety-net investment. At the provider level, commercial plans have less history with safety-net clinics and are less likely to favor specific policies to support safety-net clinic enrollment such as favorable default algorithms. Moreover, some interviewees noted interest among private providers to care for Medi-Cal patients that may be a result of commercial plan involvement. Some noted that increased competition highlights the need for the safety net to improve consumer experience to retain enrolled members. Is competition a valid concern for the safety net given recent enrollment experience? Will commercial plan investments in the safety net increase over time?

Plans perceive shifting attitudes from DHCS and CMS. Notwithstanding state policy initiatives in support of the safety net and waiver initiatives to strengthen the safety net, plans perceive, at best, an indifferent attitude from DHCS toward the safety net. CMS proposed rule changes for Medicaid managed care that eliminate specialized payment arrangements supporting the safety nets (Intergovernmental Transfer Process and Disproportionate Share Hospital) signal a possible shift.¹⁹ The combination of financing restrictions and potential reporting sanctions could result in lower rates or return of funds from health plans. If sanctions are passed on by health plans to any delinquent safety-net clinics, this return of revenue could become a significant financial loss to safety-net clinics. In the near term, this may influence the importance that health plans place on strengthening their relationships with safety-net clinics as well as financial commitments to building safety-net capacity. Moreover, as discussion of a PPS phaseout gains traction,

there is heightened uncertainty about whether guidance issued by DHCS will adversely affect safety-net clinics. A caution emerged from plan leaders about whether the relative stability that public plans currently enjoy is sustainable. As one executive put it, “Good economic times disguise the precarious, long-term viability of public plans. Major changes to Medi-Cal policy during a good year is a gamble about future consequences that could adversely affect public plans and the safety net.” How can policymakers ensure that local public payments for health care represent value for taxpayers while ensuring rates are high enough to support ongoing infrastructure investment and a robust network of providers?

Rate reductions are at the heart of uncertainty. As the state and health plans have more experience with the Medi-Cal Adult Expansion population, the state is beginning to reduce rates to the plans. This reduction in rates may impact plans’ ability to incentivize new providers if they view rates as unpredictable and trending in the wrong direction. Rate reductions also further erode the ability of public plans to invest in the safety net to expand capacity and improve quality. Over the years, health plans have raised concerns about the sufficiency of the rates and whether the rates are a barrier to ensuring access. PPS rate reimbursement for primary care providers that are FQHCs buffer the impact of low rates on primary care access. However, with active discussion of potentially ending PPS rates, and given the increased focus on performance, plans will need to invest additional resources in access and quality efforts. This adds fuel to the mounting effort to increase rates that, for the moment, aligns the interests of plans and providers. Regardless of the outcome of this advocacy, plans will be pressured to increase rates for private, non-safety-net providers to attract new providers and meet access standards, and this shift in priority could further erode the close affiliation between public plans and safety-net clinics.

Different challenges face rural Medi-Cal managed care. Huge swaths of California include rural and frontier geography. Competition and consolidation trends are less prominent in rural areas where the lack of providers and difficult economies of scale make meeting timely access requirements a daily challenge. Public plans, with local knowledge and mission, play a leadership role in rural areas to broker cooperation, spur more rapid diffusion of technology, and even recruit primary care providers. How can policy support ongoing investment in rural areas? How can standards and monitoring reflect

the infrastructure challenges that face privately insured and Medi-Cal beneficiaries alike?

Waiver renewal agreement signals greater financial uncertainty. On October 31, 2015, DHCS and CMS announced conceptual agreement on an 1115 Medicaid Waiver renewal with at least \$6.2 billion in federal funds over five years.²⁰ CMS's expectation is that this will be the last large waiver for California's public hospitals. The waiver will continue to focus on stabilizing and improving the performance of public hospitals and offers them five additional years of relatively stable funding levels. While ongoing funding may reduce pressure to increase payments to county safety-net providers in the short term, the agreement also requires moving more public hospitals to risk-based payment models with health plans over the life of the waiver. Funding for public hospitals will decline in the final years of the waiver, and this raises the likelihood of new pressure to develop risk-based payment methodologies that offset loss of waiver funding in the out years. How will public hospitals and health plans meet the challenge of competing priorities? Will new payment models shift dollars to the public hospitals and impact investment in other safety-net providers? How will Whole Person Pilots impact payment models?

Interview themes from health plan executives and consumer advocates highlight many of the challenges facing the overall health care system post-ACA. However, there is a heightened sense of urgency and uncertainty inside the safety net about these trends. Additionally, these themes reflect a number of unique challenges facing the safety net and underscore the far-reaching implications of public policy on the safety net's stability. Another looming and still to be implemented policy initiative is the 1115 Medicaid Waiver renewal.

Implications for the Future

The alignment of public plans and safety-net providers, coupled with policies to protect and strengthen the safety net, led to health plan investments to respond to the boom in insurance coverage among low-income Californians.

Looking ahead, policymaker consideration of this analysis and its findings will be critical to sustaining the safety-net

system while driving new focus on quality, performance, and system integration.

- ▶ The Medi-Cal program's reliance on public and nonprofit safety-net clinics has grown significantly. Safety-net clinics require continuing and increasing levels of investment to expand capacity and improve care.
- ▶ Historically, there has been tremendous variation between public and commercial plans' investments in safety-net clinics. At the same time, the public plans' quality scores are consistently higher than those of the commercial plans. The interdependence between public plans and safety-net clinics could be a mechanism to strengthen systems of care for Medi-Cal beneficiaries.
- ▶ Compared to commercial plans, public plans have made more consistent investments over time, and their investments have been larger and more varied. This investment by public plans in capacity and care improvements has resulted in stronger systems of care for Medi-Cal beneficiaries.
- ▶ Regulatory oversight, practice reform imperatives, and rate reductions may reduce local investment in the safety net, which is the backbone of the Medi-Cal program. With few other sources of investment and capital, such changes would threaten safety-net viability at a time of significant need for the expanded Medi-Cal population.

This paper examines the simultaneous, multiple policy and enrollment changes in 2013-2015 unfolding through ACA implementation and Medi-Cal's increasing reliance on managed care. Ongoing examination, analysis, and dialogue will be critical to fully understand the implications of change over time. For now, data and stakeholder input document significant growth of Medi-Cal enrollment in the public plans and safety-net clinics, as well as significant financial investments by public plans to drive practice transformation in their safety-net clinic partners. The alignment of public plans and safety-net clinics, coupled with policies to protect and strengthen the safety net, has successfully led to investments to prepare for and respond to the significant increase in insurance coverage among low-income Californians.

Appendix A: Medi-Cal Managed Care Expansion

Transition of Seniors and Persons with Disabilities into Medi-Cal Managed Care

Until 2011, California required mandatory managed care enrollment of all Medi-Cal beneficiaries only in COHS counties. In November 2010, California received approval for the Section 1115(a) “Bridge to Reform” Medicaid waiver that, among other things, authorized the transition of Medi-Cal eligible Seniors and Persons with Disabilities (SPDs) from fee-for-service Medi-Cal to Medi-Cal managed care. This change impacted previously exempted non-dual SPDs residing in the 16 non-COHS, Medi-Cal managed care counties.

Beginning in June 2011, nearly 240,000 SPDs were enrolled into Medi-Cal managed care plans in 16 counties over 12 months.²¹ In these counties, SPDs had at least two health plans from which to choose. As of September 2014, the number of SPDs enrolled in Medi-Cal managed care statewide totaled 647,968, composing 7.7% of all Medi-Cal managed care enrollees.²²

Adult Day Health Care Transitioned into the Community Based Adult Services Managed Care Benefit

Adult Day Health Care (ADHC) was a community-based day care program that provided health, therapeutic, and social services for people at risk of nursing home placement that was offered as an optional Medi-Cal State Plan benefit. As part of a litigation settlement agreement, the ADHC benefit transitioned to a new Medi-Cal program called “Community Based Adult Services” (CBAS), which was formally established under an amendment to California’s “Bridge to Reform” 1115(a) waiver in April 2012. As part of this transition, CBAS converted from an FFS benefit to a Medi-Cal managed care benefit. In total, the initial CBAS transition impacted Medi-Cal managed care beneficiaries in 29 counties.²³ Currently, CBAS providers serve just over 31,000 Medi-Cal managed care beneficiaries in 245 CBAS centers statewide.²⁴

Healthy Families Program Transitioned to Medi-Cal

As part of the California governor’s FY 2012-13 budget and pursuant to Assembly Bill (AB) 1494, children enrolled in California’s Title XXI-funded CHIP program, known as the Healthy Families Program (HFP), were transitioned into the Medi-Cal program as “targeted low-income children” (TLIC). DHCS identified approximately 750,000 HFP children eligible to be transitioned

to Medi-Cal over four phases in the course of one year, beginning January 1, 2013. The transition was designed in a manner to minimize disruption of services and to ensure continued access to care.²⁵

Rural Expansion

In 2013, the state completed the conversion from fee-for-service to Medi-Cal managed care as the state transitioned more than 274,000 beneficiaries into managed care in the remaining 28 FFS counties in the state. More than 102,000 people transitioned on September 1, 2013, and more than 172,000 people transitioned on November 1, 2013.

The Coordinated Care Initiative (CCI): Cal MediConnect (CMC) and Medicaid Managed Long Term Services and Supports (MLTSS)

Medi-Cal and CMS partnered to launch a Financial Alignment Demonstration (Dual Demonstration) for people dually eligible for Medicare and Medicaid (Dual Eligibles) in seven counties to promote coordinated health care delivery. The Dual Demonstration is part of the state’s larger Coordinated Care Initiative (CCI) enacted in 2012 with the goal of transforming the Medi-Cal delivery system to better serve low-income older adults and persons with disabilities.²⁶ The CCI program has two components:

- ▶ **Cal MediConnect.** Cal MediConnect (CMC) is a voluntary three-year demonstration for Dual Eligibles to receive coordinated medical, behavioral health, institutional, and home- and community-based long-term services and supports (LTSS) through a single organized delivery system. As of April 1, 2015, a total of 122,520 Dual Eligibles are now enrolled in Cal MediConnect.²⁷
- ▶ **Medi-Cal Managed Long Term Supports and Services (MLTSS).** All Medi-Cal beneficiaries, including Dual Eligibles, residing in the seven CCI counties are required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wraparound benefits. LTSS benefits include In-Home Support Services (IHSS) (the state’s consumer-directed personal care services benefit), CBAS, the Multipurpose Services and Supports Program — the state’s 1915(c) aged waiver — and nursing facility services.

Medi-Cal Optional Expansion Population

The state elected to expand Medi-Cal under the ACA to childless adults under 138% of FPL and low-income parents between 100% and 138% of FPL. As part of this implementation, the 630,000 adults on the low-income health program that had been administered by counties under the Bridge to Reform 1115 waiver transitioned to managed care. In addition, other previously uninsured Californians enrolled in Medi-Cal through this new optional category. To date, over 2 million adults have enrolled through the Medi-Cal optional expansion.

Appendix B: Medi-Cal Managed Care Plans

Alameda Alliance for Health
Anthem Blue Cross Partnership Plan
California Health & Wellness
CalOptima
CalViva Health
Care 1st Partner Plan
CenCal Health
Central California Alliance for Health
Community Health Group
Contra Costa Health Plan
Gold Coast Health Plan
Health Net Community Solutions
Health Plan of San Joaquin
Health Plan of San Mateo
Inland Empire Health Plan
Kaiser Permanente
Kern Family Health Plan
L.A. Care Health Plan
Molina Healthcare of California Partner Plan
Partnership Health Plan of California
San Francisco Health Plan
Santa Clara Family Health Plan

Appendix C: Interviews Conducted with Health Plans and Stakeholder Organizations

Health Plans

Maya Altman, CEO, Health Plan of San Mateo

Greg Buchert, CEO, California Health & Wellness

Richard Chambers, CEO, Molina Health Care

Patricia Clarey, Chief, State Health Programs, Health Net

Scott Coffin, CEO, Alameda Alliance for Health

Elizabeth Darrow, CEO, Santa Clara Family Health Plan

Jonathan Freedman, Chief of Strategy, Regulatory and External Affairs, L.A. Care Health Plan

Bob Freeman, CEO, CenCal

Brad Gilbert, MD, CEO Inland Empire Health Plan

John Grgurina, CEO, San Francisco Health Plan

Doug Hayward, CEO, Kern Family Health Plan

Jack Horn, CEO, Partnership Health Plan

Greg Hund, CEO, CalViva

Alan McKay, CEO, Central California Alliance for Health

Steve Melody, Regional Vice President, State Sponsored Business, Anthem Blue Cross

Rene Santiago, Asst. County Administrator, Santa Clara County for Valley Health Plan

Michael Schrader, CEO, CalOptima

Amy Shin, CEO, Health Plan of San Joaquin

Patricia Tanquary, CEO, Contra Costa Health Plan

Ann Warren, CEO, Community Health Group

Ruth Watson, Acting CEO, Gold Coast Health Plan

Stakeholder Organizations

Carmela Castellano-Garcia, CEO, California Primary Care Association

Sara de Guia, Executive Director, California Pan-Ethnic Health Network

Erica Murray, CEO, California Association of Public Hospitals and Health Systems

Anthony Wright, Executive Director, Health Access

Endnotes

1. A special data run provided by DHCS, Research & Analytics Studies Division in October 2015 reports 12.4 million total enrollees in March 2015.
2. A COHS is governed by a commission, a public entity that holds the Medi-Cal contract with the Department of Health Care Services and is at full risk. The COHS operates a single, countywide health plan to serve the Medi-Cal population. There are no other competing health plans. For its Medi-Cal operations, a COHS must meet selective Knox-Keene requirements, like proof of financial solvency, but is not required to be licensed.
3. A Local Initiative is governed by a commission, a public entity that holds the Medi-Cal contract with the Department of Health Care Services and is at full risk. All local initiative health plans are Knox-Keene licensed and compete with a commercial plan under the Two Plan Model. They were specifically created to protect and promote safety-net providers.
4. AB 85, Chapter 24, Statutes of 2013, www.leginfo.ca.gov (PDF), www.itup.org.
5. *Health Center Program Fact Sheet*, Health Resources and Services Administration, 2015, www.bphc.hrsa.gov (PDF).
6. *California Section 1115 Comprehensive Demonstration Project Waiver — A Bridge to Reform: A Section 1115 Waiver Proposal*, State of California, June 2010, www.dhcs.ca.gov (PDF).
7. SPD enrollees were already in managed care in COHS counties.
8. See Appendix A for a more complete history of the expansion of Medi-Cal managed care.
9. AB 85.
10. Miranda Dietz, Dave Graham-Squire, and Ken Jacobs, *The Ongoing Importance of Enrollment: Churn in Covered California and Medi-Cal*, UC Berkeley Center for Labor Research and Education, April 2014, laborcenter.berkeley.edu (PDF).
11. *Medi-Cal: Overview and Payment Issues*, Legislative Analyst's Office, July 9, 2015, www.lao.ca.gov (PDF). The proposal required a variety of Medi-Cal payment increases that would be benchmarked to Medicare payment levels, for a total estimated cost of \$5.3 billion from the General Fund annually.
12. *Adult Expansion* refers to Medi-Cal's expansion under the ACA to include most low-income adults age 19-64 without children. *SPD* refers to seniors and persons with disabilities.
13. The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90% of US health plans to measure performance on important dimensions of care and service. HEDIS consists of 71 measures across eight domains of care.
14. *Medi-Cal Managed Care Performance Dashboard*, DHCS, September 17, 2015, www.dhcs.ca.gov (PDF).
15. The CalOptima provider network is predominantly made up of non-safety net providers. CalOptima enrollment numbers were excluded from this calculation.
16. SB 147, Chapter 760, Statutes of 2015, leginfo.legislature.ca.gov. Existing federal law authorizes a state plan to provide for payment in any fiscal year to an FQHC for specified services in an amount determined under an alternative payment methodology (APM) if it is agreed to by the state and the FQHC and results in a payment to the FQHC of an amount that is at least equal to the amount otherwise required to be paid to the FQHC. This bill would require the department to authorize an APM pilot project, to commence no sooner than July 1, 2016, for FQHCs that agree to participate. The bill would require the department to authorize implementation of an APM pilot project with respect to a county for up to three years. The bill would require the department to determine an APM supplemental capitation amount for each APM aid category to be paid by the department to each principal health plan that contains at least one participating FQHC in its provider network, as specified.
17. DHCS has five related efforts:
 - ▶ Expand ongoing transition monitoring, grievances and appeals, Fair Hearings, Independent Medical Reviews, call center / ombudsman reports, secret shopping, network validation through data usage, timely access verification, and continuity of care data.
 - ▶ Respond to HEDIS scores through rapid-cycle quality improvement (QI), imposing Corrective Action Plans (CAP) on the lowest-performing plans and possible financial penalties if milestones are not met. Create Quality Factor Score that ranks health plans across all audited HEDIS measures.
 - ▶ Increase accountability and transparency by publicly posting HEDIS and CAHPS reports, medical audits and surveys, Corrective Action Plans, and a Managed Care Dashboard on enrollment, health care utilization, appeals and grievances, network adequacy, and quality of care.
 - ▶ Formalize sanctions for noncompliance related to quality and access. Plans with low scores for three consecutive quarters will be placed under a Corrective Action Plan with possible financial penalties.
 - ▶ Increase monitoring of delegated entities in response to concerns about plan's oversight across all areas of contractual responsibility from member rights and protections, to utilization management, to access and quality.
18. A health plan must have at least one primary care physician in its provider network for every 2,000 Medi-Cal enrollees within 10 miles or 30 minutes of travel time.
19. The CMS proposed rule on Medicaid managed care contains new financing policy that prohibits the state from directing plan expenditures and restricts the use of rate ranges.

The proposal restricts the ability of the state to direct plan expenditures to specific provider types like public hospitals. While this regulation may give plans more autonomy, the state and public safety-net providers are very concerned that this will prevent current practices that extend reimbursement to safety-net providers in Medi-Cal managed care. It could also prevent the hospital provider fee in managed care. In addition, these regulations prevent the state from adjusting rates to support safety-net providers. CMS is also proposing to withhold federal financing participation for incomplete encounter data. And, given the problems that DHCS and the plans have with getting complete encounter data, it could have large impacts on the state and could likely mean the state would pass the loss of FFP onto the health plans in the form of sanctions.

20. Elements include: (1) Global Payment Program for services to the uninsured in designated public hospital (DPH) systems; (2) delivery system transformation incentive program for DPHs and district/municipal hospitals (DMPH), known as PRIME (Public hospital Redesign and Incentives in Medi-Cal); (3) dental transformation incentive program; (4) Whole Person Care Pilot; and (5) independent assessment of access to care and network adequacy for Medi-Cal managed care beneficiaries.
21. Beginning December 2014, SPDs in an additional 19 rural counties (Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba) are transitioning to mandatory Medi-Cal managed care enrollment.
22. *Medi-Cal Managed Care Performance Dashboard*, DHCS, March 5, 2015, www.dhcs.ca.gov (PDF).
23. As of December 2014, Medi-Cal beneficiaries in rural managed care expansion counties began the transition from ADHC to CBAS.
24. *Community-Based Adult Services (CBAS) Program Statistical Fact Sheet*, California Department of Aging, 2015, www.cda.ca.gov (PDF).
25. *Healthy Families Program Transition to Medi-Cal: Final Comprehensive Report*, February 4, 2014, www.dhcs.ca.gov (PDF).
26. SB 1008, Chapter 33, Statutes of 2012; SB 1036, Chapter 45, Statutes of 2012; SB 94, Chapter 37, Statutes of 2013.
27. *Cal MediConnect Monthly Enrollment Dashboard*, DHCS, April 15, 2015, www.calduals.org (PDF).