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ASSEMBLY COMMITTEE ON HEALTH
DR. RICHARD PAN, CHAIR
ASSEMBLYMEMBER, NINTH DISTRICT

Briefing Paper

Oversight Hearing:

Medi-Cal After the ACA: Insurance for one in three Californians.

Tuesday, September 23, 2014
10 a.m. to 1:00 p.m.
State Capitol, Room 447

Introduction

The Assembly Health Committee is holding an oversight hearing to look at selected Medi-Cal issues the committee has previously examined in prior informational and oversight hearings. This hearing is being held to obtain status reports and updates from stakeholders and the Department of Health Care Services (DHCS).

I. Background: Health care reform and the Medi-Cal Program

On March 23, 2010, the federal Patient Protection and Affordable Care Act (ACA) became law. Among its many objectives, one of the most important was to increase the number of Americans with insurance. The ACA made statutory changes affecting the regulation of and payment for certain types of private health insurance, including the establishment of health benefit exchanges which serve as marketplaces for eligible individuals and small businesses to compare, select, and purchase private health insurance. Beginning this year, each state is required to either operate its own health benefit exchange or rely on the federal exchange. California has opted to operate its own exchange, which is called Covered California.

Also under the ACA, effective January 1, 2014, individuals are required to maintain health insurance or pay a penalty, with exceptions for religion, incarceration, immigration status, and financial hardship (if health insurance premiums exceed 8% of household adjusted gross income). Financial assistance is available. Individuals with income below 400% of the federal poverty level (FPL) who purchase insurance through an exchange may qualify for tax credits or advanced premium tax credits (APTCs) toward their premium costs, as well as cost-sharing subsidies.

The ACA was enacted, in part, to expand availability of commercial insurance but it also recognizes that there are large numbers of people who will remain on public programs. In California, the main public program is Medi-Cal, a joint federal-state program under which qualified low-income individuals receive health care benefits. The estimated Medi-Cal budget for 2014-15 is over $90 billion and there are an estimated 11 million Californians enrolled in

Medi-Cal. This equates to roughly one-third of the state's population, including half of the state's children.

Medi-Cal covers a core set of services, including doctor visits, hospital care, and pregnancy-related services, as well as nursing home care for individuals age 21. There are two main Medi-Cal systems for the delivery of medical services: fee-for-service and managed care. Beneficiaries in Medi-Cal fee-for-service generally may obtain services from any provider who has agreed to accept Medi-Cal fee-for-service payments. The other model is managed care. In managed care, DHCS contracts with managed care plans to provide health care coverage for Medi-Cal beneficiaries. Managed care enrollees may obtain services from providers who accept payments from the managed care plan; these providers are commonly referred to as being in the plan's network. Enrollment in Medi-Cal managed care (MCMC) dramatically grown in recent years, with total enrollment reaching almost 8 million beneficiaries last month.

II. Enrollment Backlog in Medi-Cal:

Until the implementation of the ACA, Medi-Cal eligibility was limited to low-income families with children, seniors and persons with disabilities, and pregnant women. The ACA expanded eligibility to additional low-income populations, including childless adults. The state conformed to the federal ACA changes. As a result, Medi-Cal coverage expanded in 2014, making 1 million to 2 million new people eligible. In addition, due to ACA implementation, and the attendant publicity surrounding purchasing insurance, many formerly eligible individuals have applied and have been enrolled in the program. The state also acted to phase out the Healthy Families program and shifted 853,000 of these children into Medi-Cal. These are some of the changes that have led to the dramatic growth in the overall Medi-Cal program.

Enrollment for Exchange plans and Medi-Cal is coordinated. Individuals seeking coverage through the Exchange are first screened for Medi-Cal eligibility. If an individual is found not eligible for Medi-Cal, the state collects necessary information and determines potential eligibility for APTC in the Exchange. States are also required, to the maximum extent possible, to rely on electronic data matches with trusted third party sources to verify information provided by applicants.

Recognizing the need to get the exchange up and running, California moved quickly to develop the infrastructure to support enrollment in time for the initial open enrollment period, which ran from October 1, 2013 through March 31, 2014 for coverage beginning January 1, 2014. The California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) procurement, conducted jointly by the Exchange and DHCS, built the information technology system to support the consumer application and enrollment process at the Exchange. Following extensive review and stakeholder comment and input, Accenture was awarded a contract for the design, development, and deployment of CalHEERs.

CalHEERS is a web-based application portal where individuals and small businesses can research, compare, check their eligibility for, apply for, and purchase health coverage. CalHEERS contains the business rules for income eligibility determinations and is used by both Covered California and counties in determining eligibility for APTC and Medi-Cal.

CalHEERS was designed to interface with various federal, state, and local information technology systems to perform the administrative functions necessary for the purchase of health insurance. For example, CalHEERS is required to interface with a federal data hub (a database that consolidates data from the Internal Revenue Service, Social Security Administration, and other federal entities) to assess income, citizenship, and other data necessary to determine eligibility for various ACA health coverage options. It also allows enrollment through multiple access points including mail, phone, and in-person applications. The CalHEERS business functions also connect with the Medi-Cal eligibility data system.

This complicated system has encountered some difficulties. The problems, combined with the large number of new Medi-Cal applicants, have resulted in a persistent backlog of Medi-Cal applications, which by May of 2014 reached approximately 900,000 applications. Significant progress has been made to reduce the backlog which now stands at approximately 350,000 applications. One of the most troubling aspects of the backlog is how long it takes to clear the status of some applicants. An August DHCS report of the backlog shows some applications were filed in October 2013. While it is a small number that date back that far, the median was March 2014.

Covered California checks enrollees' incomes to verify eligibility for health coverage and subsidies, some state residents are being abruptly switched from private coverage to Medi-Cal or are losing health coverage altogether. Officials with the Covered California said they are unsure how many individuals are being affected by such changes. Covered California states that income verifications and eligibility updates will take place continuously and could cause individuals' coverage to change. For example, if the exchange adjusts its income eligibility benchmarks after the federal government changed its poverty scale, residents might be switched into Medi-Cal from private insurance plans.

Issues for the committee to consider:

1. ***What specific actions is DHCS taking to address the backlog and improve coordination and communication with Covered California?*** There is a troublesome and persistent backlog of applicants. The result has been some pressure from the federal Centers for Medicare and Medicaid Services (CMS) in their role overseeing state Medicaid programs. In addition, advocates have filed a lawsuit to compel DHCS to clear the backlog. A portion of the blame for the backlog has been placed on the CalHEERS system. It is unclear exactly what the problem is and how it will be addressed. The existence of the backlog also raises questions about the adequacy of resources being devoted to eligibility and enrollment, especially with the counties.

   There are additional reports of a new group of people, not now in the backlog, who are being canceled from coverage they purchased in the exchange because they have been determined to be eligible for Medi-Cal. According to reports, many of these people are not being transferred to Medi-Cal, but are being dropped off the system.

2. ***What is the future of CalHEERS?*** What will happen to the system going forward and who will make the decisions regarding its use? DHCS will need to make sure the system is fixed and continues to be helpful to Medi-Cal, not just Covered California.

3. ***What actions are being taken to track and assist individuals who are switched from private coverage through Covered California to Medi-Cal?*** As individuals lose their coverage through Covered California, efforts should be made to track, monitor, and assist them with enrollment into Medi-Cal so that they do not fall through the cracks.

III. Provider Directories and Network Adequacy

Approximately 70% of the nearly 11 million Medi-Cal beneficiaries receive care through a Medi-Cal managed care plan (MCP). With such a large population reliant upon Medi-Cal MCPs for their care, the adequacy of Medi-Cal MCP provider networks is critical for enrollees to realize the promise of Medi-Cal coverage, and have timely access to needed care and services. The state is obligated to ensure that Medi-Cal MCPs contract with sufficient numbers and types of providers to ensure timely access to covered services, account for whether its providers are accepting new patients, and take corrective action if a provider network is inadequate.

Managed care is the dominant delivery system in the Medi-Cal program, as both the number and the percentage of Medi-Cal beneficiaries continue to grow as a result of several initiatives to mandate beneficiary enrollment in Medi-Cal managed care (MCMC). With the exception of certain populations, (former foster youth, beneficiaries eligible for limited scope services, individuals dually eligible for Medicare and Medi-Cal in most counties, and individuals with approved medical exemptions), enrollment in MCMC is mandatory for Medi-Cal beneficiaries.

Medi-Cal MCPs must contract with DHCS in order to serve enrollees in Medi-Cal managed care, and these contracts outline specific network adequacy requirements to be enforced. However, the adequacy of provider networks in Medi-Cal managed care (MCMC) have been an ongoing source of concern among policymakers and stakeholders as large Medi-Cal populations have been mandatorily transitioned into MCMC, and as newly eligible Medi-Cal enrollees pursuant to the ACA are required to enroll in MCMC in order to obtain services. Further, recent reports indicate significant inaccuracies within provider directories issued by some Medi-Cal MCPs, raising questions about the true viability of provider networks in those plans, and the sufficiency of provider network oversight by both MCPs and state regulators.

Provider network oversight

Medi-Cal MCPs are governed by both federal and state law, and are regulated by the federal Centers for Medicare and Medicaid Services (CMS) and DHCS, the single state agency designed by the federal government to administer the Medi-Cal program. Medi-Cal MCPs, with the exception of county organized health system plans, are also required to be licensed by the Department of Managed Health Care (DMHC) and are subject to the requirements of the Knox-Keene Act, the body of law governing health care service plans. Further, in order to serve as a Medi-Cal MCP, a plan must enter into a contract with DHCS and adhere to the requirements set

forth within which include requirements regarding provider networks and access and availability of services.

Federal Medicaid law requires Medi-Cal MCPs to ensure that health care services are available and accessible to managed care enrollees, but also provides states with flexibility to define network adequacy through state law or through managed care contracts. State law and regulations require MCPs to ensure and monitor appropriate provider networks, including primary care physicians and specialists. Additionally, MCP contracts entered into by plans and DHCS set forth specific provider network and access requirements plans must meet. According to DHCS, Medi-Cal MCP contract provisions largely reflect Knox-Keene Act requirements, and in order to have sufficient networks, MCPs must have sufficient providers to serve enrollees, meet service area needs with appropriate geographic distributions of providers, and provide timely access to care. The contracts include specific requirements for plans to:

1) Maintain appropriate network capacity and composition.
2) Meet specified primary care physician/specialist-to-enrollee ratios.
3) Maintain adequate numbers and types of specialists.
4) Meet specified time and distance standards that ensure a primary care physician within 30 minutes or 10 miles of an enrollee's residence.
5) Meet geographic access standards.
6) Meet timely access standards as set forth in the Knox-Keene Act.

To monitor provider networks and access in MCMC, Medi-Cal MCPs are required to submit to DHCS provider network reports on a monthly basis. These reports must identify the number of primary care providers, provider deletions and additions, and the resulting impact on access. DHCS also reviews quarterly grievance and appeals reports, ombudsman call statistics, state fair hearings, and DMHC consumer help center data as monitoring indicators. Further, state law requires DHCS to perform annual medical audits of Medi-Cal MCPs. Medi-Cal MCPs found to be out of compliance with contract provisions may be required to agree to a corrective action plan, and could be subject to sanctions and penalties.

Additionally, as Knox-Keene licensed plans, DMHC performs onsite medical surveys of Medi-Cal MCPs at least once every three years, during which it surveys the plan for compliance with timely access and provider network standards. Through interagency agreements, DMHC contracts with DHCS to perform specified oversight responsibilities, including network adequacy assessments, with regard to specific Medi-Cal enrollee populations, including SPDs, former Healthy Families Program enrollees, rural managed care expansion enrollees, and CCI enrollees. According to DHCS, it also intends to boost provider network oversight through new measures, including a new network adequacy monitoring unit in the Medi-Cal Managed Care Division, and through ongoing and expanded coordination with DMHC.

Provider directories

Medi-Cal MCP contracts require MCPs to provide specified information about their network providers. Such information includes the name, provider number, address, and telephone number of each provider service location. In the case of a medical group, foundation, or independent practice association (IPA), the plan shall provide the name, provider number,

address and telephone number for each physician provider. Other required information includes the hours and days the provider is open, the services and benefits available, including languages spoken, the telephone number to call after normal business hours, accessibility symbols, and identification of providers not accepting new patients.

The contracts allow MCPs to comply with this requirement by distributing a provider directory to enrollees to allow them to find, and seek services from, physicians within the plan's provider network. MCP contracts also require MCPs to submit provider directories, on a semiannual basis, to Health Care Options (HCO), DHCS' enrollment contractor that assists new Medi-Cal beneficiaries with enrollment into MCMC.

Medi-Cal MCPs that are licensed and Knox-Keene plans are required by the Knox-Keene Act to provide, upon request by an enrollee, a list of contracting primary care providers, medical groups, IPAs, hospitals, and other providers as specified. The list must indicate which providers have notified the plan that they have closed practices or are otherwise not accepting new patients. The Knox-Keene Act requires plans to update these provider lists at least quarterly.

The accuracy of provider directories has come into serious question in recent months. In June of this year, DMHC launched an investigation into the provider directories of two health care service plans selling commercial products through Covered California after receiving over 200 complaints from consumers relating to inaccuracies within the plans' provider lists. The accuracy of Medi-Cal MCP provider directories have also fallen under scrutiny. Recent media reports indicate that some Medi-Cal beneficiaries encounter difficulties finding Medi-Cal providers who will accept new patients, and found that provider directories provided by their Medi-Cal MCP contain large numbers of inaccuracies. It was also reported that, upon further investigation, approximately 95% of physicians listed in one MCP's provider directory, and over 56% of physicians listed on the plan's website, were not accepting new patients or could not be reached. In another plan serving that same county, nearly 62% of physicians in the directory, and 71% in the Website, were not accepting new patients. The report details other provider directories in which the majority of providers were not accepting new patients, or could not be reached. As a result of these reports, in July 2014, the Joint Legislative Audit Committee approved a request for an audit by the California Bureau of State Audits of the state's Medi-Cal MCP directories, provider networks, and the current regulatory framework to ensure provider directory accuracy.

Issues for the committee to consider:

1. ***What specific actions is DHCS taking to address issues raised with the accuracy of Medi-Cal MCP provider directories, and what is the department's specific plan moving forward to ensure greater accuracy in future provider directories?*** Medi-Cal MCP contracts outline the type of information that should be provided in plan provider directories, and prescribe some requirements about the distribution of those directories. However, the contracts lack provisions that would ensure more accurate and up-to-date provider data for plan enrollees to refer to. It is also unclear to what degree DHCS is proactively reviewing provider directory data for accuracy. For example, MCPs are required to provide monthly provider reports to DHCS. Does DHCS ever cross-check the monthly provider files it receives with the

directories published by the plans? As another example, MCPs are required by the Knox-Keene Act to update their provider directories on a quarterly basis. Should MCP contracts with DHCS contain similar provisions, and, as the contracting authority, should DHCS be required to independently and periodically verify the accuracy of the directories?

Similar questions could be asked of Medi-Cal MCPs, and contracting providers. Specifically, what policies and procedures do plans have in place to ensure the accuracy of their provider directories, and what steps will be taken to improve upon those policies to avoid future inaccuracies. MCPs submit provider data to DHCS on a monthly basis. Are MCPs verifying the accuracy of that data, and if so, why not in turn routinely update provider directories to reflect that data? Similarly, what role do providers play in ensuring that MCPs are kept up-to-date, and how can communication between plans and providers improve in order to ensure greater provider access by enrollees?

2. ***What specific actions is DHCS taking to ensure adequate MCMC provider networks?*** DHCS reports that it uses a variety of data sources to oversee MCP networks and access, including provider network reports, grievances, ombudsman call statistics, DMHC data, and others. Yet, despite DHCS having ready access to this data, concerns over network adequacy within MCMC remain. This hearing provides an opportunity for DHCS to inform the public of specifically how it uses the data it obtains from MCPs to regulate provider networks, as well as an opportunity to identify areas of needed improvement. For example, how does DHCS maximize the use of monthly provider reports to determine sufficient networks and access? Does it verify the accuracy of the reports? Does it review each report, or a sample of reports? Does it compare data with previous reports to track network capacity and access? What are examples of problems DHCS has uncovered as a result of reviewing and tracking this data, and what enforcement actions followed?

3. ***Can provider and other access data DHCS collects from plans be incorporated into the Medi-Cal Managed Care Performance Dashboard to enhance plan monitoring?*** As discussed later in this background document, the Dashboard is a tool to monitor the performance of Medi-Cal MCPs, and the adequacy of provider networks and access to provider services is a key performance measure. Addition of provider network data into the Dashboard would enhance plan monitoring provide the DHCS and stakeholders with an effective way to ensure appropriate plan performance in the area of access.

IV. Medi-Cal Dental Managed Care

DHCS contracts with three Geographic Managed Care (GMC) Plans and five Prepaid Health Plans (PHP) that provide dental services to Medi-Cal Beneficiaries in Sacramento and Los Angeles counties. All Medi-Cal dental managed care plans are licensed by the State of California, Department of Managed Health Care, pursuant to the Knox-Keene Health Care Service Plan Act of 1975.

Each dental plan receives a negotiated monthly per capita rate from the state for every recipient enrolled in their plan. Medi-Cal Dental Managed Care recipients enrolled in contracting plans are entitled to receive dental benefits from dentists within the plan's provider network. Covered

dental services provided by Medi-Cal dental managed care plans are the same dental services provided under the Denti-Cal Fee-for-Service (FFS) Program. Dental GMC is a ***mandatory*** program in Sacramento County. Medi-Cal recipients in Sacramento County who are eligible to receive dental services must select one of the available GMC plans for their dental care. Dental PHP is a ***voluntary*** program in Los Angeles County. This program was established to allow Medi-Cal recipients the option to enroll in Health Maintenance Organizations (HMOs) as an alternative to the Medi-Cal Dental FFS program.

While these managed care pilots were intended to control costs and improve children's ability to see a dentist, state data showed that Sacramento County consistently produced one of California's worst records for care. In February of 2012, the Sacramento Bee highlighted service issues that had plagued the program for years, including months, and in some cases years, for wait times to see a dentist, phone lines set up for Medi-Cal patients that went intentionally ignored, and school children unable to eat because of pain caused by untreated dental problems.

In response, AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, was enacted in July of 2012 to improve access to oral health and dental care services provided to Medi-Cal beneficiaries enrolled in dental managed care plans in Sacramento County. Specifically, the Department of Health Care Services is required to report on specific performance measures as listed in AB 1467. The following are the performance measures that have been established and are reported on a quarterly basis:

- Provider network adequacy,
- Overall utilization of dental services (under 21),
- Annual dental visits (under 21),
- Use of preventive dental services (under 21),
- Use of dental treatment services (under 21),
- Use of examinations and oral health evaluations (under 21),
- Sealant to restoration ratio (6-9 and 10-14),
- Preventive services to filling ratio (under 21),
- Treatment to caries prevention ratio (under 21),
- Use of dental sealants (6-9 and 10-14), and
- Survey of member satisfaction with plans and providers.

In addition to tracking performance measures, benchmarks for utilization rates were established based on Denti-Cal Fee-for-Service Data. 2014 utilization data shows a significant lack of progress towards meeting those benchmarks.

Dental Services in a Surgery Setting

In May of 2014, it was announced that Sutter Memorial Hospital would discontinue all dental services due to inadequate reimbursement rates for operating room and anesthesia fees for hospital dentistry services. Sutter Pavilion Surgery Center and Sutter Memorial were two of the last facilities in Northern California willing to accept Medi-Cal and patients with developmental disabilities or severe health conditions. This closure affects the special needs patients who receive sedation dentistry for 6 of the 21 Regional Centers.

Sutter Medical Center has been a cooperative partner in providing these services for as long as possible, and is the last remaining service provider despite the challenges the system has provided. Inadequate payment for dental services is a long standing, statewide problem. As the number of Medi-Cal enrollees and the number of people in the Regional Center system continues to increase, the problem is amplifying and is not a challenge specific to Sacramento County, but reflects the consequences of inadequate payment rates across the state.

Issues for the committee to consider:

1. ***What is the role of DHCS in addressing problems of access to dental care?*** After the announcement that Sutter would be discontinuing dental anesthesia services, three different work groups were formed to help create a more efficient and uniform anesthesia protocol, to identify administrative barriers and improvements for payments, and to identify other care providers who can accommodate and provide services to these patients. While DHCS has been cooperative by facilitating many meetings and three different workgroups, a situation this severe requires more immediate action. As a Geographic Managed Care County, DHCS needs to work working with contracted plans to ensure there is adequate access to care.

2. ***What procedures does DHCS have in place to address the lack of achievement towards utilization benchmarks?*** Prior to 2012, there was no tracking of utilization of services. Plans were being provided payment for every recipient enrolled in their plan, but there was no way to ensure that recipients were actually receiving necessary care. Regulations implemented in 2012 established a system for tracking utilization rates and benchmarks for utilization rates were established. Current data shows that these benchmarks are not being met.

V. Allergy Testing Reimbursement Policies:

Asthma is a chronic inflammatory disease of the airways. Asthma is widespread; in California an estimated 2.5 million adults have asthma along with about 700,000 children. It is one of the most common chronic diseases of childhood. The exact cause of asthma is unknown and it cannot be cured. Asthma can be controlled with self-management education, appropriate medical care and avoiding exposure to environmental triggers. Allergen exposure is a significant trigger that can worsen symptoms for many patients with asthma.

Clinical practice guidelines are compiled by expert bodies with the aim of providing the best evidence to guide decisions and criteria regarding diagnosis, management, and treatment of specific conditions in specific areas of healthcare. The National Asthma Education and Prevention Program Expert Panel guidelines for the management of asthma recommend that patients who require daily asthma medications have allergy testing for perennial indoor allergens. The guidelines also recommend that when triggers are found, exposure to allergens and pollutants be controlled through avoidance and abatement. For patients whose symptoms are not controlled adequately with these interventions and who are candidates for immunotherapy, the guidelines recommend referral to an allergist.

Food allergies are an immune-based disease that has become a serious health concern in the United States. A recent study estimates that food allergy affects 5% of children under the age of five years and 4% of teens and adults, and its prevalence appears to be on the increase. The symptoms of this disease can range from mild to severe and, in rare cases, can lead to anaphylaxis, a severe and potentially life-threatening allergic reaction. There are no therapies available to prevent or cure food allergies. The only prevention option for the patient is to avoid the food allergen. Treatment involves the management of symptoms as they appear. Because the most common food allergens—eggs, milk, peanuts, tree nuts, soy, wheat, crustacean shellfish, and fish—are prevalent in our diets, avoiding the food allergens is challenging and difficult. The development of the Guidelines for the Diagnosis and Management of Food Allergy in the United States began in 2008 to identify the best clinical practices related to food allergy across medical specialties.

Testing for allergies

Identifying the specific allergen is an essential step in effectively preventing and treating the symptoms. Allergy testing can identify the specific substance that triggers the allergic reaction. Testing can be done either through skins tests or blood tests.

There are two types of skin tests. In the first type of skin test, a drop of suspected allergens are pricked or scratched on the surface of the skin. The test spot will swell if the patient reacts to the allergen placed. The second type of skin test involves injecting a solution of allergen into the skin. Generally, skin tests are performed under the supervision of allergists.

There are situations where skin tests cannot be used. Because they involve multiple injections, young children may not tolerate skin tests. Some medications can interfere with the tests. In addition, in some people with dark skin or skin conditions, it may be hard to read the tests. Also, the skill of the tester can affect the results, and skin tests should be done only by professionals with appropriate training. Occasionally, a patient may develop a severe reaction to the skin test requiring treatment.

Blood tests are performed by a clinical laboratory upon the order of a physician, including primary care physicians. Medications and skin conditions do not interfere with the results. Because blood tests, in contrast to skin tests, do not require visits to a specialist, they may be more economical and much more accessible. Patients do not have to wait to see a specialist and avoid the time and effort involved in additional appointments for specialty care.

DHCS has developed a policy for the allergy blood test. The policy does not require prior authorization. The process requires the provider, in this case the clinical laboratory, to submit relevant information to the fiscal intermediary with the claim for reimbursement. There are two available options for submitting relevant information with the claim: 1) upload an attachment or scanned document to accompany the claim, or mail the attachment to Xerox; or 2) provide medical justification on the claim form where an explanation limited to 80 characters is available. DHCS added the second option within the last year after working with the labs on their concerns about easing administrative burdens.

Issues for the committee to consider:

1. ***Are DHCS utilization controls appropriate when it comes to allergy testing?*** Utilization controls are used to prevent overuse of services, but if not carefully developed, can prevent healthcare providers from providing necessary care. Concerns have been raised that Medi-Cal payment policies are inappropriately limiting access to care and Medi-Cal is insufficiently responsive to evidence of inappropriate utilization controls. At this committee's August hearing, DHCS committed to address the conflict between national guidelines and the department's payment policy. This hearing provides an opportunity for DHCS to provide a status update on its efforts to address this conflict.

2. ***Is DHCS changing its process to address conflicts between its payment policies and best medical practices?*** The process to resolve the conflict between the department's allergy testing payment policies and clinical practice guidelines regarding allergy testing has been very lengthy further delaying appropriate allergy testing to Medi-Cal beneficiaries in need. DHCS should evaluate its policies and processes it uses to assess and resolve conflicts between payment policies and medical practice to ensure it is efficient and responsive to those bringing forward concerns.

VI. Medi-Cal Managed Care Performance Dashboard

The dramatic growth of the MCMC program in recent years has fueled continued interest in understanding and evaluating the program and the plans with which DHCS contracts to provide services to MCMC enrollees. One product of this interest is the Medi-Cal Managed Care Performance Dashboard (Dashboard), which is an MCP monitoring tool produced quarterly by DHCS. The Dashboard provides basic MCMC enrollment data, and contains data on various measures including enrollment, health care utilization, financial performance indicators, grievances and state fair hearings, quality of care, and consumer satisfaction. The Dashboard aims to assist DHCS and its stakeholders in observing and understanding MCP performance statewide and by plan.

This hearing intends to report on the progress and application of the Dashboard in its current form. Additionally, this hearing provides an opportunity to determine how the Dashboard could be improved and enhanced to optimize use of MCP performance data, and how it can be better leveraged to monitor quality and access in MCMC today and in the future.

Medi-Cal MCP performance monitoring

CMS requires that states, through their contracts with MCPs, measure and report on performance to assess the quality and appropriateness of care and services provided to plan enrollees. In response, DHCS implemented a monitoring system that is intended to provide an objective, comparative review of health plan quality of care outcomes and performance measures called the External Accountability System (EAS). DHCS designates EAS performance measures on an annual basis and requires plans to report on them.

A primary tool DHCS uses to monitor MCP performance is Healthcare Effectiveness Data and Information Set (HEDIS) which measures health plans' clinical care quality performance. After

consulting with an external quality review organization, DHCS selects certain HEDIS measures, and requires its contracted MCPs to submit an annual report on the measures. Some of the measures are compared to national Medicaid benchmarks to determine plan performance. For example, for 2012, Medi-Cal MCPs were required to report on 30 measures, 19 of which were compared to national Medicaid benchmarks, including clinical measures relating to women's health, children's services, diabetes care, and appropriate use of services. From those measures, DHCS was able to determine that, in comparison to national benchmarks, on a statewide basis, Medi-Cal MCPs performed at or above the national median on 17 of the 19 comparable HEDIS measures.

Another tool used by DHCS to measure MCP performances is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The CAHPS survey measures plan enrollee satisfaction with adult and child health care services. DHCS requires Medi-Cal MCPs to administer the CAHPS survey every two to three years. The last CAHPS survey was administered by DHCS in 2013.

The Dashboard

In recent years, DHCS initiated the process of creating a MCMC dashboard. DHCS obtained funding and assistance from the California HealthCare Foundation to develop concepts, and engaged with a vendor, Navigant, to help facilitate the process of Dashboard development. Additionally, DHCS received guidance from a Technical Advisory Group comprised of DHCS and CHCF staff, legislative staff, health plan representatives, and other key stakeholders to identify goals for the Dashboard. According to statements made by DHCS prior to the release of the Dashboard, the Dashboard is intended to convert data into information that can be used to monitor plan performance, be transparent, ensure efficacy of the MCMC program, and provide information to stakeholders and the public.

The first quarterly Dashboard was released in early 2014, and included data covering the third quarter of 2013. Since the release of that Dashboard, DHCS has released two others covering the fourth quarter of 2014 and the first quarter of 2014. The data included in the Dashboard include:

1) Enrollment data: statewide enrollment data broken down by plan model, specified populations (e.g. families, children, SPDs, ACA expansion), age, race/ethnicity, gender, and others.
2) Financial data: medical-loss ratio and tangible net equity.
3) Grievance and State Fair Hearings data.
4) Utilization data: statewide data on emergency room visits, inpatient and outpatient admissions, and pharmacy.
5) Continuity of care data for SPDs and children.
6) Medical Exemption Request data for all beneficiaries and SPDs.
7) CAHPS and HEDIS scores broken down by MCP.

Issues for the committee to consider:

1. ***How is DHCS using the Dashboard to drive improvement in Medi-Cal MCPs?*** The data published on the Dashboard serves as a snapshot of Medi-Cal MCP performance in a variety of areas. However, for many of the data elements, it is unclear what performance benchmarks MCPs should be meeting. Performance benchmarks would provide a means to determine, based on Dashboard data, how well or poorly a plan is performing in a given area and what actions DHCS may need to take in order to drive an MCP to improve. Additionally, how is DHCS involving stakeholders in the development of performance benchmarks, and what actions would DHCS take if an MCP performs below that benchmark?

2. ***Is the Dashboard iterative, and if so, what actions is DHCS taking to improve and enhance future versions?*** The Dashboard itself is a useful tool, and DHCS as well as the organizations and stakeholders who contributed to its development should be commended. Assuming the Dashboard is iterative, it is important to understand what steps DHCS is making to improve it in order to enhance plan monitoring. In the development of the Dashboard, a variety of performance measures were initially considered, including data on quality, access and experience such as ombudsman reports, disenrollment rates, Medi-Cal enrollee surveys, utilization of long-term services and supports and behavioral health care, and network adequacy. As previously mentioned, DHCS consulted with a TAG during the development of the Dashboard. Is the department still engaging with stakeholders in order to improve the Dashboard and will it consider other performance measures that are timely and relevant to MCMC, such as timely access and network adequacy?

3. ***Should Dashboard data be further stratified?*** The population of MCMC enrollees is highly diverse, and plans should be held accountable for maintaining performance levels that offer all MCMC enrollees quality service. Recent legislation, AB 411 (Pan, 2014) would have stratified HEDIS data used by the department by various factors, including language, race, ethnicity, sexual orientation, and others in order to identify and assess health care disparities among MCMC enrollees. This bill was vetoed by the Governor in October of 2013. In his veto message, the Governor stated, "Nothing in current law prevents the [DHCS] from requiring its external quality review organization to provide more detailed data by geography, race, ethnicity, or other demographic attribute. If the department sees a need or benefit that justifies the costs of procuring this additional data, I am confident that they will procure it." Does DHCS see value in stratifying the data it uses to evaluate plan performance, and if so, are there plans to move forward with such stratification to maximize the usefulness of the Dashboard?

4. ***Would explanations of the data enhance its usefulness?*** It would be helpful if the Dashboard data had additional explanation or context. For example, it is assumed that grievance data is plan-level data, but that is not clear. Additionally, the Dashboard shows data regarding the number of Medical Exemption Requests (MER) denied, but does not provide any explanation as to the reasons for denial, or even what a "MER" is. DHCS should consider providing a narrative explanation of the data with the release of each Dashboard in order to help the public understand and interpret the data.