LOS ANGELES BUSINESS JOURNAL
THE COMMUNITY OF BUSINESS™

Baackes Looks Back on Career

HOWARD FINE
-
JULY 1, 2024

Leader: John Baackes is the chief executive of L.A. Care Health Plan. (Photo by David Sprague)

For nearly a decade, **John Baackes** has helmed **L.A. Care Health Plan**, the nation's largest public health plan. The Westlake-based nonprofit insurer's mission is to provide access to quality health care for Los Angeles County's low-income communities and to support the safety net to achieve that purpose; the plan serves more than 2.6 million members in the county.

Baackes, who is retiring at the end of this year, took over the plan in 2015, just as enrollments in the state's Obamacare health insurance exchange were adding 700,000 members to L.A. Care Health Plan in just a year's span. While Baackes was adjusting the plan to absorb all these new members, the pandemic hit, throwing the health care system into chaos. The pandemic put into sharp relief the inequities in health care, with hundreds of thousands of L.A. Care members bearing the brunt. On top of all this, the county's surging homeless population has put even more strains on L.A. Care programs.

Prior to joining L.A. Care, Baackes served as president of **AmeriHealth Caritas VIP Plans**, overseeing its Medicare Advantage business unit. Prior to that position, he served as chief executive of **Senior Whole Health**, a voluntary health care plan for more than 10,000 low-income seniors in Massachusetts and New York.

The Business Journal spoke with Baackes, discussing trends in health care coverage for low-income households in Los Angeles County and elsewhere, as well as the challenges he's had to overcome at L.A. Care and his plans after his retirement.

You've been involved in providing insurance for low-income people for decades now. How did that start for you?

I did not ever think I would be doing this. I wanted to be an architect. But I wound up with fine arts degree. I was then asked to design a logo for an HMO (health maintenance organization) then I did all their collateral material. I was hired by that HMO as a sales rep. That clicked and 12 years later I was CEO of the place. This HMO was one of the first in the 1980s to get into managed care for Medicaid population. (Medicaid is the federal health care program for the poor.) In the early 2000s, I focused a smaller HMO on low-income populations.

What are some of the biggest changes you've seen in all that time in providing and paying for health care for low-income people?

One of the biggest changes is that the Medicaid program has pivoted toward managed care to deliver health care services for low-income populations. When Medicaid started in 1965, it was strictly reimbursements for fee-for-service providers. In the 1980s, state-run Medicaid programs began experimenting with managed care. Today 40 of 50 states now use managed care. With that has come the ability to measure health outcomes for members, to look at the quality of care being provided and align doctors and hospitals with incentives to deliver the highest quality of care possible. The whole point of managed care is getting right care, at the right place and the right time and in the most efficient way possible.

How did the state-run Affordable Care Act exchanges (known in this state as Covered California) change the way health care for low-income individuals was paid for or delivered?

Before the Affordable Care Act, eligibility for Medicaid was income means-tested, while Medicare eligibility was based on age and disability status. When the Affordable Care Act came along, it created market exchanges for people who weren't covered by Medicare or Medicaid and didn't have employer-based insurance. For a plan like L.A. Care, we decided to get into the exchange. For our members whose income is above the Medicaid ceiling but still low-income, the ACA exchanges offer a way to pay nothing or a small percentage above Medicaid. All covered individuals pay is the deductibles for copays. L.A. Care has had about 50,000 people go back and forth across that line between Medicaid and the exchanges.

Any other changes?

Besides the exchanges, the Affordable Care Act said to states that if you increase the eligibility for Medicaid to 138% of the federal poverty level, then those individuals are covered as if under Medicaid. This was something states could

opt into. Millions more people became eligible for Medicaid. Now about one-third of Californians are eligible for Medicaid.

Please speak about publicly-operated health plans. What are they and how are they different from what traditional health care insurers offer?

California is unique: Back in the 1990s, when California was moving Medi-Cal into managed care, there was a move to preserve stability among insurers. The state gave the authority to each county to create public entities to negotiate for Medi-Cal contracts. We are one such public entity – not a government entity but a public entity. We operate as a nonprofit and we have no shareholders. We get along at about a 2% margin. Our board compensation is specified in county ordinance: 13 seats, with seven held by trade organizations – including for doctors, hospitals and health plans – as well as government officials.

Teaching: Sonia Guzman leads a class called Cooking Matters. (Photo by David Sprague)

When you arrived at L.A. Care nearly a decade ago, what were the biggest challenges the organization faced?

The biggest challenge was that the Affordable Care Act had just gone into effect in January 2014, along with the increased ceiling for Medi-Cal eligibility. Those steps resulted in L.A. Care adding 700,000 members in a year. We now have 2.6 million members – or, to look at it another way, every fourth resident in the county is a member.

It took some time to integrate those new members with a wider array of programs for our members. One of the biggest: we added a Medicare product.

How did you adjust the organization?

I had to reorganize the company into a matrix structure with leaders for each of these programs. Sort of like a grid organization instead of traditional top-down management. This allowed for specialization for each of the product lines. We also had to adjust the back-office operations. This was all very complex, though I found it an enjoyable challenge. The reward was in having people know who to talk to when they encountered a problem. It also fostered more cooperation between program lines and operational areas, eliminating many of the silos that had existed in the organization.

You've held administrative positions in health plans in different parts of the country. What's unique about the health care environment in Los Angeles County, especially when it comes to low-income Angelenos?

The number one difference: L.A. County has a delegated model. Doctors are organized into independent practice associations. These become medical groups that then in turn negotiate with the health plans like us. A single medical group can bring 200 doctors to the table. Also, the health plans then began taking on some of the utilization functions, such as approving coverage for procedures… It's another layer of bureaucracy for them. The structure also moved the risk down to the medical group level.

How did you handle this at L.A. Care?

By the time I came on board, this structure had frayed a little bit. I saw that there was great variation in the performance of the medical groups. So, my team drew up a scorecard for the performance measures and administrative efficiency of the medical groups. This gets back to managed care's ability to measure things. We started holding medical groups accountable. What's happened is that we can now compare the medical groups to each other and reduce the (performance) variation between plans. This annual report card has been important driver; among other things, it has helped bring our accreditation status up to where it had been years earlier. This year, we are introducing report cards for hospitals and skilled nursing facilities.

How did the pandemic change the environment for L.A. Care in terms of providing insurance for low-income individuals? What did L.A. Care have to do to adjust?

The hardest part of the pandemic was to make sure people had continued access to care, especially if they were stuck at home. We had to ramp up telemedicine services rapidly. Both doctors and patients adapted easier than we anticipated. Also, beforehand, could not have Medicaid coverage for virtual appointments. Now, in many instances, Medicaid covers virtual visits.

Any other impacts?

The pandemic also gave us stark evidence that inequality was a life and death matter. People who were of lower income and of color got infected more, had higher rates of hospitalization and had higher rates of death. This was

partly as a result of lower-income people working in public-facing positions. This impacted L.A. Care in that we had a lot of members who were sick, and we lost a lot of members. That spurred us to get as many members screened and vaccinated as possible. But as we tried to do this, we encountered a lot of resistance from a sizable group of members. That was a learning opportunity for us that brought up some cultural issues. We had to develop more trust with our members. Those are things we are still dealing with.

Leader: John Baackes is the chief executive of L.A. Care Health Plan. (Photo by David Sprague)

What have been the biggest challenges in providing health care coverage for low-income individuals since the pandemic receded?

The pandemic reinforced the realization that these health care inequality issues, also known as social determinants of health, determine members' health status. Medicaid recognized that, too. The program started letting us pay for things that are not direct health care: such as helping members get housing vouchers and eat healthy meals. We can pay for social services that members need to complement health care. There are not enough dollars to pay for everything in this regard, so we have to focus on just a few things, such as medically-tailored meals. Members with congestive heart failure may not be able to afford and don't know how to obtain a diet that may be better for them. If you have an appropriate diet for these members, it will reduce the number of emergency room visits and other health care expenses.

Any other challenges?

Yes. We have at least 40,000 homeless people in our plan at any given point of time – by any measure that's a lot. We put them into an enhanced care management program: not only is a doctor assigned, but there's also a community health worker on board to help find housing, get them on food stamps or other social service programs.

What do you consider as your two or three biggest achievements during your tenure as chief executive of L.A. Care Health Plan?

First, was the report card system we established and that we talked about earlier. Second is a program called Elevating the Safety Net that is designed to bring more doctors of color to both our pool of doctors and for the community at large. We have found that when doctors are of the same race, ethnicity and/or speak the same language as their patients, those patients relate to them more. We have put 5% of our unassigned reserves toward this type of workforce development. We award eight medical education scholarships a year – half to women and all to people of color. We have made a total of 48 of those scholarship awards to date, with another eight being awarded later this month.


Food: Volunteers serve food during a cooking class at L.A. Care's Whittier location. (Photo by David Sprague)

What are some of the other components of this Elevating the Safety Net initiative?

A second component is awarding grants of up to $125,000 apiece to the practices and clinics serving large Medicaid populations that bring doctors in from outside the county. The grant money can also be used to retire medical school debt.

The third component has been the opening up more street-level community education centers. We had four when I came on board and now we have 12.

In all, we have made a $200 million investment in workforce development.

At the time of your retirement announcement, you mentioned you wished to devote more time to your board position at the Charles R. Drew University of Medicine and Science. What do you still want to accomplish there?

I'm the board chair now. Most people don't know this, but Charles Drew is an HBCU (a group of Historically Black Colleges and Universities) – the only one west of the Mississippi River with its own medical school. We are welcoming 60 new students each year and I want to maintain that level of new students over the longer term. This will involve more fundraising.

Anything else in your post-retirement plans?

I of course want to spend more time with my children and grandchildren. Also, one of my daughters has a travel blog and wants me to travel more with her.