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Academic Health Centers and Medicaid: Advance or Retreat?

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Abstract

The expansion of Medicaid under the Affordable Care Act has strained the capacity of many academic health centers (AHCs) to deliver primary and specialty care to this traditionally underserved population. The authors, longtime faculty members in the University of California Davis Health (UCDH) system, discuss the challenges of UCDH's participation in Medi-Cal, the nation's largest Medicaid program, and their institution's controversial decision in 2015 to withdraw from all Medi-Cal primary care contracts, which has had untoward effects on UCDH's social and educational missions. The authors conclude by suggesting an alternate approach for engaging with Medi-Cal. They call on AHCs to leverage their considerable intellectual and human capital as well as their focus on education and research to aggressively pursue innovative models of high-value primary care for underserved populations in their local communities, highlighting several recent successful examples of such programs. The UCDH experience has implications for other AHCs grappling with the financial realities of an increasingly competitive, value-based health care marketplace and the inherent difficulty in balancing educational, research, patient care, and social or community service missions.

One of the most far-reaching effects of the Affordable Care Act (ACA) has been the expansion of Medicaid. Nowhere has this expansion been more dramatic than in California, where nearly five million beneficiaries were added to Medi-Cal (California's Medicaid program) after the ACA went into effect. Medi-Cal is the nation's largest Medicaid program and is now California's largest health insurer, expending some \$100 billion in 2017 to cover nearly 14 million low-income and/or disabled children and adults (i.e., a third of adults and half of children in the state).¹ In some counties, more than half of the population has Medi-Cal coverage. Hispanics and Blacks make up the majority of Medi-Cal beneficiaries² and are significantly more likely to be poor than Whites and Asians.³

The expanded role of Medi-Cal as a health insurer has presented many challenges for California's academic health centers (AHCs), including our own institution, the University of California Davis Health (UCDH) system. UCDH was established in 1966, when the Sacramento County Hospital signed an agreement with the University of California to become the primary teaching facility for its new medical school at the University of California, Davis. UCDH now includes a 627-bed hospital with a Level 1 trauma center designation, 17 primary care clinics, a broad array of tertiary and quaternary specialty services, and nearly 14,000 faculty, staff, and students, among other health care delivery assets.⁴ Since its founding, UCDH has earned a reputation for educating primary care physicians and serving the area's poor and disenfranchised. In recent years, however, these traditions have proved an insufficient bulwark against perceived economic realities, and in 2015 UCDH terminated its last Medi-Cal primary care contract. Despite being a non-profit, state-designated public hospital system, UCDH no longer routinely accepts Medi-Cal patients in most of its ambulatory care clinics. And while Medi-Cal beneficiaries account for nearly 40% of hospital discharges, UCDH now provides care to

fewer Medi-Cal inpatients than one of its three private non-profit health system competitors and provides fewer Medi-Cal emergency department visits than all three of its local competitors. This retreat from Medi-Cal has prompted medical student, housestaff, and faculty protests and generated widespread public criticism.

UCDH's Medi-Cal experience has relevance for other AHCs that are struggling to care for Medicaid populations in today's emerging value-based health care economy. In this Invited Commentary, we discuss UCDH's withdrawal from providing Medi-Cal primary care services and the consequences for our AHC's social and educational missions, and we suggest an alternative approach for engaging with Medi-Cal. None of us were involved in UCDH's decision-making with regard to Medi-Cal. One of us (K.W.K.) previously administered the Medi-Cal program and pioneered Medi-Cal managed care when serving as director of the former California Department of Health Services.

A Medi-Cal Primer

California has long offered one of the most comprehensive Medicaid programs in the nation and was the first state to operationalize Medicaid managed care. Since the early 1980s, Medi-Cal has been transitioning from a fee-for-service (FFS) payment model to one that relies on risk-based contracts with managed health care plans. Capitated arrangements have been the dominant mode of financing care delivery for Medi-Cal since 2004 and now cover more than 80% of Medi-Cal beneficiaries. Under this model, the state Department of Health Care Services (DHCS) contracts with state-licensed health plans to oversee the delivery of health care services in exchange for a monthly per member capitated payment. The plans are accountable and at financial risk for providing services according to their contracts with DHCS, although the plans transfer varying

amounts of risk to the frontline providers who contract with the plans to actually deliver the health care services.

An unusual feature of California's approach to Medicaid managed care is that DHCS contracts with different types of plans in different counties. The majority of Medi-Cal beneficiaries are enrolled in what is known as a two-plan model, which gives them a choice between a local publicly-run health plan and a commercial plan.⁵ This model operates in 14 counties, including many of the most populous counties. Twenty-two counties operate county organized health systems, in which all Medi-Cal beneficiaries are enrolled in a single locally-developed and publicly-administered managed care plan. In San Diego County and Sacramento County, where UCDH is based, DHCS contracts with multiple commercial and non-profit health plans, which compete to serve Medi-Cal beneficiaries; this is known as the geographic managed care model. In all but one of the remaining 20 counties, DHCS contracts with two commercial plans to serve Medi-Cal members. In one small rural county, DHCS contracts with just one commercial plan. A perennial challenge for health care providers has been Medi-Cal's very low payment rates, resulting in low provider participation and thus limited access for many beneficiaries. A 2014 federal report showed that only 49% of office-based physicians in California were accepting new Medicaid patients, compared to 70% nationally.⁶ Low Medi-Cal FFS reimbursement rates (the 47th lowest in the United States) prompted several providers to sue DHCS for violation of federal rate-setting standards.⁷ A 2015 State Auditor's report identified significant problems with the Medi-Cal managed care plan provider networks and raised multiple concerns about the adequacy of beneficiary access.⁸ Medi-Cal's lower-than-market payment for services has been an ongoing challenge to ensuring access under both the FFS and managed care models and has discouraged AHCs such as UCDH from deeply engaging with the program.

UC Davis and Primary Care

The University of California, Davis, School of Medicine (UCDSOM) was founded to train primary care physicians to serve underserved populations in northern California, among other missions. Its student body is among the most racially and ethnically diverse in the United States,⁹ mirroring the rich racial and ethnic diversity of California, especially the Central Valley. Not surprisingly, many students strongly identify with Medi-Cal patients (a plurality of whom are non-White) and believe that providing this population access to primary care is a moral imperative. The proportion of UCDSOM graduates practicing primary care has consistently been in the top fifth of medical schools nationally.¹⁰

So, why would a public AHC with a well-established reputation for training primary care physicians stop participating in a federal health insurance program on which a third of Californians depend for primary care?

AHCs and Medicaid: The Many Challenges

Many observers have long viewed AHCs as the crown jewels of the U.S. health care system, although they face daunting challenges in balancing their educational, research, patient care, and social or community service missions in a health care marketplace that is increasingly driven by competition for value.¹¹ AHCs are pursuing several different strategies to overcome these challenges. Some have tried to deflect market forces by pursuing mergers and acquisitions aimed at growing their market share, thereby reducing competition and increasing bargaining leverage with payers. Others have focused on offering more tertiary and quaternary services or highly specialized boutique services. Still others have focused on improving the patient experience or improving quality of care. A few have partnered with community agencies to address upstream social determinants of health. These strategies are not mutually exclusive, and many AHCs are

employing varying combinations to achieve their goals. However, demonstrating health care value for members of underserved populations, such as Medicaid beneficiaries, who often lack basic social and economic stability, can be a challenging and risky proposition for an AHC. An atmosphere of uncertainty and strained resources tends to promote risk aversion. Thus, organizational leadership may be inclined to hunker down and strategically focus on what they are passionate about, what they do best, or what drives their economic engine.¹² For AHCs, this often means focusing on high-end tertiary and quaternary services. This logic may help explain why, in June 2017, UCDH announced that it was withdrawing from Western Health Advantage, a regional health maintenance organization it helped establish in 1996 for middle-income and working-class individuals. UCDH leaders concluded that it no longer made sense, at least financially, to be a partner in a low-cost health plan. Similarly, some University of California officials recently opined that its AHCs should stick to what they are “best at” (i.e., specialty care), leaving primary care to nurse practitioners and other community-based health care providers. Through this lens, the demise of the Medi-Cal and Western Health Advantage primary care contracts may appear not only necessary but perhaps even desirable, despite the importance of a strong primary care patient base for medical education, specialty care referrals, and to meet local community health needs.

Unfortunately, UCDH’s decisions regarding its Medi-Cal primary care contracts have had untoward effects on graduate medical education programs in family medicine, internal medicine, pediatrics, and obstetrics, among others. These programs have experienced substantial losses of patients and disruption of established doctor-patient relationships. UCDSOM students, a third of whom come from ethnic or racial groups underrepresented in medicine, have become discouraged because their institution no longer provides primary care to patients from their

communities. In response to the public and internal outcries, UCDH leadership is now attempting to forge new partnerships with federally-qualified health centers to “make up” for the lost Medi-Cal primary care contracts, although many of these organizations have little experience with medical education.

In many ways, UCDH is confronting an existential crisis stemming from competing values--its commitment to research and dependence on highly specialized clinical care, especially tertiary surgical procedures and trauma care, versus its historical and cultural commitment to primary care education, vulnerable populations, and community health.

A Better Way Forward

We assert that this does not have to be an “either-or” proposition. Instead of retreating from Medi-Cal, we believe a better way forward is for UCDH and other AHCs to commit to pursuing innovative models of high-value primary care for underserved patients in their local communities. By leveraging their culture of inquiry, research and teaching infrastructure, and faculty and staff members’ commitment to the social mission, AHCs should be able to advance the care of Medicaid beneficiaries while maintaining fiscal health, accepting the fact that government payers generally reimburse care at lower rates than commercial insurance. AHCs should also redouble their efforts to become true learning health care systems,¹³ training the next generation of physicians from all specialties to practice high-value, cost-conscious care.

Instead of withdrawing from its Medicaid primary care contracts, we believe that UCDH should judiciously expand its care of Medi-Cal beneficiaries by pursuing a multi-faceted strategy of: (1) partnering with community-based providers and service organizations to both facilitate access to care and address the social determinants of health; (2) aggressively using telehealth and other virtual care modalities to increase access and improve continuity of care; (3) vigorously

enhancing care coordination; (4) utilizing community health workers, such as community paramedics and home health nurses; and (5) assiduously focusing on quality of care, particularly for vulnerable patients.

One example of such an approach is the Learning From Every Patient pilot at Ohio State University, which simultaneously reduced inpatient days (by 43%), hospitalizations (by 27%), and emergency department and urgent care visits (by 30% and 29%, respectively) for children with special needs, while reducing health care costs by \$1.36 million over one year for a savings of \$6 for every dollar invested in the program.¹⁴ Brigham and Women's Hospital in Boston reduced emergency department costs by 15% by focusing on care coordination for frequent emergency department users.¹⁵ The Healthcare for the Homeless-Houston project, originally a partnership with Baylor College of Medicine, reduced health care costs by 57% and emergency department visits by 64% after implementing a care coordination and social assistance intervention for emergency department high utilizers.¹⁶ Montefiore Medical Center, an academic medical center in New York City that serves primarily low-income patients, achieved financial and organizational sustainability by integrating care management across the system, nurturing traditional and innovative models of primary care, and focusing on population health management.¹⁷ These and other examples show that the fiscal challenges of caring for Medicaid patients can be addressed by well-planned, carefully coordinated, clinical care improvement initiatives.

Developing new models of comprehensive primary care for Medicaid beneficiaries and other underserved populations will entail some risk for UCDH or any AHC. However, the risk of inaction or disengagement is arguably greater, whether measured in terms of reduced educational opportunities, diminished institutional reputation, or lost community good will. The risks of

complacency--betting on the continuation of FFS reimbursement of tertiary care services as the foundation for long-term fiscal stability--will only grow. We believe that AHCs should maximize their options, continuing to deliver the highly specialized health care services that only they can provide, while concomitantly conducting bold experiments in primary care and population health management to advance knowledge of high-value care delivery for the underserved. Ultimately, the failure to tackle issues of access and quality for the most vulnerable may represent the biggest risk of all--abandoning our moral compass and the values on which medicine was founded.

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References

1. California Department of Health Care Services. Medi-Cal Monthly Enrollment Fast Facts, August 2017.
http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_Aug2017_ADA_FIN_AL.pdf. Accessed May 7, 2018.
2. California Department of Health Care Services. Medi-Cal at a Glance, August 2017.
http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_Glance_Aug_2017_ADA.pdf. Accessed May 7, 2018.
3. The Henry J. Kaiser Family Foundation. The California Health Care Landscape. August 2015 Fact Sheet. <http://files.kff.org/attachment/fact-sheet-the-california-health-care-landscape>. Accessed May 7, 2018.
4. UC Davis Health. Points of Distinction. 2017.
http://www.ucdmc.ucdavis.edu/common/includes/shared/publications/pointsofdistinction/Points-of-distinction-2017_web.pdf. Accessed May 7, 2018.
5. Tatar M, Paradise J, Garfield R. Medi-Cal Managed Care: An Overview and Key Issues. March 2, 2016. The Henry J. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/medi-cal-managed-care-an-overview-and-key-issues>. Accessed May 7, 2018.
6. Centers for Disease Control and Prevention. National Center for Health Statistics. National Electronic Health Records Survey, 2015. Figure: Percentage of office-based physicians accepting new Medicaid patients, by state.
https://www.cdc.gov/nchs/data/factsheets/factsheet_hiac_fig2.png. Accessed May 7, 2018.
7. Rosenbaum S. Medicaid Payment Rate Lawsuits: Evolving Court Views Mean Uncertain Future for Medi-Cal. California Health Care Foundation. October 10, 2009.

<http://www.chcf.org/publications/2009/10/medicaid-payment-rate-lawsuits-evolving-court-views-mean-uncertain-future-for-medical>. Accessed May 7, 2018.

8. California State Auditor. California Department of Health Care Services. Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care. Report 2014-134. June 2015. <https://www.bsa.ca.gov/reports/summary/2014-134>. Accessed May 7, 2018.
9. Association of American Medical Colleges. FACTS. Table B-5: Total Enrollment by U.S. Medical School and Race/Ethnicity, 2017-2018. <https://www.aamc.org/download/321540/data/factstableb5.pdf>. Accessed May 7, 2018.
10. Association of American Medical Colleges. Missions Management Tool. Report Prepared for University of California, Davis, School of Medicine; 2017.
11. Lee TH. Discovering strategy: A key challenge for academic health centers. *Trans Am Clin Climatol Assoc.* 2016;127:300-312.
12. Collins J. *Good to Great: Why Some Companies Make the Leap...and Others Don't*. New York, NY: HarperCollins Publishers; 2001.
13. Smith M, Saunders R, Stuckhardt, McGinnis JM, eds. *Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*. Washington, DC: The National Academies Press; 2013.
14. Lowes LP, Noritz GH, Newmeyer A, Embi PJ, Yin H, Smoyer ER. 'Learn from every patient': Implementation and early results of a learning health system. *Dev Med Child Neurol.* 2017;59:183-191.
15. Lin MP, Blanchfield BB, Kakoza RM, et al. ED-based care coordination reduces costs for frequent ED users. *Am J Manag Care.* 2017;23:762-766.

16. Holton-Burke RC, Buck DS. Social interventions can lower costs and improve outcomes. NEJM Catalyst. March 7, 2017. <https://catalyst.nejm.org/social-interventions-improve-outcomes/>. Accessed May 7, 2018.

17. Chase D. Montefiore Medical Center: Integrated Care Delivery for Vulnerable Populations. Commonwealth Fund pub. 1448, Vol 53. October 2010. <http://www.commonwealthfund.org/publications/case-studies/2010/oct/montefiore-medical-center>. Accessed May 7, 2018.

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