Q&A with the Health Care Safety Net Institute and Local Health Plans of California on collaborating to improve care

July 10, 2024

Earlier this year, the California Health Care Safety Net Institute (SNI) and the Local Health Plans of California (LHPC) gathered quality teams and executive leadership from 16 public health care systems and 12 local health plans across the state. This convening, the first of several in a series, aimed to build stronger partnerships between plans and systems, which share a mission to deliver high-quality and equitable care for individuals with Medi-Cal coverage.

In this interview, Giovanna Giuliani, Executive Director of SNI, and Linnea Koopmans, CEO of LHPC, discuss what plans and systems learned about each other at the convening, what forces are shaping these relationships today, and how a model collaborative approach resulted in significant gains for patients.

Q. Local health plans and public health care systems have worked together for many years. Why is strengthening these relationships a priority now?

Linnea Koopmans: As of January 2024, 99% of all Medi-Cal beneficiaries were in managed care, and over 70% of those statewide were enrolled in a local health plan.

And while our roots and history together go way back to the origins of the local plans, the stakes are higher both because the populations we're serving are becoming more similar and more members are in managed care. This gives plans and systems the opportunity to align incentives and align programs. It feels like the right time to see what else we can do together to strengthen these partnerships and relationships locally.

Giovanna Giuliani: Because there are many more individuals in Medicaid managed care, and because of some of the state's strategic initiatives, the state is really centering the plans as key partners in being able to accomplish

Cal-AIM [California Advancing and Innovating Medi-Cal] and the state's priorities. And the state is being much more thoughtful about the alignment of incentives, which I think is a good change.

Increasingly, the plans and the public health care systems, or any providers, are tied together financially. So, our actions when we collaborate will lead to shared success, and when we don't collaborate will lead to shared loss.

Q. How is a lack of close collaboration between plans and systems ultimately detrimental to patient care?

Linnea: My initial thought is that if we're saying a lack of collaboration is detrimental to patient care, I think we're making the direct linkage between partnerships and collaboration influencing health outcomes and quality of care. And I think that's the premise of all this.

The success of local plans and public health care systems is highly interdependent. As we quite literally serve the same members or patients, when we work together instead of in silos, we will see greater improvement in timely access to care and quality of care.

Giovanna: I think you might see a lack of collaboration in the way a patient experiences care. For example, if you go into a hospital, then you need to follow up with your primary care provider. That might not be a public health care system. That might be another type of provider that the plan manages. Then you might need to go to step-down care. You might need follow-up care and county behavioral health. There are all of these sort of handoffs that public health care systems may not have a view into, but plans do. So, we really need to be coordinated in ensuring those transitions and handoffs take place.

Q. What examples or evidence do you have that closer collaboration ends up benefiting patients?

Linnea: The proof is in the pudding with the outcomes that IEHP [Inland Empire Health Plan] and Riverside University Health System presented at the convening.* That was the most compelling part.

They talked about the starting point for leadership commitment as the shared vision partnership. They talked about meeting regularly. They talked about data sharing. And at the end of the day, they showed the difference it made on their quality scores, which directly translated to more people having controlled blood pressure. And it wasn't just a small difference. It was a really meaningful difference.

**The IEHP-RUHS collaborative approach resulted in increasing patients' blood pressure control 15% between 2021 and 2023.*

Giovanna: In that Riverside example, the plan did a lot of work around data sharing, but it also supported the remote patient monitoring for blood pressure, sending patients the blood pressure cuffs. And that was obviously a critical component of success to that work, as well as how they supported one another as organizations and as people. There's a lot I love about that Riverside continuum because it lays out what's possible.

Q. At your first plan-system convening earlier this year in Burbank, did anything stand out to you or surprise you? Any observations?
Linnea: The energy and interest around collaboration was palpable. The attendance by nearly all local plans and public health care systems signified an appetite to learn from one another about how they are leveraging partnerships to improve quality outcomes. The room was packed!

Plans and their system partners have success stories to share, and the information about how they do this work together is not proprietary. There's an interest in sharing – in detail – how plans and systems have solved problems, improved quality metrics, and unified their leadership.

Giovanna: I have a couple of ahas from our first convening. One was that I learned a lot from Linnea about what financial incentives are at stake for the plans, which I didn't know at my level. And similarly, I think there were sort of raised eyebrows, in particular, about how big the Quality Incentive Pool [QIP] is. It's $1.8 billion.

I shared at the convening what QIP means to our systems. The loss of any of those dollars really impacts care on the ground, direct services to patients. And when I talked to a couple of plans, they shared that maybe a few people at their plan knew about QIP, but it didn't penetrate very far. And they certainly did not know about the level of financial incentive. So, I think we at SNI need to do a better job of figuring out how we can communicate about QIP, and we need to encourage our members to do a better job of communicating about what's at stake.

I joined one table where folks from a plan and system were talking, and they realized that they had some similar touch points around QIP, CalAIM, and transitions of care, but none of it was coordinated. So, they had been working together, but in a fragmented, siloed way. There wasn't an overall governance

structure. When they left, their intention was to get everyone together to build out this structure so they can work together more systematically, and all be on the same page.

The other big aha for me was that some of the people really were in the room for the first time. Some flew from Northern California to Southern California to be at this meeting, but they're not meeting in their local region on a regular basis. We need to create an environment and a communication approach where those relationships are developed with more intentionality on an ongoing basis.

Q. Linnea, what challenges do the plans face that systems might not be aware of or appreciate?

Linnea: There is an interdependence between plans and systems that may not always be apparent. It's not a matter of systems doing what they need to do to earn QIP dollars and plans doing what they need to do to avoid sanctions. Given the magnitude of how many patients overlap in who the systems and plans serve, the interests are aligned.

Over the last few years since COVID, with CalAIM and the state's Comprehensive Quality Strategy, and the recent implementation of the 2024 MCP [Medi-Cal managed care plan] contract, the expectations around how the Medi-Cal system performs have really changed.

This means that for the plans, there are now multiple different policies and programs that are driven by quality performance. While there is generally alignment across those programs with respect to the priority measures or populations, the stakes for performance are now much higher.

So, for example, plans are subject to sanctions and penalties if they do not meet the established minimum performance levels, and MCP enrollment is now driven based on quality as the auto-assignment algorithm now only considers a plan's quality performance. All of these policies and programs directly impact how the plans are engaging with and supporting their public health care system partners in quality improvement efforts.

Q. What are you collectively focusing on next?

Giovanna: I think it's building out what Linnea has talked about, which is we have to make sure the momentum continues between the plans and the systems. Whether or not that's something that we host or facilitate or encourage, we need to figure out how to keep that momentum for those who

have already started the work, and frankly, how to help kickstart it for other pairs.

Our other intention over the next couple of months is to dive more deeply into the content for our October plan-system convening. It will be around the exchange of data between the plans and systems so that they have similar information and a shared understanding of performance that matches. That can really be a barrier to forward progress, so we really need to try and figure out how to tackle it together.

*For more information about promising practices and pilots of system-plan collaboration, the specific external drivers that impact systems and plans, and overlapping quality measures, please see our **reference guide**.*

*For greater context about SNI and LHPC Institute's partnership, and why collaboration is essential to improving quality, please see our "Partnering to Improve Quality of Care" **issue brief**.*