Medi-Cal Discussion Panel
Richard Chambers, CalOptima
Elizabeth Landsberg, Western Center on Law and Poverty
Elizabeth McNeil, California Medical Association
Herrmann Spetzler, Open Door Community Health Centers
Anne McLeod, California Hospital Association
Burt Margolin, Moderator
Notes by Kiwon Yoo

- can/should our reimbursement system be changed to incentivize cost-effectiveness?
    - McLeod: agree with Toby's discussion → CA needs to get credit for efficiency/low-cost in Medi-Cal program; CA spends 8% less per capita than national average despite outperforming most US states and national average AND despite high cost of living
    - Landsberg: Andy's point is an important reality check; dangerous time to negotiate w/ federal government re: savings; now is not a politically prudent time
    - McNeil: agree with Landsberg; US senate comprised of rural states who have more control than CA senators who will create an uphill battle for CA; CA should work internally to improve financial situation rather than going to the federal government
- Is the state moving too quickly without the capacity for future demand?
    - Spetzler: 1 out of 50 Americans living in rural areas; VERY large portion of our state is frontier; rural and urban areas need each other (raw materials, recreation/tourism etc.) → we need to explore what the opportunities are in rural areas; don't believe traditional numbers support managed care but technology gives us new opportunities to creative virtual networks and combine populations together → aggregates population to make it worthwhile
        - Urban areas will always have economies of scale that rural areas will never have, but technology can provide new opportunities
        - Excited about bringing managed care to rural places, not opposed to it
    - Chambers: important to not fall into trap of what we're used to (large MCO), but use different models (COHS) → Partnership Health Plan
        - Minnesota: implemented modified COHS where some counties joined together to build infrastructure for single delivery system to coordinate care across all levels of care (physicians, labs, hospitals, pharma etc) → can find cost savings in rural areas
    - Landsberg: need to see current problems in SPD managed care transition
        - Many cannot receive Rx drugs, continuity of care etc.
        - Appreciate Toby talking about accountability and future improvements, but many reservations → agree that we need to look creatively but disagree that traditional HMO is the way to go → state should proceed slowly and carefully
    - McNeil: state has problem of overstating physician supply; major problem in rural areas (not enough physicians in those communities)
        - Need to find ways to bring physicians into these areas
        - Not opposed to managed care (definite successes like CalOptima) and trying to do it in the private sector, but wish the state would talk about medical homes for Medi-Cal patients (better care at lower cost)
    - McLeod: experiences with SPD managed care transition → mental health issues, long term care, disenrollment process causes unnecessary hospitalization and delays; need to ensure that proper linkages are in place to improve efficiency and outcomes
        - Very supportive of moving toward managing population health
        - Need to change how we deliver care (not just providers, but everyone involved in continuum, such as plans etc)
- Undersupply of physicians? How will we treat 2+ million new Medi-Cal eligibles?
    - Spetzler: obvious undersupply in rural and urban areas
        - Medium and long term approaches
        - Allow professionals to work to their maximum potential; not everyone needs to see a physician → tiered health care providers

        - Hospitals need well-trained medical assistants, physician assistants, home-based care providers, front desk admin, physicians, etc.
        - Full workforce is lacking in rural areas
    - McLeod: academic and teaching institutions have higher costs than other providers, but they provide clinical practice and research that are invaluable
        - They must be included in continuum of care; cannot focus narrowly on the cheaper providers
    - McNeil: original HR would have increased Medi-Cal reimbursement to Medicare levels, but alas
        - Cannot maintain practice at such reduced Medi-Cal reimbursement rates → half of physicians in CA don't participate because they're so low
        - In a real crisis → need to ensure that we didn't promise million of Californians health coverage without enough providers; extremely worried about this potential problem
        - Must look at medical home model and involve other types of providers to save money on both ends so we can attract doctors back to Medi-Cal
    - Chambers: integration of behavioral and acute care services is crucial
        - E-consults can decrease the number of specialist visits by increasing communication between PCP and specialists
- Should UC hospitals/clinics be required to accept Medi-Cal managed care?
    - Chambers: very difficult because they are very high-end facilities; usually a cost issue despite being state-supported institutions
    - McNeil: should not be mandated to participate but need to think of big picture → how do we keep these institutions alive and well despite devastating budget cuts?
        - 1/3 of ER visits are Medi-Cal and have only increased and continue to drain institutions → right care at right place at right time
    - McLeod: maybe need risk adjustment mechanism like in the Exchange
    - Landsberg: consumers have experienced disruptions in continuity of care at UC facilities
    - Chambers: UCI provides hometown discount but still costly in comparison
- Payment reform, DRG, FQHC…?
    - McLeod: proponent of moving toward acuity-based payment system
- HFP into Medi-Cal → provider networks overlap enough to minimize disruption?
    - Landsberg: agree with merge but needs to be done right
        - Concerned about bandwidth of DHCS after merging with MRMIB and other departments
    - Spetzler: one FQHC interacts with 650+ payors → huge burden to provider
        - All for it but need to do some wordsmithing (move Medi-Cal into Healthy Families than vice-versa); a trivial but huge difference re: branding
    - Chambers: Orange is in a unique system since COHS → single plan for Medi-Cal while competing with 4 other plans for HFP, which enrolls 50%
        - From pure administrative standpoint is good, but 24% reimbursement cut makes it less attractive
        - CHIP has 2:1 federal match, while Medicaid has a less attractive federal financial incentive
    - McNeil: how to handle cost of free vaccines?
- Re-branding of Medi-Cal → should we combine into one large brand that closely resembles one program to the consumer?
    - Landsberg: lot of benefits to rebranding; simplified for consumer
        - Remake the program, not only the name
- Undocumented?
    - McLeod: DSH will be reduced in 2014 through ACA but hope that they won't be as sizeable in other states, which has a VERY large number of uninsured (and will still have millions of uninsured even after health care reform implementation)
    - Landsberg: major failure of Obamacare despite its many successes
        - Some counties do provide services regardless of immigration status, but still a huge challenge going forward for safety net providers
    - Spetzler: will continue to see anyone who walks through our door

        - Identification will become a problem; will providers have to become identifiers and check patients' papers? If so, then everyone must do the same (Costco, Target, Walmart), and not unnecessarily burden hospitals
    - Chambers: they will continue to receive care at most expensive sites; need to set up systems of care for undocumented
    - Landsberg: eligibility/enrollment system and mixed status families will be difficult; parents need to feel safe to apply for coverage for their children
- Anything else?
    - Spetzler: need hospitals to run in rural areas with achievable goals
    - McNeil: truly in interesting times (difficult political and financial situations), need to speak up to ensure best implementation
    - McLeod: no wrong door, need to train everyone for the same goal
    - Landsberg: need to ensure right people get elected, and successfully implement waiver to change minds re: Obamacare