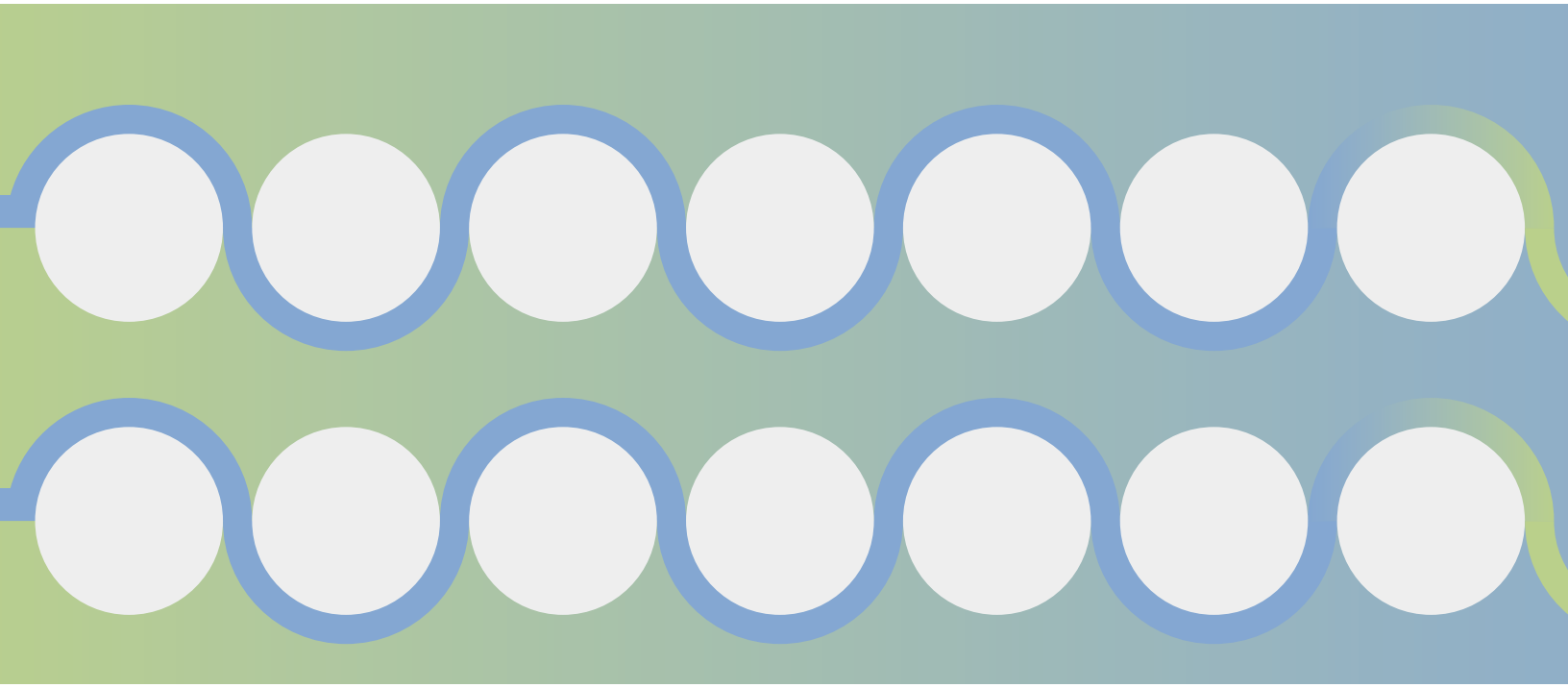


"What I wish I had known about health plans when I worked at a health center..." Insights for Strategically Engaging with Public Medi-Cal Health Plans

JULY 2018

AUTHORED BY:
SOFIA ROJASOVA, BA
RACHEL TOBEY, MPA

JSI Research & Training Institute, Inc. (JSI) is a public health consulting and research organization dedicated to improving the health of individuals and communities in the United States and around the world.

INTERVIEWEES:

- Adam Sharma, MPA, Director of Health Outcomes Improvement, San Francisco Health Plan
- Brianna Lierman, JD, Chief Executive Officer, Local Health Plans of California
- Jennifer Sayles, MD, MPH, Chief Medical Officer, Inland Empire Health Plan
- Jessica Thacher, MPH, Former Director of Quality and Performance Improvement, Partnership HealthPlan of California
- Richard Seidman, MD, MPH, Chief Medical Officer, LA Care Health Plan

We are grateful to Blue Shield Foundation of California and the California Health Care Foundation for their support for this work. We appreciate all interviewees, Carolyn Wang Kong of BSCF, Kathryn Philips of CHCF, Robert Moore, MD, Chief Medical Officer, Partnership HealthPlan of California, and Jeremy Cantor, MPH for their thoughtful review of this brief.

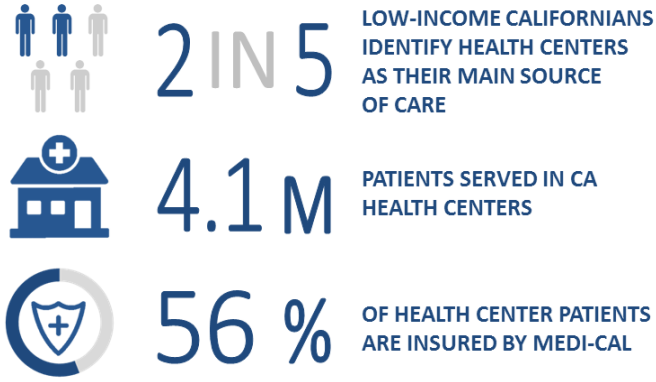
INTRODUCTION

California community health centers are an essential provider group in the Medi-Cal program, and Medi-Cal is the most important payer for a majority of health centers. The Affordable Care Act's Medicaid expansion furthered this mutual dependence. In fact, 41% of Medi-Cal beneficiaries are community clinic and health center patients,[1] and over half of all health center patients in California are insured by Medi-Cal. As the Medi-Cal population has grown, Medi-Cal health plans' provider networks have been challenged to provide access to care to the 13.3 million Medi-Cal enrollees across the state,[2] with health centers representing an increasingly important provider group within those networks. For example, in 2015, community clinics and health centers had 66% of the overall Medi-Cal market share in Northern California and 25% in Southern California.[3]

Research has shown that health centers have succeeded in providing high-quality, cost-efficient care.[4,5,6,7] Nonetheless, many health centers believe they can continue to improve their services and benefit from more strategic relationships with their Medi-Cal health plan(s). Partnerships with health plans can be critical to strengthening infrastructure and securing investments that improve care for socially complex individuals and communities while improving the financial stability and innovation ability of health centers.[8] In addition, both health centers and plans in California have expressed interest in pursuing payment reform as a tool for improving patient care and the overall value of the healthcare system. Conversations around payment and care delivery transformation will require health centers to better understand "where plans are coming from."

This brief aims to answer the question: **What should health centers understand to build improved and mutually beneficial relationships with Medi-Cal managed care health plans?** To gather practical insights that health centers could use to improve such partnerships, **we interviewed**

experts in the field with a special qualification: their careers included roles at both health centers and public Medi-Cal health plans, including both County Operated Health System (COHS) plans and Local Initiative plans in two-plan counties. We asked these individuals with both medical and administrative backgrounds to reflect on what they wish they had known about health plans when they worked at a health center. We have synthesized the following insights based on our interviews, additional conversations with key informants on strategic health center-health plan partnerships, and literature findings.



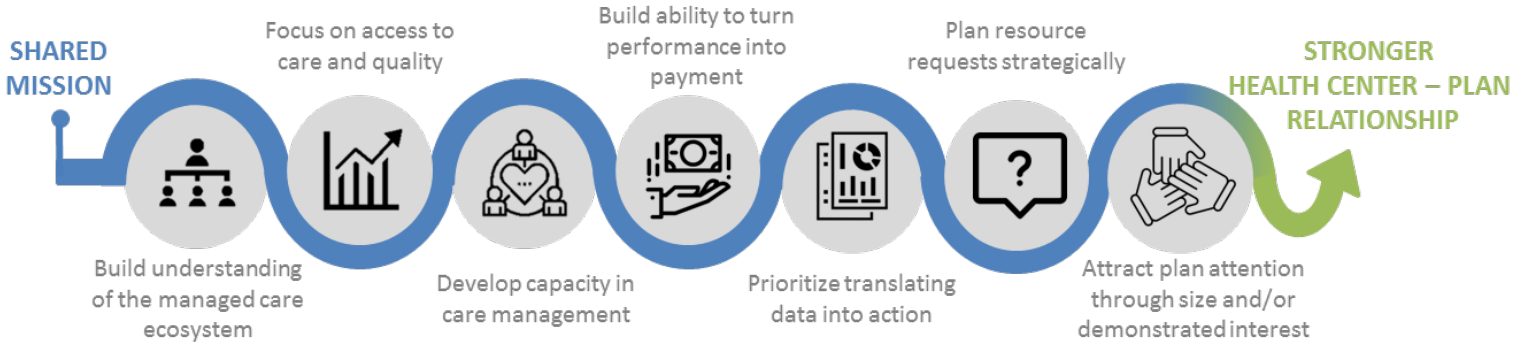
Sources: HRSA UDS 2015, "Medi-Cal Managed Care Plans and Safety-Net Clinics Under the ACA" (CHCF, 2017)

To begin, root relationships in a shared mission.

All interviewees noted that the key to creating a powerful foundation for care, payment, and collective advocacy is to build a health center-health plan relationship rooted in a shared mission or sense of purpose. The notion of "shared" comes from understanding that plans first and foremost perceive health centers as "completely critical" to their network and the community. All interviewees described the health center-health plan relationship as "mutually dependent"; for example, while health centers need health plans to assign them members, health plans cannot afford to lose health center providers, who serve as essential access points for Medi-Cal beneficiaries as well as critical implementation partners for large parts of a health plan's quality strategy.

As our experts reflected on their careers, many commented that they had been surprised to learn that public Medi-Cal health plans are often as mission-driven as health centers, and have similar mission-driven cultures and employees.

> *"Everything in our motivation is to have the best network and provide the best set of support services. We talk everyday about how we can add value. We don't want to be just a payer – we have a mission to improve the lives of all [our community members]."* – Richard Seidman, MD, MPH, Chief Medical Officer, LA Care Health Plan



However, plans' and health centers' approaches to fulfilling their missions may differ; thus, interviewees recommended building relationships with broad shared-mission frameworks. They also stressed having an explicit understanding of what each organization brings to the table and when one entity should defer to the other in decision-making. For example, while both health plans and health centers may have capacity to provide care management services, both research and practice have shown that care management is most effective when delivered by the entity that is as close to the patient as is feasible.[9,10]

Recommendations for health centers seeking to build health plan partnerships rooted in a shared mission include:

- Identify champions within the health plan and build a positive relationship with these individuals. Suggestions include medical directors, directors in quality and access, and directors of provider relations departments. Forge relationships between individuals in similar roles (e.g. CEO to CEO, CMO to CMO).
- Get to know the history (e.g., purpose for creation) and mission of local plans.
- Be able to explicitly articulate your vision for improving the health of your community.
- Ask plan leaders about their priorities and pain points. Be ready to clearly articulate yours.
- Begin initial discussions by putting forward ideas (areas or goals you want to pursue together with the plan) rather than starting conversations about specific proposals or bills.
- Find opportunities to work together outside of your contracted relationship (e.g., partner on legislative issues).

Like health centers, public Medi-Cal health plans are non-profit organizations. This not only allows for close relationships from a structural perspective, but also creates avenues for health centers to participate as board members on health plan governing boards and to serve on committees that influence health plan decisions. Health center leaders serving in these roles are a structural way of ensuring that the notions of a shared mission are put into practice. By interacting on governing boards, health center and health plan leaders can also develop stronger professional networks and have an opportunity to symbiotically address challenges presented by local and state politics that affect both of their businesses.

One expert wished he had not "demonized" health plans during his health center career. He added that his health plan role has allowed him to better understand plans as public agencies motivated by improving and investing heavily in the quality of care and services of all members. As public agencies, they are also subject to government regulations, pressures to keep their doors open, and the need to experiment through trial-and-error to understand which promising new practices should be widely implemented.

All experts echoed the sentiment that the primary myth about health plans is that decisions are "purely profit-driven." Rather, public plans' decisions are more often driven by a mix of mission, regulatory parameters, and the need to stay financially afloat.

Interviewees consistently saw multiple opportunities for health center-health plan alignment and voiced a belief that health centers are uniquely positioned to leverage resources that would allow both health centers and health plans to fulfill their missions. Rooted in a strong sense of shared purpose, interviewees offered the following seven key insights for health centers interested in building a stronger or more strategic relationship with their plan(s).

1: Build a strong understanding of the managed care ecosystem

All experts believed that health centers would be surprised by the lack of flexibility with which health plans operate due to state and federal regulations. Health plan representatives stressed the rigor of plans' financial solvency requirements and filing processes, which happen at least once a year and, more frequently, if plans have shown poor performance on quality measures and/or financial stability. Interviewees wished they had better understood during their health center tenures that health plans operate under intense regulatory oversight. Plans are required to maintain a high level of transparency to avoid regulatory action and to maintain a positive reputation and negotiating power with the state.

Plans also have financial incentives to demonstrate performance on quality and access measures. For example, COHS plans have a financial incentive to avoid five-year Corrective Action Plans (CAPs) that include state-mandated improvement projects if the plan has subpar performance on quality and access measures. While plans expressed skepticism about the utility of CAPs for encouraging creative problem solving, CAPs continue to be a reality within Medi-Cal managed care that can place highly prescriptive pressures on plans to raise scores. If plans do not hit targets after being put on a CAP, the state presents the health plan with a fine. In counties that follow the two-plan model, External Accountability Set (EAS) scores influence auto-assignment of members, thus creating an additional financial incentive to perform on quality measures. Finally, interviewees reflected that prior to working at a plan, they had underappreciated the challenging position a plan is in with respect to being held accountable for outcomes that they only indirectly influence.

> *"The state holds health plans accountable for the quality of care that members receive even though the plan does not directly deliver care to anybody. This puts the plan in the challenging position of trying to manage and improve quality via a dispersed and highly varied network of contracted providers. You don't have direct control; you only have influence."* – Jessica Thacher, MPH, Former Director of Quality and Performance Improvement, Partnership HealthPlan of California

Despite complex regulatory pressures, interviewees encouraged health centers to continuously build their understanding of the managed care ecosystem, and to critically "look above themselves" in the ecosystem to fully recognize the incentives for the variety of entities that participate in the ecosystem.

Recognizing the pressures that health plans are under from the state (e.g., access and quality – see Section 2), and even understanding the pressures the state is under from the federal government can help a health center most strategically craft communications and engagement with plans. Health plan leaders interviewed commented that health plans do not strive to be regulators or to have health centers fear retaliation. Rather, their actions are dictated by a need to ensure good standing with state regulators, avoid probation status, and optimize membership through auto-assignment and positive reputation. In other words, actions are aimed at positioning plans so that they may continue to adapt and innovate with health centers and other network providers toward the improved health of individual patients and community populations.

Understanding the managed care ecosystem can have additional benefits for health centers. By researching all the entities in their broader managed care contracting environment, including what types of contracts are available, health centers can understand whether plans are, for example, open to refining pay-for-performance (P4P) incentives, contracting with independent practice associations (IPAs), or contracting through dual risk arrangements where hospitals and IPAs split risk and share in collective risk pools. One interviewee also suggested that having a solid understanding of how risk

pools function can help a health center leader "make the business case" to team members that working to reduce emergency department admissions is a priority activity.

Importantly, another interviewee commented that if he could have changed his practices as a health center leader now that he has worked inside a plan, he would have spent more time thinking about how to fit into the health care system and the contracting environment as a whole, and less about the unique space in which health centers operate.

> *"Given the insights I have now that I've worked at a health plan, as a health center, I would have spent less time thinking about how FQHCs are different compared to other providers. Rather, I would have invested in the right information systems, better management practices, efficient work flows, and understanding the regulations that govern health care. In particular, the access requirements for specialty care could have improved how we collaborated with the public hospital."*
> – Adam Sharma, MPA, Director of Health Outcomes Improvement, San Francisco Health Plan

Others reiterated that health centers would be well-advised to consider and articulate how they fit into the overall managed care ecosystem, including how they can outreach to members who need primary care and how they can coordinate care outside of primary care.

> *"At a plan, you're looking for systems-ness and connectivity and how can we get systems to fit together to serve patients and to produce a good results and be cost effective. I feel like some FQ's are not fully recognizing their piece of that larger picture and focusing on the population in a way they could."* – Jennifer Sayles, MD, MPH, Chief Medical Officer, Inland Empire Health Plan

2: Focus on access to care and quality

Access to care and quality–as measured by HEDIS–are two chief health plan priorities for which health centers are seen as strong, valuable partners. Access and quality measures affect both the health center reputation with the plan (i.e., if a health center helps improve a plan's HEDIS standings, it will be in better standing with the plan for following requests) and the health plan reputation with the state (i.e., if a health plan performs well on access and quality measures, the plan will be in better standing with the state).

Health centers also have a stake in improving low HEDIS measures for multiple reasons. First, as plan ratings become more transparent to the public, patients could become less inclined to choose plans with lower scores and fewer members could become assigned to health centers, compromising health centers' financial stability. Second, many health centers have pay-for-performance contracts with their plans and stand to be rewarded financially for improving quality measures.

> *"Our plan cares a lot about our HEDIS scores, and I think [Health centers] are starting to know that, but they still think we care about the money more. Fundamentally, we care about HEDIS because it's a reflection of care quality and outcomes and it is part of our mission to be successful on these metrics…The other reason that is motivating is that DHCS is moving more towards very public ratings for plans, so that's been a lot of pressure on us. We can do a lot of shiny projects, but if those scores are low, it's hard to say you're an excellent plan or that you're providing good care to members."*
> – Jessica Thacher, MPH, Former Director of Quality and Performance Improvement, Partnership HealthPlan of California

By understanding exactly how HEDIS measures are calculated, health centers can gain better insight into how to play a role in improving the measures. In addition, health centers can set themselves up for successful partnership with a plan by learning two sets

of measures that are important to the health plan: (1) measures on which a health plan is currently performing below the state average and (2) measures that a plan emphasizes for other reasons, such as a measure's important link to patient morbidity and mortality. Health centers should also consider where they have existing programs that could help improve an emphasized measure (e.g., a diabetes care management program to improve HbA1c). (See also: Section 4 on Pay for Performance Measures.)

Health plans place great importance on accurate and complete encounter data, as it allows a plan to demonstrate that contracted providers are providing quality care and access. A second reason encounter data is a focus is that such data is used to calculate quality scores that factor into the auto-assignment algorithm for members that do not actively select a plan. As the Department of Health Care Services (DHCS) moves towards public ratings for plans, these scores will become increasingly important for a plan's reputation. As a result, health plan interviewees conveyed that plans have a strong interest in working with health centers on improving encounter submission and clinical quality. Finally, encounter data is also critical in health plan rate setting. A health plan's rates depend on data entered in the rate development template (RDT), which is only as accurate as the underlying encounter data received from providers.

Recommendations for health centers seeking to improve their focus on access and quality include:

- Prioritize improving quality scores. Plans care more about HEDIS than about the Uniform Data System (UDS).
- Demonstrate how your health center is increasing access, including extended hours.
- When discussing access and quality with your plan, do not claim that your patient population is "more difficult" or "sicker" unless there are very clear specifics to point to in the data.
- Focus quality improvement activities on population health – thinking about members, not just patients.

Health centers stand to benefit from a focus on improving access to care and quality as the push toward value-based payment and care continues (see Sections 4 & 5 on Payment and Care Management). Demonstrating proficiency in improving on quality and access measures sets health centers up to be priority partners when plans launch new initiatives aimed at improving population health.

3: Develop capacity in care management

Public plans are interested in investing in major levers to help their providers, including health centers, improve care outcomes while remaining financially strong. Previously, one historical lever that plans invested in was provider adoption of electronic health records (EHRs). Today, experts point to the federal, state and plan interest in care management and care coordination for high-risk beneficiaries as a key lever to improve cost and quality outcomes in the Medicaid population.

Despite the growing interest in care management across the healthcare field, to date, only some health centers have successfully been able to uniquely position themselves to show capacity and willingness to fulfill all the functions of delivering care management. Interviewees stressed that health plans want to invest where the dollars are going to help the most, and they need to have some confidence that the investment will be productively put to use; in other words, plans are hesitant to invest in health centers until they show some capacity and preparedness for a successful care management program. At the same time, many health centers with interest in growing their care management capacity cite a need for upfront investment to build capacity such as hiring and training staff, implementing new data systems and analytics and forging new

relationships with hospitals. Our key informants acknowledged this challenge, which other health center leaders have described as the "Virtuous/Vicious Cycle of Payment and Delivery System Reform."[11]

Despite this challenge, public plan leaders held a belief that there were untapped opportunities for health center-health plan alignment around high-value and evidence-based care. They also voiced that health centers are uniquely positioned to leverage resources for care management, care coordination, and more integrated care. For example, one plan leader cited funding behavioral health staff in health centers as a way to operationally grow care management and coordination capacity. Another plan cited funding a pilot care management program in health centers. Multiple plan leaders pointed to new resources for care management that the state would soon provide through the Health Homes program.

> *"The health plan has care management assets and leadership with a keen interest in committing the resources necessary to improve care coordination for patients with complex needs. Health Plan staff are willing to go out into the field and work with members directly, supporting the work of FQHC providers."* – Adam Sharma, MPA, Director of Health Outcomes Improvement, San Francisco Health Plan

Care management represents a priority interest among plans for the promise of delivering high-quality care. Given the Health Homes opportunity for providers to receive supplemental funds for performing care management and coordination services, improving care management capacity can also result in a new source of funding for health centers. Health centers have the opportunity to seize this moment to engage in strategic discussions with their plans on charting a path toward sustainable care management that is beneficial for patients, providers and plans alike.

4: Build ability to turn performance into payment

Moving from volume-based to value-based payment continues to be pursued as a necessary element of a higher quality and more cost-effective healthcare delivery system. California-based and national health centers have articulated multiple ways that payment reform can take shape for primary care, including primary care capitation, supplemental payment for care management and coordination and performance-based payment in the form of shared savings or pay-for-performance (P4P).[12,13] The state decision not to pursue a Federally Qualified Health Center (FQHC) Alternative Payment Methodology (APM) under a Medicaid Section 1115 waiver has left both health centers and plans eager to engage in conversations on how to craft new payment methodologies that will meet Department of Health Care Services (DHCS), health plan and health center goals.

Some interviewees thought the top priority in payment reform should be finding a way forward for an FQHC APM that would give health centers more flexibility to deliver care while removing the financial incentive to do more visits; this was seen as an essential change because there is a sentiment that health centers can get very focused on being encounter-driven, without recognizing that a volume-focused mentality is not aligned with the managed care model.

Others expressed the most interest in tying dollars to outcomes in P4P programs. P4P programs are increasing in prevalence across the state; as of 2017, 18 of 22 California health plans had P4P programs in place.[14, 15] In fact, most interviewees believed that there is appetite among health plans to invest more in P4P for health centers than they currently do, including tying more performance payment to outcomes measures

such as inpatient and emergency department utilization.*

Being able to perform tasks such as care management and coordination for high-risk individuals is another way health centers can translate performance into payment. As mentioned in Section 3, there continues to be an interest in identifying opportunities to provide health centers with funding for care management when they have capacity to deliver the services. It is also notable that the Health Homes demonstration that will allow plans to pay community-based care management entities for care management and coordination services for select high-risk patients explicitly says such payments to health centers are to be considered supplemental to health center prospective payment system (PPS) payments.

For health centers, the implications are that they can position themselves for payment reform by building care management capacity, devising interventions that can improve quality and avoid hospitalizations, and preparing to deliver care through non-face-to-face modalities and with non-billable providers.

* Despite plans' interest to better leverage P4P as a tool to improve outcomes in collaboration with health centers, a court case and actions by DHCS auditors have posed a significant obstacle to pursuing more robust P4P strategies. As of this writing, DHCS had recently declared that the State and its auditors will cease actions to reconcile past P4P payments to health centers until the Department clarifies its P4P policy. Such clarity will allow health centers and health plans to better use P4P as a lever to improve outcomes. The legal case in question is one in which the State prevailed in an argument that P4P payments received by one FQHC must be included in PPS reconciliation, effectively requiring that the FQHC return P4P payments to the state. In the wake of the case, DHCS auditors asked other health centers to pay back P4P payments in reconciliation. A September 2000 State Medicaid Directors' Letter states that incentive payments "that are linked to utilization outcomes or other reductions in patient costs" should be excluded from PPS reconciliation calculations. "Risk pool payments, bonuses and withholds" have also been held up as meeting the definition for exclusion, especially when "coupled with benchmarks or measures used to determine if the goal has been reached." (Citations 16-20)

Lastly, plans may not represent the only opportunity to turn performance into payment. While interviewees spoke of multiple payment reform opportunities with plans, they also mentioned health centers should continue to take advantage of participating in payment reform opportunities presented by participating in IPAs. Participation in an IPA also allows health centers to engage in risk taking for professional services and to reap the financial rewards if they are successful in controlling utilization.

> *"I found [FQHCs] more focused on HEDIS since P4P has become bigger because it's significant dollars for them."* – Jennifer Sayles, MD, MPH, Chief Medical Officer, Inland Empire Health Plan

5: Prioritize translating data into action and recognize health plans' data capacities are finite

Much has been written about the need to prioritize data analytics and data infrastructure in the era of value-based care.[19,20] Health centers and health plans should partner to improve data and analytics for the benefit of rate setting and risk adjustment, increasing movement toward value-based payment, and executing on the promise of population health. According to interviewees, specific data to prioritize includes data to identify assigned members, access data, clinical quality data, and data about what is happening to members outside of primary care.

> *"Most important [levers of health plans on a daily basis] are data, data, data – encounter information, where members are, what services they're getting, if they are hitting their HEDIS. Data is a primary focus."* – Brianna Lierman, JD, Chief Executive Officer, Local Health Plans of California

Interviewees also cautioned that health centers should avoid overestimating data-related resources and data powers of health plans. Some health plans felt they have room for growth in their own data capabilities and

that some health centers were better resourced in this area. Health centers have an opportunity to build a relationship with the plan by sharing analyses and specific actions they undertake based on data requests. Similarly, health centers also have an opportunity to be viewed as a strategic partner on data by being selective with data requests. For instance, some interviewees advised that health center data requests meant to satisfy the reporting needs of small grants may not be seen as a strategic use of a plan's limited IT resources. One interviewee also reflected frustration that the health plan pushes out a monthly roster of all Medi-Cal insured members, but only half of providers look at this data in a timely manner.

> *"All types of data we're talking about sharing – plans don't have hesitations, but have technical limitations in being able to share timely, accurate data. I don't think it's unwillingness, but it can be lack of capacity."* – Richard Seidman, MD, MPH, Chief Medical Officer, LA Care Health Plan

Because of finite data sharing and analytic capabilities, plans only want to spend time and resources pulling data that health centers have the capacity to utilize in the service of improving care for patients and the ability to keep secure. Thus, any data request needs to have explicit rationale, objectives and areas for action that accompany the results. Health centers who can demonstrate through their work that they have the capacity to manage and act on data are seen as key partners for plans. Over time, this reputation can be built by communicating back to the health plan how the health center has used received data to improve quality and access for the plan's members. Using care management (Section 3) as an example, health centers could show they have the capacity to address the needs and coordination of care for high-risk members after identifying care improvement and cost-containment opportunities in the data.

> *"Some provider organizations are equipped to handle the data we share and use it to drive high-value care. Other times we will get asked for spreadsheets and then we'll ask if it was useful, and they'll tell us they haven't had time to open it yet. So part of it is: Will they have the capacity to make it useful enough for us to spend the time getting it for them?"* - Jessica Thacher, MPH, Former Director of Quality and Performance Improvement, Partnership HealthPlan of California

Interviewees did suggest that health center data requests, especially in pre-agreed upon areas of collaboration, are welcomed. Several plans also expressed that they were working hard to improve the way they push data in a timely fashion to health centers, such as through provider portals.

6: Plan resource requests strategically

As the healthcare landscape continues to evolve, health centers have two paths to obtain resources to support innovative and high-quality care: react to open opportunities or proactively pursue investments and funding. The latter lends itself to potential win-win partnerships with health plans and requires planning resource requests strategically.

Multiple considerations go into a strategic request for resources. Some interviewees advised against asking health plans for money, suggesting that requests for operational assistance may be better received. Others noted that plans are approached frequently by a wide variety of entities for financial investments, thus heightening the need for health centers to carefully consider and plan requests for funding or investment.

Other points interviewees highlighted for health centers to consider when crafting a resource requests included:

- Meet face-to-face with health plan leaders to understand and align priorities before creating finalized plans or asks. Understanding priorities before fully developing an idea can allow a plan to provide helpful input and generates buy-in.
- Consider and align with the plan's major areas of focus. Even if your current priorities don't align with the plan's, consider whether supporting the plan's priority could be beneficial in building a relationship.
- Know that health plan financial performance goes in cycles, which can be tracked by reviewing comments of the CEO or publicly available board meeting minutes. In "up" cycles, a plan may have more appetite to invest strategically in initiatives that have longer-term returns. In "down" cycles, more immediate return on investment (ROI) becomes a more important criterion for investment.
- Have a well thought out financial business case. Health plan boards will require it. That being said, the "added value" of any ask is not solely captured in the business case, but on how a proposal contributes to the health plan's mission, goals, and quality improvement efforts as a whole. Health plans aim to generate the most overall—not just financial—value for the dollars they oversee and invest in the community.
- One-time investments (e.g. more efficient and effective information systems, management practices, and infrastructure that will improve quality outcomes) may be easier to gain approval for than requests for ongoing support.

For health centers thinking about a strategic ask of a plan, it bears repeating that interviewees stressed the importance of articulating a shared mission and identifying champions within the health plan that could be helpful carrying the request forward internally. Additionally, health centers should consider other key players or stakeholders, such as the county, that could support or provide buy-in to the requests. Plan leaders acknowledged liking to see support from others when assessing a request.

> *"[Our board] recently approved spending a significant amount of money on housing in our communities…In order to put up this money, … we want to see that we're not the only ones at the table and we're doing something with broader engagement."* – Jessica Thacher, MPH, Former Director of Quality and Performance Improvement, Partnership HealthPlan of California

Finally, interviewees—who themselves have experienced frustration with requests as their careers have had them sit at both sides of the table at different times—advised that health centers should not be discouraged after being turned away. Proving that a health center is worthy of investment may require several tries. Interviewees acknowledged the importance of repeated—though thoughtful and responsive—action and ideation.

> *"[The proposals] that get traction are the ones that are approached with business plans and repeated action…It's always best to find a champion inside the plans because the relationships are so important."* – Brianna Lierman, JD, Chief Executive Officer, Local Health Plans of California

7: Attract health plan attention through size and/or demonstrated interest

Medi-Cal health plans in California are responsible for many hundreds of thousands of lives. However, health centers range widely in their patient population size; in California, 43% of health centers see fewer than 10,000 patients in a year while the largest health center in the state sees over 180,000 patients annually.[21] From the perspective of health plans, efficiency is necessary; as much as many health plans might want to be able to provide tailored support to each health center, it is often impossible to meet and meaningfully engage with every provider regardless of size.

> *"Health plans are more likely to partner with large health centers or banded together ones, absolutely. Minimum size probably depends on region and health plan…. It's easier to work with small ones if they're together or they're mixed - big and little.*
> – Jennifer Sayles, MD, MPH, Chief Medical Officer, Inland Empire Health Plan

To reach the point of having strategic conversations with plans, health centers first need to have the attention of plan leaders. Health plans can better justify spending time, attention, and resources on health centers that represent a larger portion of the health plan's lives. However, this does not necessarily mean that health centers must find a way to increase their own patient populations before seeking partnerships with health plans. Strategies to increase the number of lives represented can take many shapes, including working through consortia, health center controlled networks (HCCN), or health center-led IPAs.[22] In other words, partnering with other health centers can increase collective power and capacity to execute on quality improvement that plans would value.

Approaching a health plan through a partner organization that can provide infrastructural support to the health center can also demonstrate to the health plan that the health center has the necessary capacity to allow the plan's investment to succeed. For example, partner organizations are often helping health centers to have the necessary tools to identify gaps in care and conduct outreach to populations that have not sought care.

> *"We're doing a contract with [the quality and contracting arm of a consortia], and they're functioning as a pseudo-IPA for our network. What I like about it is that they're really focused on quality and infrastructure in what they're building. Many IPAs are focused on specialty referrals. I like the closer connection with FQHCs…there is value in [health centers] getting together and when they do, that's powerful."* – Jennifer Sayles, MD, MPH, Chief Medical Officer, Inland Empire Health Plan

If partnership strategies that can help a health center to approach a plan as part of a larger entity are not feasible, interviewees advised that demonstrating interest in collaboration by "showing up" frequently and noticeably enough for a plan to see the health center as a key partner can also give a health center influence.

> *"For smaller clinics, you don't always have economies of scale – things like a robust HR department, IT infrastructure to make information systems work… But, the plan doesn't turn down a meeting with a provider group or clinic when they ask; the plan wants to hear from them." –*
> – Adam Sharma, MPA, Director of Health Outcomes Improvement, San Francisco Health Plan

CONCLUSION

The seven insights described in this brief represent the synthesis of experts who have deep experience in both health center and public Medi-Cal health plan settings. While our interviewees had not worked in commercial Medi-Cal plans, many of these insights may also hold true when exploring more strategic relationships with commercial partners.

Lastly, and importantly, just as every health center is unique, every health plan also has its own set of internal priorities, operates in its unique local environment, and approaches health center relationships in its own way. Interviewees unanimously emphasized that it is essential to take into account local context when building relationships and starting conversations with plans.

Many health centers may still feel unsure about how to best improve their relationship with their health plan(s). In such a case, the following are three starting questions that might launch a first strategic conversation:

1. What are the key pain points and priorities for your plan?
2. What are your plan's gaps in care that health centers could help to fill?
3. What are high-priority regulations for your plan that health centers could help the plan to meet?

Health plans and health centers will need to work as partners in any sustainable care transformation or payment reform effort within Medi-Cal. These strengthened relationships also hold great promise to result in improved outcomes for patients, providers, plans, DHCS and the health system as a whole.

CITATIONS

[1] Wunsch, B., Reilly, T. Hogan, L. "Medi-Cal Managed Care Plans and Safety-Net Clinics Under the ACA." California Health Care Foundation. December 2015: https://www.chcf.org/wp-content/uploads/2017/12/PDF-MediCalMgdCarePlansSafetyNet.pdf

[2] "Medi-Cal at a Glance, January 2018". California Department of Health Care Services. http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_at_a_Glance_Jan2018_ADA.pdf

[3] Wunsch, B., Reilly, T. Hogan, L. "Medi-Cal Managed Care Plans and Safety-Net Clinics Under the ACA." California Health Care Foundation. December 2015: https://www.chcf.org/wp-content/uploads/2017/12/PDF-MediCalMgdCarePlansSafetyNet.pdf

[4] Nocon, Robert S., et al. "Health care use and spending for Medicaid enrollees in federally qualified health centers versus other primary care settings." American journal of public health 106.11 (2016): 1981-1989. https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2016.303341

[5] "Value of Community Health Center Study." John Snow Inc., California Primary Care Association. 2013. https://www.jsi.com/JSIInternet/Resources/publication/display.cfm?txtGeoArea=US&id=13177&thisSection=Resources

[6] Sharma, Ravi, Lydie A. Lebrun-Harris, and Quyen Ngo-Metzger. "Costs and Clinical Quality Among Medicare Beneficiaries: Associations with Health Center Penetration of Low-Income Residents." Medicare & medicaid research review 4.3 (2014). https://www.ncbi.nlm.nih.gov/pubmed/25243096

[7] Falik, Marilyn, et al. "Comparative effectiveness of health centers as regular source of care: application of sentinel ACSC events as performance measures." The Journal of ambulatory care management 29.1 (2006): 24-35. https://journals.lww.com/ambulatorycaremanagement/Abstract/2006/01000/Comparative_Effectiveness_of_Health_Centers_as.4.aspx

[8] Katie Coleman, Rachel Tobey, et al., "Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment," California Health Care Foundation, March 2018, http://www.chcf.org/PartnerToSucceed

[9] Eubanks, Crystal. "Transforming Primary Care – Strategies to Improve Quality". California Association of Health Plans. Seminar Presentations: The Intersection of Quality & Health Care – How California's Healthcare System Can Transform Care Delivery. 22 May 2018, Burbank, CA. http://www.calhealthplans.org/2018-may-sem.html

[10] Powers, Brian W., Sreekanth K. Chaguturu, and Timothy G. Ferris. "Optimizing high-risk care management." Jama 313.8 (2015): 795-796. https://jamanetwork.com/journals/jama/article-abstract/2099528?linkId=12477280

[11] Katie Coleman, Rachel Tobey, et al., "Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment," California Health Care Foundation, March 2018, http://www.chcf.org/PartnerToSucceed

[12] Health Care Payment Learning & Action Network (HCP-LAN). Accelerating and Aligning Primary Care Payment Models. Rep. no. 17-0478. The MITRE Corporation, 2017. https://hcp-lan.org/workproducts/pcpm-whitepaper-final.pdf

[13] Tobey, Rachel, Jim Maxwell, Elena Faulkner, and Clancey Bateman. "Update on Payment Reform Trends Implications for California Community Health Centers." John Snow, Inc., California Family Health Council and the Regional Associations of California, Jan. 2013. https://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=13162&lid=3

[14] Lally, S., Yegian, J. "California's Medi-Cal Managed Care Pay for Performance Landscape". Integrated Healthcare Association. July 2015. http://www.iha.org/sites/default/files/files/page/issue-brief-medi-cal-p4p-landscape-2015.pdf

[15] Personal communication between Sarah Lally (Project Manager, Integrated Healthcare Association) and Rachel Tobey (Director, John Snow Inc. California), August 2017.

[16] "Best Practices for FQHC Incentive Programs" California Primary Care Assocaition. November 14, 2017.

Accessed May 2018. https://ccalac.org/wordpress/wp-content/uploads/Pay-for-Performance-Best-Practices-for-FQHC-Incentive-Programs.pdf

[17] Letter "In the Matter of San Mateo Medical Center FQHCs, et al. Appeal No.: FQ 14-0610-745B-LM & FQ 14-0610-746B-LM" January 2017.

[18] "Best Practices for FQHC Incentive Programs" California Primary Care Assocaition. November 14, 2017. Accessed May 2018. https://ccalac.org/wordpress/wp-content/uploads/Pay-for-Performance-Best-Practices-for-FQHC-Incentive-Programs.pdf

[19] "Using Data to Manage Population Health Under Risk-Based Contracts" Health Information Technology, Evaluation, and Quality Center (HITEQ). Health Resources and Services Administration. June 2017. https://hiteqcenter.org/Resources/HITEQ-Resources/using-data-to-manage-population-health-under-risk-based-contracts-4

[20] Katie Coleman, Rachel Tobey, et al., "Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment," California Health Care Foundation, March 2018, http://www.chcf.org/PartnerToSucceed

[21] Katie Coleman, Rachel Tobey, et al., "Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment," California Health Care Foundation, March 2018, http://www.chcf.org/PartnerToSucceed

[22] Katie Coleman, Rachel Tobey, et al., "Partnering to Succeed: How Small Health Centers Can Improve Care and Thrive Under Value-Based Payment," California Health Care Foundation, March 2018, http://www.chcf.org/PartnerToSucceed