DEPARTMENT OF
Managed
Health Care

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

October 18, 2012

The Honorable Richard Pan, Chair
Assembly Committee on Health
Room 6005, State Capitol
Sacramento, CA 95814

RE: ASSEMBLY COMMITTEE ON HEALTH OVERSIGHT HEARING

Dear Dr. Pan:

Thank you for your letter of September 28, 2012 inviting the Department of Managed Health Care (DMHC) to participate in an oversight hearing on the expansion of Medi-Cal Managed Care. In preparation for the hearing, you requested information on the DMHC's role with regard to the Medi-Cal managed care initiatives recently undertaken by the Department of Health Care Services (DHCS). This letter provides that information.

1. **A description of the DMHC role with regard to the Medi-Cal and Medicare Knox-Keene plans that contract with DHCS.**

Overview of DMHC Authority over Medi-Cal plans

The DMHC has regulatory authority over Medi-Cal health plans since the vast majority of managed care organizations that contract with the DHCS to provide Medi-Cal services are also required to be licensed as health care service plans under the Knox-Keene Act. These health plans must comply with many provisions of the Knox-Keene Act and regulations, which govern health plans in California, as well as the federal and state laws governing Medi-Cal and the regulations –adopted by the DHCS for the Medi-Cal program. Under the Knox-Keene Act, a health plan must comply with standards regarding financial solvency, network adequacy, administrative capacity, and grievance and appeals systems.

The Knox-Keene Act does not apply to managed care health plans organized as County Organized Health Systems (COHS). If a COHS has multiple lines of business, such as participation in the Healthy Families Program (HFP), the health plan must obtain Knox-Keene licensure, but the Medi-Cal line of business is not subject to the requirements of the Knox-Keene Act. Even though a COHS' Medi-Cal line of business is not subject to the Knox-Keene Act, the Department has authority over issues pertaining to financial solvency for the health plan as a whole, across all lines of business.

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Many health plans have multiple lines of business, including both commercial and public business. For both commercial and public products, the DMHC reviews plan documents to ensure compliance with the Knox-Keene Act. Medi-Cal products have benefit and coverage requirements that are exempt from the Knox-Keene Act or are "carved out" to other non-plan providers. For example, mental health services for Medi-Cal beneficiaries are exempt from the mental health parity requirements of the Knox -Keene Act under Health and Safety Code Section 1374.72. Substance use services and services for children eligible for the California Children's Services program are also carved out of Medi-Cal managed care products.
To address requirements for the Medi-Cal program that are consistent with the Knox-Keene Act, the DMHC coordinates review of the Evidence of Coverage (EOC) plan documents with the DHCS.

Overview of DMHC Authority over Medicare Advantage Plans

Federal law requires that Medicare Advantage (MA) managed care plans be state licensed. However, federal law explicitly limits state regulation of those plans to licensure and oversight of financial solvency. Therefore, the DMHC has limited authority to oversee MA plans and may not take enforcement action for any violation of state law that does not fall into the category of financial solvency or issues related to the licensure of the MA plan. The DMHC does have authority to discipline (censure, suspend, or bar) persons who engage in fraud, dishonest dealing, or unfair competition in the solicitation of MA managed care plans.

2. Information on your plan readiness review for each of the initiatives DHCS is undertaking.

Mandatory Enrollment of Seniors and Persons with Disabilities (SPDs)

On or about August 9, 2011, the DMHC entered into an Interagency Agreement (IA) with the DHCS to conduct quarterly network assessments of all Medi-Cal managed care plans involved in the transition of SPDs into Medi-Cal Managed Care. This agreement defined the DMHC role as a consultant to the DHCS for ongoing post-implementation network assessments. The DMHC did not participate in DHCS' plan readiness review for the SPD transition.

Pursuant to the IA, the DMHC receives eighteen separate health plan reports from the DHCS after the close of each quarter. These reports provide specified network-and access-related data for each health plan's Medi-Cal line of business, including:

- Detailed Primary Care Provider (PCP) Networks (including provider location, number of members assigned to the provider, and whether the provider is accepting new patients),
- Detailed Specialist Provider Networks (including provider location and specialty type),
- Out-of-Network Reports (including out-of-network requests and approvals by specialty type),
- Grievance and Appeals logs and summary data,
- Quality Reports, and
- SPD Utilization.

Currently, the DMHC reviews all plans operating in the 2-Plan and Geographic Managed Care (GMC) counties. The DMHC conducts a separate assessment for each county in which a health plan operates. The DMHC currently conducts 37 separate network assessments, one for each

plan by county. Starting in the fourth quarter of 2012, the DMHC will also assess network adequacy in the COHS counties. The DMHC network adequacy assessment includes:

- Identifying primary care and specialist providers' availability, capacity, and geographic accessibility in accordance with the Knox Keene Act and DHCS contract standards,
- Analyzing detailed provider and utilization data to evaluate whether the plan's network is responsive to demand,
- Evaluating individual health plan grievances and DMHC complaints related to access to care that may indicate specific areas of network inadequacy
- Reviewing the DMHC block transfer data for any potential disruptions to networks due to provider contract terminations,
- Evaluating out-of-network requests to determine any areas where members are having difficulties obtaining in-network specialty care, and
- Reviewing quality reports to identify quality issues related to network inadequacies.

The DMHC analyzes this data and delivers its assessment and suggestions for follow-up to the DHCS 60 days after receipt of all of the health plan data. The DHCS conducts any necessary follow-up with the health plans and the DMHC remains available to the DHCS for consultation.

Duals Demonstration Project

Over the past several months, the DMHC has been collaborating with the DHCS and other state departments regarding the framework for ensuring that health plans are capable and ready to deliver services to beneficiaries under the Dual Eligible Demonstration Project, or Duals Demonstration.

During this process, the DMHC has helped to clarify and define roles that will be played by various governmental entities overseeing the Duals Demonstration. The federal Centers for Medicare & Medicaid Services (CMS) will continue to provide oversight of health plans with regard to Medicare-based services. The DMHC will focus on providing direct consumer assistance to beneficiaries and performing medical surveys, financial audits, and provider network adequacy reviews in connection with the delivery of Medicaid-based services. These include long-term care services and supports which historically have not been delivered by health plans.

The DMHC and the DHCS are working on an IA that will further delineate the DMHC's responsibilities under this project. The DMHC anticipates that the IA will be completed by the end of October 2012.

Healthy Families Program (HFP) Transition to Medi-Cal

The DMHC's primary task regarding the transition of HFP children to Medi-Cal relates to assessing, in consultation and collaboration with the DHCS, the network adequacy of the Medi-Cal managed care health plans that will be receiving the membership from the HFP beginning January 1, 2013. This analysis is conducted for both medical and dental plans. The network assessment for Phase 1 is due to the Legislature 60 days prior to the transition date on November 1, 2012. The network assessments for the other three phases are due 90 days prior to the transition dates. For Phase 2 which begins April 1, 2013, the network assessments are due by January 1, 2013; for Phase 3 which begins August 1, 2013, network assessments are due by May 1, 2013; and for Phase 4, network assessments are due June 1, 2013.

Medical Services

For Phase 1, the members will remain in their current health plans. For this phase, the DMHC and the DHCS jointly developed a data request from plans. The data request included PCP, Specialist and Extender (e.g., physician assistant or nurse practitioner) provider lists. Because the HFP covers children up to age 19, the provider network data requested included specific data related to pediatricians and pediatric subspecialists. For PCPs, which includes pediatricians, the requested information included fields for:

- the number of Medi-Cal members that can (in total) be assigned to each provider,
- the number of Med-Cal members that are assigned to each provider,
- the number of HFP members assigned to each provider,
- whether each provider would continue to treat (under Medi-Cal) the HFP members that the provider is currently assigned, and
- whether each provider would accept new Medi-Cal membership post transition.

The DMHC also requested information from each health plan on how that health plan would provide for continuity of care as well as the steps the health plan would take to assure that its current HFP providers would also contract to provide services under Medi-Cal managed care.

This data request was sent August 31, 2012 with a requested September 14, 2012 response date. The DMHC has received responses from all the queried health plans and anticipates completing the assessment by November 1, 2012. The DMHC and the DHCS are in the process of developing the data request to be used for Phase 2.

Dental Services

Dental services are also part of the transition from HFP to Medi-Cal. Dental managed care will be required in Sacramento County and optional in Los Angeles County. Denti-Cal will arrange for services in the other counties. For the dental managed care plans, the DMHC and the DHCS developed a joint data request to determine network adequacy of the plans for all phases. The DMHC and the DHCS sent this request to the dental plans on September 6, 2012, with dental plan responses due by September 14, 2012. The DMHC has received responses from all managed care dental plans and anticipates completing the assessment by November 1, 2012.

Vision Services

As children transition from HFP to Medi-Cal, they will move out of their HFP vision plan and will receive vision services under either the managed health care plan or in Medi-Cal fee-for-service, as applicable. To the extent such services will be covered by the managed health care plans, the DMHC will include a review of appropriate specialty vision services as part of its network adequacy review of the managed health care plans.

Rural Expansion

DHCS is working with stakeholders and health plans to develop a plan to expand Medi-Cal managed care to all 58 counties. Currently, Medi-Cal managed care exists in 30 counties; the managed care expansion would expand Medi-Cal managed care to the other 28 counties. The DMHC will review any application to create a new Med-Cal managed care health plan in those

counties. For such applications, the DMHC will review the proposed service area and the providers located within that area in order to determine network adequacy. Similarly, the DMHC will also review any proposed material modification of an existing licensed health plan to expand into a rural county that currently does not have Medi-Cal managed care.

3. A description of the routine and non-routine audit process and the audit results of any of the health plans involved in these initiatives in the last year, including dental and vision.

The DMHC is required to conduct a routine medical survey of each of its licensees at least once every three years pursuant to California Health and Safety Code Section 1380. The DMHC's Division of Plan Surveys (DPS) conducts these medical surveys, which review the following:

- Quality Management,
- Access and Availability,
- Grievances and Appeals,
- Utilization Management,
- Access to Emergency Services and Payment,
- Continuity of Care,
- Prescription Drugs, and
- Language Assistance.

The DMHC staff and the DMHC's contracted medical surveyors conduct medical surveys for health plans with commercial, Medi-Cal, and HFP lines of business.

An exception to the DMHC survey requirement is outlined in California Health and Safety Code Section 1380.3, which provides that the DMHC is not required to conduct medical surveys of health plans that provide services solely to Medi-Cal beneficiaries when the DHCS has conducted a medical survey audit for the same period and the DMHC Director finds that no additional review is necessary.

In addition, section 1380(c)(2) provides that, in order to avoid duplication, the DMHC Director shall employ, but is not bound by, the findings of reviews of Medi-Cal managed care plans conducted by DHCS. Based on these statutory provisions, in the past, the Director found that no additional quality review or survey was necessary for certain plans. Under other circumstances, the Director determined that additional review was required based on the DMHC's internal tracking and/or the DHCS' audit findings. These statutory provisions allow flexibility in determining the need for additional survey work, while at the same time avoiding duplicative efforts by the two departments. When a DHCS audit report is not available, the DMHC conducts a full medical survey of the health plan. Currently, the DMHC is conducting medical surveys independently, but is working closely with the DHCS with the expectation of conducting joint audits in the near future.

Under the IA with the DHCS regarding the transition of SPDs into Medi-Cal managed care plans, the DMHC performs medical surveys to ensure that the health plans are complying with all contractual and statutory obligations that protect this population. In 2012, the DMHC conducted five onsite medical surveys of Medi-Cal managed care plans: Health Plan of San Joaquin, San Francisco Health Plan, LA Care Health Plan, Inland Empire Health Plan, and Kaiser Foundation Health Plan. A sixth survey, of Alameda Alliance Health Plan, will begin in mid-October 2012.

The DMHC has issued a final report of survey findings to the Health Plan of San Joaquin. That survey, which is posted on the DMHC website at http://dmhc.ca.gov/library/reports/med_survey/surveys/338full092905.pdf, identified three Knox-Keene Act deficiencies : one in the area of Access and Availability and two in the area of Grievance and Appeals. Because two of the deficiencies remain uncorrected, although the health plan is in the process of making corrections, the DMHC will be conducting a follow-up survey within six months.

The DMHC has issued a preliminary report of survey findings to San Francisco Health Plan. Preliminary reports are confidential; final reports are posted on the DMHC website. The DMHC anticipates the final survey report for San Francisco Health Plan will be completed no later than November 9, 2012. In 2013, the DMHC expects to survey eight other plans serving SPDs and seven additional plans in 2014.

The DMHC also conducts routine surveys of specialized plans including dental and vision plans.

In addition to routine surveys, the DMHC may initiate a non-routine survey when it has information, from consumer complaints or other sources, that there is a potential compliance problem at the health plan. The cost for a non-routine survey is charged to the health plan. Currently, the DMHC and the DHCS are jointly preparing reports of non-routine surveys, conducted in 2012, of the four dental managed care plans that serve Sacramento County Medi-Cal enrollees: Access Dental Plan, Liberty Dental Plan of California, Western Dental Plan, and Health Net of California. The DHCS has reviewed three preliminary reports completed by the DMHC. The fourth report will be delivered to DHCS for review by October 8, 2012. The DMHC plans to issue all four preliminary reports to the dental plans the week of October 15, 2012. The plans will have 45 days to respond to the preliminary reports by submitting corrective action plans to address any statutory, regulatory, or contractual deficiencies to the DMHC and DHCS. DMHC will review each plan's proposed corrective actions to ensure they are appropriate, and plans to issue final reports by December 31, 2012.

4. Fiscal solvency analyses of the medical groups with significant Medi-Cal, Healthy Families Program and Medicare populations.

SB 260 (Chapter 529, Statutes of 1999) established financial standards for capitated provider groups which are referred to as Risk Bearing Organizations, or RBOs.

There are approximately 185 RBOs that are required to file quarterly and annual financial reports to the DMHC Provider Solvency Unit (PSU). RBOs self-report compliance with the five solvency criteria:

- Timeliness of claims processing and provider reimbursement,
- A methodology acceptable to the DMHC for estimation of Incurred But Not Reported claims (IBNR),
- Positive Tangible Net Equity (TNE),
- Maintaining a positive level of Working Capital, and
- Cash to Claims Ratio of 0.75.

The DMHC performs ongoing assessments of the financial capacity and financial trends of the RBOs that assume financial responsibility for providing medical services for a fixed, periodic

payment. The DMHC assesses the adequacy of financial reserves and the administrative capacity of the RBO to fulfill its delegated responsibility to timely process and pay all medical claims for the medical services that are delegated by a health plan to the RBO. The DMHC's assessment activities also include review of all financial information submitted by the RBOs, including CPA-audited and company-prepared financial statements.

If an RBO becomes noncompliant with Knox-Keene financial solvency requirements, the RBO is required to develop a corrective action plan (CAP) which the DMHC reviews to ensure the RBO's proposed CAP actions and financial assumptions are viable and will correct the RBO's financial problems. After the DMHC approves the CAP, the DMHC continues to monitor and review any updates to ensure that the RBO is progressing toward compliance. The DMHC may schedule additional audits to verify that the RBO is on track towards obtaining compliance or to verify that compliance was attained.

As of June 30, 2012, there were 64 RBOs with 50 percent or more Medi-Cal (including HFP) enrollees. These 64 RBOs had approximately 2.6 million enrollees. The DMHC's oversight activities have identified the following:

- Five (5) out of the 64 RBOs (8 percent) were on a CAP for failure to meet the financial solvency requirements.
    - 3 RBOs are on CAPs for noncompliance with TNE, Working Capital, cash to claims ratio, and claims timeliness standards.
    - 2 RBOs are on CAPs for failing to meet claims timeliness standards.
- Twenty-three (23) RBOs are being monitored closely for reasons such as rapid increase in Medi-Cal enrollment, low reserves and consecutive net losses.
- Thirty-six (36) RBOs were meeting the DMHC's grading criteria and presented no concerns.

The DMHC also conducts claims and financial audits of RBOs. These audits focus on an RBO's claims liabilities and its method for ensuring claims and provider disputes are processed in accordance with applicable law and regulations. In 2012, the DMHC conducted ten audits on RBOs with more than 50 percent enrollment in Medi-Cal and/or the HFP.

The DMHC posts information regarding the financial solvency of RBOs, as well as quarterly and annual summarized information regarding RBO financial submissions, on its public website. In addition, the PSU presents updates regarding the financial status of RBOs at quarterly meetings of the Financial Solvency Standards Board (FSSB). The materials and presentations for all FSSB meetings are available on the DMHC website.

5. **Information on corrective action plans, informal, formal or other DMHC actions with regard to plans and medical groups with significant Medi-Cal, Healthy Families and Medicare populations relating to deficiencies in access to qualified providers, timely access to care, continuity of care or other quality and access standards, including dental and vision.**

Consumer Assistance and Independent Medical Review

The DMHC's Help Center assists Medi-Cal managed care enrollees who experience difficulties with their health plans by resolving health care disputes and determining health plan compliance with applicable laws. The Help Center has an urgent nurse review process to expedite urgent, clinical complaint issues and also has an early review process for other time-sensitive issues such as the loss or termination of coverage. Routine paperwork and administrative issues are resolved through a quick resolution process whereby a 3-way call is initiated with the enrollee and the health plan to immediately resolve an enrollee's complaint. Medi-Cal managed care enrollees may also utilize the Standard Complaint and Independent Medical Review (IMR) processes.

Enrollees may seek an IMR to challenge a health plan's denial, delay or modification of a requested service based on the health plan's finding that the service is not medically necessary or is investigational/experimental. Health plans are required to notify enrollees of their right to an IMR. The DMHC contracts with Maximus Federal Services, a national external review organization, to conduct the IMR. Unless an expedited review is warranted, the review organization is required to render its decision within 30 days of receipt of the patient's relevant medical records. These decisions are binding on the health plan.

Enrollees who are not satisfied with their health plan's response to a grievance or appeal on any other (non-IMR) issue, or if the health plan has not resolved the grievance or appeal within 30 days (or within three days if the issue is urgent), may bring the disputed issue to the Help Center for review and resolution within 30 days. The Help Center issues a finding in each case as to whether the health plan was in compliance with the law.

The DMHC uses complaint and IMR data to develop the Scope of Work for the routine medical survey of each health plan. The Scope of Work identifies potential areas of concern and the strategy the DMHC will use to investigate those concerns. Additionally, findings from individual complaints and IMRs may result in those issues being referred to the Office of Enforcement for further investigation.

The Help Center reports information on phone calls, urgent nurse cases, quick resolutions, Standard Complaints and IMRs from SPDs to the DHCS on a quarterly basis.

Enforcement Actions

The DMHC, through its Office of Enforcement, is responsible for handling cases involving health plans' noncompliance with the requirements of the Knox-Keene Act, including noncompliance with Knox-Keene Act quality, accessibility, continuity of care requirements, denial of treatment complaints, and health plan or RBO noncompliance with the financial requirements of the Act, including claims payment and provider dispute resolution issues, and reporting and solvency requirements of RBOs. A typical enforcement action typically begins with an administrative investigation into the allegations presented.

There is a variety of enforcement actions that the DMHC is authorized to take.

The DMHC may:

- Suspend or revoke a plan's license,
- Impose fines or administrative penalties,
- Issue orders requiring or prohibiting action taken by the plan, RBOs, marketers, and any person or persons who violate the statutes,
- Issue an order appointing a conservator over a health plan and seize its assets, and
- Seek an injunction or other equitable remedies to enforce compliance with the Knox Keene Act, or any rule or regulation adopted by the Director pursuant to the Knox Keene Act.

In addition, to ensure an RBO's administrative and financial capacity, the Director has the ability to audit the RBO, approve and provide CAPs, order the freezing of enrollment, and require health plans contracted with a RBO to de-delegate risk arrangements in order to protect the interests of the enrollees.

The DMHC's most common enforcement actions are assessing an administrative penalty and requiring the plan to complete a CAP. The combination of a fine and a CAP provides both a punitive action and a mechanism for changing plan behavior.

The DMHC's enforcement actions have increased in number and complexity in recent years. During 2011-2012, the Office of Enforcement screened, accepted, and prosecuted numerous enforcement actions and collected over $3 million in penalties against health care plans that have significant Medi-Cal, HFP, and Medicare populations. Many of these deficiencies include issues relating to access to qualified providers, timely access to care, continuity of care, and other quality and access standards. A few examples of these enforcements are described below

Medi-Cal Local Initiative

Last year, a local initiative health plan serving primarily Medi-Cal members was found to be in violation of Knox-Keene timely access regulations. The plan was challenged by its inability to recruit physicians into its geographic service area. The DMHC, in consultation with the DHCS, took enforcement action against the plan, which resulted in a cooperative agreement between the health plan and the DMHC to enable the health plan to develop and maintain an adequate network. The settlement involved the creative review of available resources such as telemedicine and other programs that could increase the provider network in the health plan's service area. The health plan agreed to commit $250,000 to programs designed to improve and expand its provider network in order to increase access to care for its enrollees. The health plan also agreed to develop a Telehealth program and to work with federally qualified health centers, rural health centers, and community clinics to enhance the plan's ability to improve access to its enrollees. The settlement agreement also called for the health plan to pursue other avenuesfor expanding its provider network.

Dental Managed Care Plan

Due to the DMHC's concerns regarding a dental managed care plan's ongoing financial problems, and in order to protect the plan's enrollees and providers, the DMHC took enforcement action against a dental managed care plan in Los Angeles that serves both

commercial and Medi-Cal enrollees. The DMHC appointed a conservator to take possession of the dental plan and to manage its day-to-day operations. As part of this action, and because there was no hope to financially rehabilitate the plan, the DMHC and the DHCS worked with the dental plan to expediently transfer its enrollees and providers to another dental managed care plan. This transfer ensured that the dental plan's enrollees did not suffer harm, and there was no disruption to their care.

Medi-Cal Risk Bearing Organization (RBO)

Anonymous whistle-blower letters alleged wrongdoing, including, but not limited to, claims payment and utilization management (UM) violations against a large Medi-Cal RBO. The DMHC launched an investigation and discovered the RBO's UM log revealed over 100 instances of non-licensed individuals making UM decisions to deny, delay, or modify enrollee treatment authorization requests. The DMHC Director issued a Cease and Desist Order stopping the unlawful UM activities by unlicensed persons. The DMHC requested that the contracting plans undertake a focused audit of the RBO's activities. The DMHC also negotiated with the RBO to install a DMHC-controlled monitor to organize, conduct, and complete the focused audits and UM review, and to work directly with the RBO's management and employees to reform, as quickly as possible, all of the RBO's policies, procedures, practices, systems, and processes including, without limitation, UM practices to bring the RBO into full regulatory compliance.

I hope this information is useful to you as you prepare for the oversight hearing. If you have any questions, please contact Sherrie Lowenstein, DMHC Acting Deputy Director for Legislation.

Sincerely,

Brent A. Barnhart, Director
Department of Managed Health Care

cc: Assembly Member Dan Logue
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