

Addressing Unmet Needs in Sacramento's Health Care Safety Net: Challenges and Opportunities for 2019 and Beyond



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June 12, 2019

Introduction

For many years, Sacramento County has been challenged in providing adequate access to health care for its low-income residents, both its Medi-Cal beneficiaries and its uninsured and medically indigent population. This paper seeks to identify specific ways that Sacramento County and its residents can advocate to secure and improve their health care safety net—at the federal, state, county, and other arenas.

Background

For a county of its size and prominence, Sacramento County has historically lagged in providing safety net services, at the policy and provider level. The Affordable Care Act along with state Medicaid waivers have provided real opportunities for improvement. The question the county now must ask is how Sacramento can go from laggard to leader in caring for its vulnerable populations.

At the provider level, unlike a dozen other large California counties, Sacramento does not run a public hospital system, but rather one county clinic, down from eleven county clinics from a few decades ago. The University of California Davis Medical Center, the local UC medical center, broke its contract with the county to serve the uninsured several years ago. Since then it has failed to consistently contract with Medi-Cal managed care plans to provide access to Medi-Cal patients outside the emergency room, although a new contract with HealthNet is starting to reverse this. More recently, UC Davis and other local hospitals are taking on more indigent patients. Community clinics have grown substantially, fueled by the health coverage expansions under the Affordable Care Act. But more capacity and coordination is needed in terms of acute care, primary care, specialty care and other elements of care.

At the policy level, Sacramento County has not distinguished itself as a leader. In 2013, Sacramento was the 53rd and last California county to set up a Low-Income Health Program, the early expansion of the Medicaid program under the ACA, partially because of the difficulty in setting up a network of participating providers. Sacramento was one of three counties that cut its indigent care program for its undocumented population in 2009; thankfully, it restored such services under a similar program with the creation of Healthy Partners in 2014. Another example has been regarding the state's Medi-Cal 2020 waiver to draw down funds for whole-person care pilot programs to provide wrap-around services to homeless populations. The County originally declined the opportunity, leaving the City of Sacramento to apply in an unusual arrangement, in partnership with county services. All other whole-person care pilot programs are sponsored by counties, given they are responsible for the broad array of human services as well as health and mental health services.

This leaves many in Sacramento County with huge gaps in access to care. The 425,000 residents with Medi-Cal coverage in Sacramento struggle to find a provider or access specialty care while the uninsured are left with even fewer options for both primary and specialty care.

The Sacramento region also has the lowest percentage of primary care physicians (PCPs) accepting new Medi-Cal patients. A “secret shopper” study by UC Davis researchers on access in the 8-county region around Sacramento found that Medi-Cal beneficiaries had limited access to primary care providers and that Sacramento County had the worst access to PCPs in the region.ⁱ

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These challenges are not unique to Sacramento: Several state audits and studies have found challenges in access to the state's safety net Medi-Cal program in other counties, and also highlight the state's struggle to ensure health plans have adequate provider networks. In 2014, the California State Auditor found that the state's Medi-Cal regulators did not have reliable health plan data in order to understand where consumers are having challenges accessing care. But the challenges seem more problematic in Sacramento than in most other, large urban counties in California.

Unlike many other California counties with a "County Organized Health System" of one major Medi-Cal managed care plan, or those with a "Two Plan Model," Sacramento is only one of two counties with a Geographic Managed Care model with a multiplicity of health plans contracting with the state Medi-Cal program to deliver care. This structure in which the plans contract directly with the State of California has led to a lack of local input and control. It also creates complexity and confusion in navigating the system for both patients and providers, a problem that creates even more dislocation when plans and providers are in contract disputes. Most Sacramento Medi-Cal managed care plans rank near the bottom on quality metrics.ⁱⁱ While Kaiser is an exception to this rule, they serve a limited number of Medi-Cal patients with their unique delivery system.

The Sierra Health Foundation conducted a market analysis on the region's health care safety net between 2012 and 2016 which showed a significant increase in health insurance coverage under the Affordable Care Act, exceeding expectations in the Sacramento region. At the same time, the report documented ongoing issues regarding lack of access to primary care, specialty care, and behavioral health services within the system, and particularly among vulnerable communities. The report found barriers to access stemming from a lack of providers within safety net clinic system and a lack of providers who accept Medi-Cal elsewhere in the health care system.

The Foundation's report pointed to an "overarching need to convene the region's stakeholders who influence population's health...in a collaborative effort to address gaps in meeting needs of the Sacramento region's low-income and vulnerable populations."ⁱⁱⁱ

In 2018, Health Access convened stakeholders in the Sacramento region and identified an overall need for better access to care for Sacramento's uninsured as well as better oversight of Sacramento's Medi-Cal managed care programs. A panel of plans, providers, and advocates presented on the current state of the county safety net and raised questions about the delivery of care and the lack of local input. While health plans and providers highlighted pilot programs and specific successful initiatives on public health or helping specific populations like the homeless, patient and community advocates saw a lack of an overall vision to address the bigger access and equity issues. One county-wide effort was the African-American Perinatal Health Program, which is showing cross-county results of a 46% reduction in black infant mortality in two years, and could be a model for broader actions. Senator Dr. Richard Pan, the then-newly established chair of the Senate Budget Subcommittee on Health, said he wanted to work with stakeholders in Sacramento to "end the 25-year pilot of Geographic Managed Care," to learn the lessons from the experiment while improving the system.

In early 2019, Senator Dr. Pan, now also chair of the Senate Health Committee, convened an even broader set of stakeholders with Chet Hewitt, President and CEO of the Sierra Health Foundation and Peter Beilenson, Sacramento County's Director of Public Health. As of this writing, they are in the middle of hosting a series of meetings to develop community recommendations for moving forward, with a specific focus on the Medi-Cal served populations.

The Recommendations

This paper seeks to inform the broader discussion about improving Sacramento's safety net, with recommendations for advocacy based on what Health Access has learned from our conference last year and in many discussions since. This list focuses on challenges and opportunities for advocacy with state and federal policymakers, recognizing there is a more comprehensive list of actions Sacramento County can undertake with its own resources.

This discussion paper outlines seven opportunities Sacramento and California can take to improve Sacramento's safety net. These seven recommendations include:

- 1) defending our safety net against federal repeals, rollbacks and administrative attacks,
- 2) advancing state efforts to expand access and affordability,
- 3) preserving state funding for Sacramento's safety net,
- 4) augmenting the medically indigent program for the remaining uninsured, including the undocumented,
- 5) encouraging UC Davis, as well as other hospital chains like Sutter and Dignity, to contract more with Medi-Cal and Medi-Cal managed care plans,
- 6) increasing oversight of plans under GMC model in Sacramento, and
- 7) transitioning Sacramento out of GMC, ensuring the transition and model maintains consumer protections required of the Medi-Cal Managed Care program regulated by the Department of Managed Health Care.

This list is not comprehensive, and is evolving, as these recommendations have been adapted to new developments in the last several months from state budget proposals, changes in Medi-Cal hospital contracting, or the current thinking about the Geographic Managed Care model. Here are our recommendations at this point in time, with detailed descriptions and background for each one:

1) Defend against federal repeals, rollbacks and administrative attacks

Under California's efforts to implement and improve the Affordable Care Act, our state has seen the biggest reduction in the uninsured rate of all 50 states. This expansion of coverage has been a boon to all areas of California, including Sacramento, and to much of the health care safety net. Therefore, Sacramento has also seen dramatic reductions in the number of uninsured. Federally qualified health centers have increased their capacity, in part fueled by the Medicaid expansion.

Proposals debated in Congress in 2017 would have undone not just the last five years of health reform by repealing the ACA, but the last 50 years of federal guarantees by cutting and capping the Medicaid program. We appreciate our California Senators Feinstein and Harris, as well as the local House delegation from the Sacramento area, including Reps. Matsui, Bera, and Garamendi, for taking leadership roles in helping prevent those cataclysmic impacts.

The November 2018 elections resulted in a change in control of the U.S. House of Representatives that ends for the moment the threat of Congressional repeal of the ACA and further damage to Medicaid and Medicare. However, major threats to our health care continue, such as a Texas lawsuit to invalidate the entirety of the ACA, a proposed "public charge" regulation to discourage legal immigrants from seeking care, and the tax bill that zeroed out the individual mandate penalty, which is projected to lead to decreased enrollment and potentially higher premiums.

California has taken policy action to mitigate the impact of these administrative attacks on our health system, but should continue to be vigilant. Sacramento policymakers at the federal, state and county levels should support these anti-sabotage efforts.

2) Advance state efforts to expand access and affordability

The receding threat of Congressional repeal has provided greater security for state and local lawmakers to make progress in further expanding access to care. While this paper focuses on local policy changes, Sacramento County would be well served to be an advocate for state proposals that seek to improve access and affordability. A recent UC Berkeley study shows how pending proposals in the California Legislature could help 3.6 million Californians secure, obtain, or better afford health coverage, not only preventing a rise in the uninsured despite the Trump Administration's attacks, but in fact cutting the uninsured further.

The package of proposals, which is backed by Health Access California and a broad #Care4AllCA coalition of 70 organizations, would

- a. Take additional steps to expand Medi-Cal for more income-eligible Californians, under 138% of the poverty level, without regard to immigration status. [SB 29 (Durazo) and AB 4 (Arambula, Bonta, Chiu, Gonzalez, Santiago)]
- b. Pass a state-level individual mandate to ensure health coverage, which will help reduce premiums and increase enrollment. [AB 414 (Bonta)]. The money raised from assessing the penalty would join funding to:
- c. Provide greater affordability assistance in Covered California, for low- and moderate-income Californians. [SB 65 (Pan) and AB 174 (Wood)]
- d. Expand Medi-Cal to additional seniors and persons with disabilities by changing income eligibility (the "senior penalty") as well as making other Medi-Cal eligibility improvements. [AB 715 (Arambula, Wood)]

These actions, together, would bring new resources to Sacramento's safety net providers, and could bring California's (and Sacramento's) uninsured rate down to around 5%, in line with other "universal coverage" countries.

Governor Newsom deserves significant credit for leading on this issue, along with the planning at the state level to get to a fully universal health system. On Day One of his administration, the Governor announced support for elements of the above proposals, including in his first budget the continuation of the ACA individual mandate in California, investing those funds in greater affordability assistance in Covered California, and expanding Medi-Cal to low-income undocumented young adults as steps toward universal coverage.

Sacramento legislators, including Dr. Pan in his role as chair of the health policy committee and the relevant budget subcommittee, supported efforts to build on the Governor's proposal and press for additional steps toward universality and greater affordability. The final California 2019-20 budget includes additional affordability assistance in Covered California, for both families around or below the poverty level, and even more for many middle-income families who don't get help under the ACA. A new state-level individual mandate keeps more Californians in coverage, and thus helps prevent premium increases while also raising revenue for subsidies. The money raised from the mandate will also be augmented by an additional general fund investment to make health care more affordable. The final budget also expands full-scope Medi-Cal for seniors and people with disabilities currently impacted by the "senior penalty," and to all income-eligible young adults regardless of immigration status.

While hundreds of thousands of Californians may become newly covered under this budget, more expansions of Medi-Cal and increased affordability assistance in Covered California are needed to meet the needs of the community and get to universal coverage. Moving this agenda would be a boon to Sacramento County, and deserves the continued support of County leaders in future state budget cycles.

3) Working to preserve state funding for Sacramento's safety net into the future

The Governor's original 2019-2020 budget proposal contained a significant threat to Sacramento's safety net, but after community and county leader advocacy, the threat has been avoided. But this action shows that Sacramento County should take additional steps to secure state funding streams for its public health programs. After hearing concerns from Sacramento County and other counties, Governor Newsom's Administration in May withdrew a budget proposal that would have had a potentially significant and disproportionate impact on Sacramento's safety net. As part of its proposed Medi-Cal expansion, the Administration's budget proposal would have clawed back county realignment dollars used to care for medically indigent Californians as well as public health services. The proposal would have impacted Sacramento County, as well as Placer, Stanislaus, and Santa Barbara. A related proposal still seeks to reclaim the funding stream from the 35 counties in the County Medical Services Program (CMSP).

While Health Access strongly supports the Governor's proposal to expand Medi-Cal to undocumented young adults, and in fact to all income-eligible Californians regardless of immigration status, we raised significant concerns about this related proposal to cut the \$7.2 million that Sacramento County currently uses for public health and safety net care services.

In particular, Sacramento's Healthy Partners program, which serves nearly 4,000 uninsured, and in many cases undocumented, Californians, would have been severely undermined if the proposal went forward. The county projects they would have had to cut provider services by 50%. In contrast, Sacramento reports only 2.5% of their Healthy Partners program are ages 18-26 and thus eligible for the Governor's proposed Medi-Cal expansion. It was not a viable solution to reduce the funding for the county safety net by such a significant percentage given a projected reduction of the uninsured of less than 5%. In 2014, Sacramento created the Healthy Partners program to recognize the needs of the remaining uninsured, including the undocumented, and it would be a real loss to the community for that progress to be rolled back.

Sacramento County also estimated that such a redirection of funding would have had severe impacts on public health work as well, including efforts to address a recent increase in syphilis and other sexually transmitted diseases, California Children's Services program, and Sacramento County's successful African-American Perinatal Health Program. The cuts would have forced reductions in services, from direct services to medically fragile children to home visitation by public health nurses, and the wait-listing or inability to serve patients.

The Governor's May Revise, and subsequent guidance from the Department of Finance, withdrew this initial proposal. But the state may look to the counties in the future for any savings related to coverage expansions. Under the AB85 realignment in 2013, the state developed a formula to leave sufficient funds to counties to care for the uninsured and perform key public health purposes. Most counties adopted that formula. Only the CMSP counties and four other "Article 13" counties chose a "60/40" split instead—and those are the counties (Sacramento, Placer, Stanislaus, and Santa Barbara) that the state is seeking to renegotiate the that deal.

In 2014, Sacramento made a calculation that just the 60/40 split was a better fit for their situation. But since then, Sacramento launched the Healthy Partners program for the remaining uninsured, and undertaken other public health investments. For Sacramento's long-term funding prospects, Sacramento County should calculate how it would fare under the AB85 formula now and especially if the county sought to provide more health services. Switching to be a "formula" county might provide a more stable funding base, more resources for indigent care and public health, and could rebuff future clawback efforts at the state level. While such a switch from a 60/40 county to a formula county would require a change in state law, it begins with Sacramento County asking for the law to be changed.

In particular, Sacramento is in a different situation than Placer, Stanislaus, and Santa Barbara, which do not explicitly serve the undocumented in their indigent care programs. Beyond public health, Sacramento has a

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more compelling case for keeping indigent care money. Even if the AB85 formula does not yield more resources for the county, Sacramento would benefit from doing further analysis to figure out how to meet the needs in the county—and then advocate for those needs as appropriate. This Governor, with his own history of a county-based and clinic-based safety net programs, as well as this Legislature, might be more amenable to Sacramento keeping more of the money if there was a clear commitment that it would be used for further expanding access, as a bridge to a universal state solution he has stated is his goal.

We want Sacramento to be committed to continuing and expanding its base programs of medically indigent care, including Healthy Partners. Sacramento County should explore changes in state law to accompany the changes the county is making, and has made, in its approach to the safety net.

4) Augmenting Sacramento County's medically indigent program for the remaining uninsured, including the undocumented

One of the areas of pride for local low-income health advocates was their critical work in advancing the county-based initiative, Healthy Partners. The county program was a needed response to address insufficient access to primary care in Sacramento County, and it should be given the opportunity to grow to meet the needs of the community.

The Sacramento Healthy Partners Program (SHPP) is a limited-benefit pilot program. In 2017, the program had an enrollment cap of 3,000, with over 500 individuals on the wait list as of February 2018. The program at first accepted referrals from La Familia, Sacramento ACT (PICO Chapter), and Sacramento Covered. Dignity Health, through the volunteer-based SPIRIT Program, provides pro-bono work for specialty care.

Advocates recommended raising the SHP program cap from 3,000 to 4,000 people, and increasing or eliminating the age limit of 65 years. In 2017, the county considered an additional \$1.5 million for specialty care access.

In February 2018, Sacramento Building Healthy Communities' Health Action team advocated at the Sacramento Board of Supervisors for lifting enrollment caps in the SHPP program. The Board of Supervisors expanded the program to include those on the waitlist, and those who otherwise would have aged out of the program. There are additional funds to provide care to as many eligible patients. However, the enrollment cap and limits on eligibility remain. Additionally, there is no guarantee that persons over age 65 will continue to remain eligible for the program.

Efforts at the state level to expand health care coverage to persons who would have otherwise been eligible for Medi-Cal but for their immigration status were unsuccessful in 2017 and 2018, under a prior Administration reluctant to use state budget dollars for on-going commitments. Health4All efforts continue in the state legislature, under a new Governor's promise to get to universal coverage, including covering the undocumented. In December 2018, Assembly Bill 4 (Arambula, Bonta, Chiu) and SB 29 (Lara & Durazo) were introduced to extend Medi-Cal coverage to all eligible persons, regardless of immigration status.

We recommend that the Board of Supervisors:

- a. remove enrollment caps to the HPP program, and
- b. grant Sacramento County DHS the ability for additional flexibility and control over the Sacramento Healthy Partners Program budget, to allow the program to provide services to as many eligible patients as possible, and
- c. augment the HPP Program to improve access to specialty care by expanding the list of conditions covered under HPP, encourage comprehensive screenings of patients, and contract to build an adequate network of specialists available to HPP patients, and finally,

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- d. make the Healthy Partners Stakeholder Advisory Group a formal advisory group of the Board of Supervisors to help ensure the Board is appropriately advised of community needs and recommendations for the program.

5) Encourage UC Davis, as well as Sacramento's other hospital systems, to do more to contract with Medi-Cal and Medi-Cal managed care plans

In addition to bolstering care for the indigent and uninsured, Sacramento County must improve its ability to deliver care to Medi-Cal managed care beneficiaries.

Last year, the exit of United Healthcare as a Sacramento Medi-Cal managed care plan, the only Medi-Cal managed care (MCMC) plan that was contracting with UC Davis, raised concerns among low-income health advocates, faith-based organizations, and Sacramento Building Healthy Communities. These organizations have expressed interest in greater county-level oversight over procurement of MCMC plans and network adequacy. While UC Davis provided services to Medi-Cal patients through the emergency room, which it must, the lack of a contract meant UC Davis was effectively not providing primary care services or most specialty care, even though the medical school and its facilities are in the heart of a medically needy community in Oak Park, Sacramento.

UC Davis' recent contract with HealthNet's Medi-Cal managed care plan was a positive step, but does not fully resolve community concerns. There are currently 425,000 people with Medi-Cal in Sacramento, and even though there is growing community clinic capacity, the increased caseloads as a result of the Medicaid expansion require all our local hospital systems to contract to accept Medi-Cal patients.

Given its affiliation as a public university, UC Davis Medical Center can and should do more for Medi-Cal patients. This would be good for the community, as well as for the Davis Medical Center and their residents who are training to become doctors in a state where over a third of the population, and half of births, are under Medi-Cal coverage.

Previous administrative advocacy efforts, including by Western Center on Law & Poverty, to require each UC medical center to have at least one Medi-Cal contract have been considered by the Legislature. However the UC Regents opposed including this provision in California's Medicaid 1115 waiver. Given UC's unique role in California, the State should consider action to require UC Hospital Systems to contract with Medi-Cal providers. Potential solutions include state advocacy efforts to the UC as well as other hospital systems, to contract with Medi-Cal managed care plans.

UC Davis is the most visible example of the need for more engagement by local health institutions. A conversation about increasing the capacity of Sacramento's safety net is needed not only with UC Davis, but also Sutter and Dignity hospital chains, as well as Kaiser. Kaiser serves a relatively small portion of the Medi-Cal population with positive quality metrics, but given its unique model, it is unclear whether Kaiser's success can be replicated more broadly. All four major health systems in California should be partners in providing a comprehensive safety net for Sacramento County.

6) Transition Sacramento County out of GMC Model, to a more streamlined system, while ensuring this transition and model maintains consumer protections and increases local oversight

Medi-Cal Managed Care serves about 13 million Medi-Cal beneficiaries in 58 counties. In California, there are six models of managed care, but only two counties have the "Geographic Managed Care" model (GMC), serving almost one million beneficiaries. In the GMC counties of Sacramento and San Diego, DHCS directly contracts with multiple commercial plans to manage the care of Medi-Cal beneficiaries.

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Sacramento’s Geographic Managed Care model was the first—some might say guinea pig—and is officially, many decades later, still considering a “pilot project.” Sacramento’s new Health Director, Dr. Peter Beilenson, has signaled interest in transitioning to another model of managed care.

Issues that have been raised about Sacramento’s Medicaid “GMC model” include:

- Lack of local control and local oversight, since all of the contracting and oversight is done by the state, rather than local stakeholders and partners.
- Many patients shifting among a multiplicity of plans and providers, leading to general confusion and less continuity of care.
- The fragmentation of the market may mean it is harder to coordinate care and there is less opportunity for plans to develop the scale to focus on high-need populations and engage in public health strategies.

Sacramento’s issues with its safety net may be less about the GMC model than that Sacramento is a large urban county without the corresponding infrastructure of a public hospital, clinics, and other providers. But having lots of health plans dividing up a relatively small number of patients, contracting with the same limited number of clinics, hospitals, and other providers, seems unnecessarily complex. Medical records are hard to transfer between plans, and providers have to get credentialed and learn the IT and payment systems and procedures of six different plans and reimbursement rules, with little standardization between them.

Health Access California, as well as other consumer and community groups, would potentially support a change or modification to the GMC model, moving to a model with fewer health plans and a more streamlined, simpler, and standardized experience for providers and patients. For example, a switch to a single health plan would simplify a complex system, but also might be a tough transition given the numerous health plans, delegated medical groups, providers, and hospital systems. Also, a Sacramento County Organized Health System (COHS) managed care plan should be Knox-Keene licensed, providing the same consumer protections and Department of Managed Health Care oversight as other managed care plans in the state. Virtually all Medi-Cal managed care plans are licensed by the Department of Managed Health Care, but a few are not. Trading one model of inadequate oversight, GMC, for another model of inadequate oversight, an unlicensed County Organized Health System, would not assure an improvement in access or care.

If Sacramento County chooses to stay with the GMC model, at the very least, it should advocate to get a more robust local voice in decision making. San Diego County, the other county with a Geographic Managed Care model, has a decades-long history of local stakeholder involvement and input that could serve as a model for Sacramento County.

Community engagement would also be key if there is real transition away from GMC in Sacramento: we would recommend a phased-in approach, advised by the county and local advocates. An advisory group with a larger number of consumer advocates, and with a role similar to those in San Diego County, their other GMC counterpart, could help provide an oversight tool to local advocates until such a transition begins.

7) Increase oversight of Sacramento’s Medi-Cal managed care plans, including the new Medi-Cal procurement process, and more aggressive oversight on quality and equity

Although Sacramento County has an advisory group to discuss Medi-Cal managed care issues in Sacramento, they are not able to exercise meaningful oversight over managed care plans. This group serves only in an advisory role to the county, and do not have any voting power on items elevated to the Board of Supervisors. By contrast in San Diego County, the only other county in California under the GMC Model, the advisory committee has voting authority over contract elements and terms, including whether specific managed care plans will receive contracts.

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A significant difference in the way Geographic Managed Care is handled in Sacramento as opposed to San Diego is that the Sacramento County advisory board serves only in an advisory capacity, whereas San Diego has a stronger charter for its advisory group. SB 2139 (Haynes, 1996) authorized San-Diego's "multi-plan" Geographic Managed Care model, included two advisory boards appointed by the Board of Supervisors that would work with the state in procuring managed care plans and building networks. One advisory board was consumer representatives, and the other board was representatives of health care professionals. These boards were eventually consolidated into one group. Participating health plans in San Diego GMC must first be designated for approval by the county department, and approved by the County Board of Supervisors. The Advisory Board at the county must vote on all GMC policies and issues that are submitted to the Board of Supervisors for approval.^{iv} This voting power was exercised during San Diego's last round of procurement, with San Diego County rejecting one of the plans from joining their GMC program.^v

If a transition away from GMC happens in Sacramento County, an advisory group with voting power and authorities similar to their other GMC counterpart will help provide an oversight tool to community members until a transition begins.

Sacramento County tried to include this type of oversight when they formed an advisory group, but was unsuccessful. Some advocates recall that the state was unwilling to include a stronger charter for Sacramento in 2010 because of the recession, with the State being unwilling to provide additional funding for the level of oversight needed to ensure network adequacy in Sacramento's managed care programs and increased access to care.

Even without transitioning away from the GMC model, the state has a new opportunity in 2019 as it goes into a new round of procurement for all commercial health plans in Medi-Cal statewide, and thus sets standards for plans who wish to contract with the state. Just because more than one or two plans can be contracted with in Sacramento, that does not mean that Medi-Cal should be contracting with all comers. Even if Sacramento County does not seek changes in managed care contracts, the State of California may reduce the number of health plans or change the managed care plans with GMC contracts in Sacramento County. Given the current planning taking place, Sacramento County should engage with the State of California with respect to the Medi-Cal procurement process for GMC.

Statewide, the California Department of Health Care Services has also proposed setting a higher quality standard for health plans, including that any Medi-Cal managed care plan must be in at least in the 50th percentile with regard to HEDIS quality metrics which would be a significant improvement over the current standard to be above the 25th lowest percentile. This new standard on quality and equity would be more frequently examined, and the subject of corrective actions plans and administrative penalties, but first and foremost it is a clarion call for the remaining health plans to improve.

Consumer advocates have sought a process for setting standards and expecting year over year improvements in quality and equity in terms of reducing health disparities, and will continue to do so administratively as well as legislatively. By encouraging the state to adopt a higher standard of what plans are allowed to serve Medi-Cal patients, the state could use this procurement opportunity to evolve from the current fragmented system to a more centralized and hopefully accountable system. While the procurement process happening this year is largely internal to DHCS, Sacramento County leaders and community groups should weigh in with their ideas of what should be in the Medi-Cal managed care contract, and find ways to engage the process.

These points are not meant as an alternative to a broader move away from Geographic Managed Care, but consideration to be included in any transition timeline. Changing from a GMC model in Medi-Cal may need state legislation and may require federal permissions as well.

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Other recommendations from local stakeholders include:

In addition to the recommendations listed above, Health Access heard many other suggestions and opportunities for improvement at our 2018 Sacramento convening and in subsequent discussions. While this paper is not attempting to be fully comprehensive of all the options to improve Sacramento County's safety net, we wanted to acknowledge some areas for additional help.

Several in the health industry raised the issue of Medi-Cal reimbursements and funding for more high-quality clinics in the Sacramento, in areas of high-need. Other providers collectively recommend cultivating more transparency and communication between hospital systems and beneficiaries, including a centralize information exchange. Another suggestion was making sure that Medi-Cal beneficiaries assigned to an FQHC are also assigned to a contracted hospital to help facilitate specialty care. Many referred to the need for a "no Wrong Door" approach, while some advocates argue there aren't enough doors to open for patients.

Many comments focused on improving behavioral health. Another whole paper could be written on improvements needed for Sacramento County's Mental Health System, even in the context of the safety net. Access to mental health is seen as particularly problematic but also essential to the Medi-Cal and uninsured population. Ideally, mental health should be fully included and integrated in Medi-Cal managed care services, even as the challenge to meet that goal are significant, given the differences in providers, structures, and funding streams.

While Sacramento County has lagged in providing safety net services, we acknowledge the improvements already made. Yet that progress should not be an excuse for the status quo. Sacramento County can and should seek a stronger safety net, in part through aggressive advocacy with our state and federal policymakers to partner with Sacramento to improve the health system we all rely on. We hope these recommendations help facilitate reaching that goal.

This report was written by Anthony Wright and Myriam Valdez of Health Access Foundation. The paper and related work was supported by The Sierra Health Foundation. This report can be found on Health Access' website at www.health-access.org.

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