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Managed Care Program Initiatives at the Department of Health Care Services *Assessing the Promise of Coordinated Care*

Thursday, October 25, 2012
1:30 pm – 4:30 pm
State Capitol, Room 4202

Part I. Overview

Introduction. The California Department of Health Care Services (DHCS) has embarked on an ambitious array of initiatives that will substantially change the delivery systems of public programs in California and could result in over 2 million new enrollees into Medi-Cal managed care (MCMC) plans. These program changes include all age groups and all geographic regions. For oversight, regulations, monitoring and program standards, DHCS is partnering with the state Department of Managed Health Care (DMHC) and the federal Centers on Medicare and Medicaid Services (CMS) on many of these initiatives. This hearing is intended to review the state's plans for monitoring and evaluating the effectiveness of these program changes with regard to quality and access to care. In addition, for those that are considered demonstration or pilot projects, this hearing will explore the state's plans to evaluate the demonstration and pilot projects.

Medi-Cal. Medi-Cal is California's version of the federal Medicaid program. Medicaid is a 46-year-old joint federal and state program offering a variety of health and long-term services to low-income women and children, elderly, and people with disabilities. Each state has discretion to structure benefits, eligibility, service delivery, and payment rates under requirements established by federal law. State Medicaid spending is "matched" by the federal government, averaging about 57%, based largely on per capita income. California uses a combination of state and county funds augmented by a small amount of private provider tax funds to be eligible as the state match for the federal matching funds.

Medicaid is the single largest health care program in the United States. According to the Kaiser Family Foundation (KFF), in 2011, the average monthly enrollment is projected to exceed 55 million, and a projected 70 million people, roughly 20% of Americans will be covered by the program for one or more months during the year. In California, the estimated average monthly enrollment is 8 million or roughly one seventh of the national total and approximately 29% of all Californians.

Seniors and Persons with Disabilities. In November of 2010, California obtained federal approval for a Section 1115(b) Medicaid Demonstration Waiver from CMS entitled “A Bridge to Reform Waiver.” Among the provisions, this waiver authorized mandatory enrollment into MCMC plans of over 600,000 low-income seniors and persons with disabilities (SPDs) who are eligible for Medi-Cal only (not Medicare) in 16 counties. Enrollment was phased in over a one-year period in the affected counties. This new mandatory enrollment began on June 1, 2011 and approximately 20,000 people per month were enrolled. Prior to this, enrollment was mandatory for children and families in 30 counties and for SPDs in 14 counties served by County Organized Health Plans (COHS), one of three models of MCMC in California. SB 208 (Steinberg), Chapter 714, Statutes of 2010, contained the provisions implementing this and other waiver requirements.

Medicare. Medicare is a federally-sponsored health insurance program for people age 65 and older; people younger than 65 who have been disabled for 24 months; people diagnosed with amyotrophic lateral sclerosis, also known as Lou Gehrig’s disease; and, those with end-stage renal disease. Medicare provides coverage for hospital care (Part A), medical services (Part B), and prescription drugs (Part D). Medicare Part C, also known as Medicare Advantage, offers beneficiaries the option of receiving their Medicare benefits through private health plans. For citizens and legal residents over age 65 the cost sharing requirements vary depending on the number of quarters the person or their spouse has worked in Medicare-qualifying employment.

Dual Eligibles. In California, as in most states, low-income SPDs may qualify separately for both Medicare and the state Medicaid program (Medi-Cal in California) and are called “dual eligibles.” Nationally, nearly 9 million people are dual eligible, of those approximately 1.1 million are in California. For dual eligibles, Medicaid fills in the gaps in Medicare coverage. For those who qualify, Medi-Cal pays the Medicare Part B premium (Medicare part B covers physician services, and the premiums were \$96.40 per month for most beneficiaries in 2010), pays the cost sharing charged for many Medicare services, and covers a range of benefits not covered by Medicare such as long-term care. Medicare is the primary payer, covering medical care such as hospital, physician, diagnostic tests, post-acute care and other services, and prescription drugs.

Medicare and Medi-Cal Dual Eligibility. Part of the 2010 federal Patient Protection and Affordable Care Act (ACA) was an effort to improve coordination between Medicare and Medicaid for this dually eligible population and to provide incentives to lower the costs. To that

end, the ACA established two new federal entities - the CMS Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) and the Center for Medicare and Medicaid Innovation (CMI) to test innovative payment and delivery models to lower costs and improve quality for dual eligible enrollees. SB 208 required DHCS to establish a demonstration program to begin enrolling dual eligibles into coordinated health care delivery models in up to four counties and specified a process for selection. During the 2010 waiver negotiations, CMS requested that California pursue the dual eligible pilots through this new federal initiative rather than as part the Bridge to Reform Waiver. California was one of 15 states to receive a \$1 million design contract through the CMI and the Medicare-Medicaid Coordination Office in April 2011.

According to the KFF report titled, “Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 state Design Contracts Funded by CMS” (KFF August 2011 Report), dual eligibles are attracting attention in part due to the medical needs and associated health care costs that typically exceed those of other Medicare and Medicaid enrollees. As an example, the KFF August 2011 Report states nationally they are a relatively small number (9 million) comprising 15% of Medicaid enrollees but 39% of total Medicaid spending. Similarly, they represent 21% of Medicare enrollees but 36% of total Medicare expenditures. In addition, 66% have three or more chronic conditions and 61% are considered to be cognitively or mentally impaired.

Coordinated Care Initiative. In the 2012-13 Budget, the Brown Administration requested authority from the Legislature for a substantial expansion of this dual eligible demonstration to allow statewide implementation and proposed to include Long Term Supports and Services (LTSS) for dual eligible and SPDs into a coordinated delivery system that would be delivered using managed care models. The LTSSs that were proposed to be integrated into MCMC include In-Home Supportive Services, Community-Based Adult Services, Multipurpose Senior Services, and skilled-nursing facility services.

The Legislature enacted a modified version of the Governor’s proposal in SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, and SB 1036 (Committee on Budget and Fiscal Review), Chapter 45, Statutes of 2012, the Duals Demonstration Pilot Project/Coordinated Care Initiative (CCI). The CCI will be implemented in eight counties, pending federal approval, beginning June 2013. It is a three-year demonstration to combine the continuum of health care, acute care, behavioral health, and LTSSs through MCMC health plans in order to maximize the coordination of benefits between Medicare and Medi-Cal. The eight counties are Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. The CCI will use a capitated payment model to provide Medicare and Medi-Cal benefits through existing MCMC health plans. DHCS is required to consult on a regular basis with the Legislature, the federal government, and stakeholders and has hired a consultant to assist in convening stakeholder work groups and developing a Programmatic Transition Plan.

The state is proposing to use a passive enrollment system through which dual eligible persons may choose to opt out of the Demonstration for Medicare services. However, enrollment in managed care for Medi-Cal services is mandatory. SB 1008 also requires SPDs who have been mandatorily enrolled in MCMC health plans in the Demonstration counties to have all LTSSs services covered through the MCMC plan. Pending federal approval, those who do not opt out for Medicare services will be enrolled in the Duals Demonstration for an initial six-month lock-in. Additional key features of the CCI legislation include:

- 1) Required standards for DHCS and health plan readiness prior to implementation of the demonstration project to, among other things, ensure network adequacy, adequate grievance and appeals processes, and measurement and monitoring of health plan performance.
- 2) Increased Legislative oversight by requiring transition plans, participation in stakeholder processes, and reporting on managed care plan readiness.
- 3) Specified additional consumer protections and notifications to ensure timely and appropriate communications to enrollees, care coordination and care management activities, and stakeholder participation in the planning and development of this demonstration project.
- 4) Required DHCS to enter into an interagency agreement with DMHC to perform some or all of the department's oversight and readiness review activities, including providing consumer assistance to beneficiaries and conducting financial audits, medical surveys, and a review of the adequacy of provider networks of the managed care plans participating in the demonstration.
- 5) Established legislative intent that the demonstration project expands statewide within three years, but requires that the expansion beyond the initial eight counties is contingent on statutory authorization and subsequent budget appropriation.

CMS has not approved the state's proposal for the Demonstration to date. At a recent National Academy for State Health Policy Conference, Melanie Bella, the Director of the Medicare-Medicaid Coordination Office, stated that CMS has not and will not approve lock-ins. The specific terms will be established in a Memorandum of Understanding between CMS and the state. According to the September 28, 2012, DHCS Transition Plan (Plan), the state held a rigorous joint selection process with CMS to identify health plans with requisite qualifications and resources best suited to provide beneficiaries seamless access to an integrated set of benefits. In addition, the National Committee for Quality Assurance (NCQA) independently evaluated the Model of Care for each health plan. The Plan states that the state and CMS are jointly assessing each plan's readiness during the fall of 2012.

Healthy Families Program. Currently the Healthy Families Program (HFP) is administered by the Managed Risk Medical Insurance Board (MRMIB) which enters into contracts with health plans to provide a choice of plans for families, including dental and vision plans. HFP is the state's version of the federal Children's Health Insurance Program (CHIP). The Governor's January 2012-13 Budget proposed to shift over 860,000 children currently in HFP into Medi-Cal.

The ACA requires all children in families with income up to 133% of the federal poverty level (FPL) to be enrolled in Medi-Cal in 2014. However, the Brown Administration proposed to move this up to 2013 and to shift the remainder of the children (with incomes up to 250% FPL) to Medi-Cal. Upon implementation, newly enrolled children would also go into Medi-Cal. The Legislature adopted a modified version as part of the 2012-13 Budget. AB 1494 (Committee on Budget), Chapter 28, Statutes of 2012, provides for the transition of children from HFP to Medi-Cal starting no earlier than January 1, 2013. This transition is projected to result in \$13.1 million General Fund savings in 2012-13, \$58.4 million General Fund savings in 2013-14, and \$72.9 million General Fund savings annually thereafter. (However, the savings is more than offset by an estimated loss of over \$200 million due to the expiration of a Managed Care Organizations tax. The extension failed passage as a result of the transition.) The California Health and Human Services Agency was required to work with MRMIB, DHCS, and DMHC to develop a strategic plan for this transition of children from HFP to Medi-Cal no later than October 1, 2012. This plan was required to include at least the following information:

- 1) State, county, and local administrative activities that will facilitate a successful transition;
- 2) Methods and processes for stakeholder engagement to assist in the transition;
- 3) State monitoring of managed care health plans' performance and accountability for provision of services;
- 4) Health care and delivery system components, such as standards for informing and enrollment materials, network adequacy, performance measures and metrics, fiscal solvency and related factors that ensure timely access to quality health and dental care; and,
- 5) Operational steps, timelines and key milestones.

The plan is available at <http://www.dhcs.ca.gov/services/Pages/HealthyFamiliesTransition.aspx>

The transition, as modified by the Legislature in AB 1494, breaks up the transfer to Medi-Cal into four phases. Phase 1 is to begin no earlier than January 1, 2013 and includes about 415,000 children who are in an HFP plan that is also a MCMC plan. Phase 2 is to begin no earlier than April 1, 2013 and includes about 249,000 children enrolled in an HFP plan that subcontracts with a MCMC plan. It also requires, to the extent possible, the child to be enrolled in the MCMC plan that sub-contracts with the same plan. Phase 3 is to begin no earlier than August 1, 2013 and consists of about 173,000 children enrolled in an HFP plan that is not a Medi-Cal plan and does not contract with a Medi-Cal plan in that county. Plan enrollment for these children is to include consideration of whether the child's primary care provider is available through the new plan. Phase 4 is to begin no earlier than September 1, 2013 and transitions about 43,000 children in HFP residing in counties with no MCMC into Medi-Cal fee-for-service (FFS).

The HFP shift also includes a change in dental and vision benefits. In most counties, Medi-Cal has a FFS dental program entitled Denti-Cal. In Los Angeles, there is voluntary dental managed care and in Sacramento, mandatory dental managed care. For Sacramento and Los Angeles counties, dental coverage for individuals transitioning would continue to be provided by their current dental managed care plan if the HFP dental plan is a Medi-Cal dental managed care plan. For Sacramento County, if their plan is not a Medi-Cal dental managed care plan, the individual is required to be assigned to a plan, with preference to a plan with which their current provider is a contracted provider. For Los Angeles County, if their plan is not a Medi-Cal dental managed care plan, the individual may select a Medi-Cal dental managed care plan or choose to move into Medi-Cal FFS for dental coverage. For all other counties, dental coverage for these children transitions to Medi-Cal FFS dental coverage. Additionally, children will be moved out of their HFP vision plan and will receive vision services through the MCMC health plan.

Expansion to 28 Counties. AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the expansion of MCMC to 28 mostly rural counties. The stated purpose is to provide a comprehensive program of managed health care plan services to Medi-Cal recipients residing in these counties that currently receive Medi-Cal services on a FFS basis: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Lake, Lassen, Mariposa, Modoc, Nevada, Mono, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, and Yuba. Currently, approximately 365,000 enrollees would qualify for managed care. A Request for Application (RFA) was released to the public for comment in the beginning of August and responses were due by the end of the month. Implementation is set for June 2013. There were six current managed care plans that expressed interest, two expressed interest for all 28 counties. Eight non-California managed care plans expressed interest, six expressed interest for all 28 counties. Two plans recommended case management/care coordination models. All other responses varied from offering coverage to a few counties to entire regions. Stakeholder meetings were held in July and August 2012. DHCS reiterated that the applicants' relationships with local health resources will be considered in awarding a contract. Stakeholders indicated there is a collaborative of eight counties – Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity – that have been working together for years with Partnership Health Plan to develop a COHS managed care delivery system in their area. These counties would like to be carved out of the 26 contiguous - county region and the upcoming RFA. Stakeholders from the eight-county collaborative indicated their concern that DHCS has disregarded several years of work and extensive planning already performed by these counties, including involving and educating local officials and providers as well as involving residents in an advisory capacity.

Populations Currently Served by MCMC. As of October 2012, MCMC in California served about 4.8 million enrollees in 30 counties, or about 65% of the total Medi-Cal population. As a result of the new initiatives that have been implemented, primarily the mandatory enrollment of

SPDs, this has increased by 5% in the past year. The oldest model is the COHS. COHS plans serve about 885,000 beneficiaries through six health plans in 14 counties: Marin, Mendocino, Merced, Monterey, Napa, Orange, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura, and Yolo. In the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors and all Medi-Cal enrollees are in the same health plan.

Fourteen counties are part of the two-plan model. In most Two-Plan model counties, there is a “Local Initiative” (LI) and a “commercial plan” (CP). DHCS contracts with both plans. Local government, community groups, and health care providers were able to give input when the LI was created. The CP is a private insurance plan that also provides care for Medi-Cal beneficiaries. The Two-Plan model serves about 3.3 million beneficiaries in Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Two-counties employ the Geographic Managed Care (GMC) model: Sacramento and San Diego. DHCS contracts with several commercial plans in those counties and there are about 500,000 enrollees.

Part II. Evaluating and Monitoring

Purpose of the Hearing. In December 2011, the Assembly Health Committee, jointly with the Senate Health Committee held a hearing to fulfill the legislative oversight role with regard to two of the health care initiatives affecting SPDs; specifically, mandatory enrollment into MCMC and the dually eligible Demonstration Project. A primary goal of the December 2011 hearing was to inform the public and legislature as to the status of these initiatives and the focus was on enrollment and transition. The timing of that hearing also provided an opportunity to use lessons learned from the current activities to inform and shape current and future policy decisions and program implementation.

The purpose of this hearing is to move to the next phase and to set the framework for an evaluation of the SPD and duals initiatives. In addition, the Legislature has recently approved a transition of all HFP children to the Medi-Cal Program and authorized an expansion of managed care to 28, mostly rural, additional counties. This hearing will address the Brown Administration’s plans to evaluate and monitor these policy changes as well.

For the purpose of this hearing, the Brown Administration has been asked to identify the roles and responsibilities of DHCS versus DMHC. They have also been requested to provide examples of metrics being used to monitor program transitions in the near term, including contingencies if program objectives are not achieved and efforts planned for future ongoing monitoring.

To make these assessments, this hearing will review some of these current measures and the DHCS and DMHC plans to coordinate oversight and review. In addition, outside experts and stakeholders will be providing information on ways to supplement existing measures tailored to the nature of the population. The focus is primarily on access to care, network adequacy, and quality performance measures. It is not intended to cover all measures comprehensively, but rather to highlight certain key areas as examples of setting baselines and monitoring programs over time. Most importantly, it is intended to emphasize the concept of evaluating the data that are collected, determining acceptable results, how to determine what is working and not working and how to make corrections

Policy Questions. With the exception of the HFP transition, these program changes were for the stated purpose of providing a more coordinated approach to care and to align payment incentives with higher qualities of care and of life. The overarching policy questions include the following:

- 1) What does DHCS or the Administration view as success?
- 2) What are the benchmarks, milestones, red flags?
- 3) Are the current measures adequate?
- 4) The state collects volumes of data and claims information, but are we making the best use of it to evaluate the programs?
- 5) What additional data or indicators should be utilized?
- 6) How will we know if adjustments must be made and what should they be?
- 7) What contingencies should be established if objectives are not being met?

Part III. Managed Care Oversight and Regulation

Knox-Keene Act. The Knox-Keene Act of 1975 is the regulatory framework that most managed care plans (generally referred to as Health Maintenance Organizations or HMOs) operate under in California. It is a comprehensive set of rules that includes mandatory basic services, financial stability, availability and accessibility of providers, review of provider contracts, administrative organization, consumer disclosure, and grievance requirements now regulated by DMHC.

Among the factors that led to its passage, including the selection at the time of the Department of Corporations, as the regulatory entity, were a number of scandals associated with Medi-Cal prepaid health plans (PHP) and lax oversight by the Department of Health Services (now DHCS) in the early 70's when Governor Reagan expanded use of PHPs in the Medi-Cal program as a means of reducing costs.

By 1990, there were more than 35 HMOs in California with nearly 10 million enrollees. In addition, due to changes in federal law, many that had begun as not-for-profit converted to for profit. According to, a report by Debra L. Roth and Deborah Reidy Kelch titled “Making Sense of Managed Care Regulation in California,” November 2001, prepared for the California HealthCare Foundation, as providers, consumers, and consumer advocates witnessed dramatic changes in health care delivery precipitated by the growth in managed care, they increasingly sought additional consumer protections and legislative and regulatory changes in how HMOs operate and are regulated. In 1999, comprehensive health plan reform legislation led to the creation of DMHC. This led to passage of a series of managed care reform legislation, including 20 bills referred to as the “Patient’s Bill of Rights.” In some cases Medi-Cal plans were specifically excluded based on the assertion that federal Medicaid requirements were in conflict, more protective, or that it would result in higher state General Fund costs. This also led to the creation of a stand-alone department, (DMHC), and responsibility for Knox-Keene regulation was transferred to the new department in July 2000. However, it continued to be under the Business, Transportation and Housing Agency, rather than the Health and Human Services Agency until DMHC was transferred in 2012 by AB 922 (Monning), Chapter 552, Statutes of 2011.

In addition to required financial reporting, oversight and enforcement by DMHC is done through a licensing audit of each plan every three years. DMHC operates an “HMO Help Center” with a toll free hotline that is answered 24 hours a day. Through coordination among help center, licensing, and enforcement staff additional audits, investigations, or enforcement activities are initiated if DMHC identifies a pattern of problems through consumer or provider complaints.

As stated above, the Knox-Keene Act includes regulations on accessibility of services. For instance, regulations require the location of facilities providing the primary health care services of the plan to be within reasonable proximity of the business or personal residences of enrollees, and so located as not to result in unreasonable barriers to accessibility. Hours of operation and provision for after-hour services are required to be reasonable and emergency health care services are required to be available and accessible within the service area 24 hours a day, seven days a week. The Knox-Keene Act also requires that there shall be at least one full-time equivalent physician to each 1,200 enrollees. Geographic standards require that all enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord all enrollees a ratio of at least one primary care provider to each 2,000 enrollees. With regard to hospitals, enrollees must be within 30 minutes or 15 miles of a contracting or plan-operated hospital which has a capacity to serve the entire enrollee population based on normal utilization. There are no equivalent specifications for specialists. These ratios also apply to Medi-Cal plans, but Medi-Cal requires access to be within 10 miles and 30 minutes.

Timely access to care remained one of the outstanding issues not resolved by the passage of the Patient's Bill of Rights. Approximately 5% of the consumer complaints that were received at the newly established DMHC related to accessibility. Consumer advocates continued to sponsor legislation and eventually were successful. AB 2179 (Cohn), Chapter 979, Statutes of 2002, required DMHC to develop and establish regulations that were more specific with regard to waiting times for appointments, timeliness of referrals, and waiting times to talk to a triage nurse or physician. However, regulations were not finalized until 2010 and were not fully implemented until January 2011. Plans are required to contract with adequate numbers of doctors and other health care providers in each geographic area to meet the specific clinical and time-elapsd standards for appointment waiting times.

Regulation of State Funded Managed Care Programs. California has adopted the national trend to use various models of managed care in place of FFS in its public programs such as Medi-Cal and CHIP (or HFP in California). Similar to commercial HMOs, the enrollee receives a subset of the Medi-Cal benefits through a managed care plan. The plan is paid a per member capitated rate for each enrollee which is set by an actuarial methodology. The plan in turn pays contracted providers to provide care. As in commercial managed care, the enrollee's choice of providers may be limited to those in the plan's network, but the plan is required to ensure timely access to care. A recent report by KFF, "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey," discusses factors that contribute to the success or failure of these models. Specifically, it states that while managed care offers significant potential to improve access and care for enrollees, it can fail as a strategy if capitation payment rates are not adequate, transitions from FFS are not well-conceived, provider networks are not sufficient to meet the care needs of the enrolled population, or state oversight of managed care programs is lacking.

MCMC developed along two separate paths in California. In 1985 federal law specifically authorized the Health Plan of San Mateo and the Santa Barbara Regional Health Authority as Health Insuring Organizations. Known under state law as COHS, a COHS is a non-profit, independent health plan that is created by the County Board of Supervisors and contracts with DHCS to administer Medi-Cal benefits to all eligible Medi-Cal enrollees in the counties that it covers. There is no choice in these counties as all enrollees are in the same plan, although some services may be provided outside the plan or are "carved-out". California was granted authority for three more in 1990: CalOptima (Orange County); Partnership Health Plan of California (Solano); and, Central Coast Alliance for Health (Santa Cruz), but enrollment was capped at 14% of the total Medi-Cal population. In 1996 federal law allowed an individual COHS to operate in more than one county. Recently federal authority was also granted to Ventura County to operate a COHS which has been in operation since July 1, 2011. Six COHS now cover 14 counties. Because of the specific federal authority, these entities are not required to be licensed by the state. Even prior to mandatory enrollment of SPDs in the two-plan and GMC counties, in a

COHS county everyone, regardless of disability category is in the same health plan. Although COHS are not required to obtain a Knox-Keene license for Medi-Cal, DHCS requires them to meet Knox-Keene standards by contract. In addition, when the HFP program was implemented in California, participating plans were required to be Knox-Keene licensed. Currently all COHS, except the Gold Coast Health Plan in Ventura have a Knox-Keene license for at least one line of business and some have included all lines. According to DMHC, licensure for any line of business allows regulation and review of the entire plan for fiscal solvency standards.

While HMOs were growing in the commercial world, along a parallel path in the use of PHPs was again proposed as a means of reducing costs in Medi-Cal in 1993. DHCS (then the Department of Health Services) developed a strategic plan to implement a planned expansion of MCMC. The plan envisioned a choice between a CP that would be similar to what was available in the commercial market and one that was locally developed, a LI, with the County Board of Supervisors having the right of first refusal as the entity responsible for creating the LI. This time, a basic tenet was that the plans in the two-plan model would be required to obtain Knox-Keene licensure. In order to ensure the financial viability of the newly created LI and a stable volume of business to support the participating traditional and safety net providers, DHCS set minimum and maximum enrollment levels. The concern was that the transition to managed care could result in a substantial shift of Medi-Cal revenues away from traditional and safety net providers who were frequently the only source of primary care for the medically underserved populations. In addition, these providers were more likely to service culturally and linguistically diverse populations. In order to protect these traditional sources of care, an LI was required to include all traditional and safety net providers that agreed to the terms and conditions set for other similar providers in its network. In addition, the LI was guaranteed an enrollment of approximately 60% to 70% based on the current safety net utilizations. The CP was encouraged to include traditional and safety net providers in its network in the initial bidding process, which was one factor used to weigh competing proposals. San Diego and Sacramento opted for a multi-commercial plan model, known as GMC. DHCS contracts with four plans in Sacramento and five plans in San Diego and all are required to be Knox-Keene licensed.

In 2011, the California State Auditor, Bureau of State Audits (BSA) reported on a request by the Joint Legislative Audit Committee to conduct an audit of the oversight of the LIs in the two-plan model. The BSA Audit Report of December 2011 concluded that DHCS and DMHC could improve their shared oversight. DMHC is responsible for monitoring financial viability and DHCS oversees compliance with Medi-Cal requirements. The BSA found that DMHC had been chronically late in completing financial reviews and did not have a tracking system until May 2011. The BSA also found that DMHC did not detect that two LIs had incorrectly reported administrative expenses as medical expenses and when it did find deficiencies, it did not follow up on corrective action plans arising from the financial examinations. With regard to DHCS, the BSA found that it had not analyzed all financial requirements in seven instances of the 16 reports

reviewed and that both DMHC and DHCS had failed to conduct medical audits (DMHC refers to these as surveys). According to the BSA, in the past the departments jointly conducted some of their medical audits on a schedule set by DHCS. DHCS was responsible for conducting follow-up on any corrective action plan resulting from deficiencies. However, as of October 2010 the joint audits were discontinued and neither DHCS nor DMHC were performing medical audits of the eight LIs with the frequency required by state law.

It should be noted that both departments concurred in most of the findings and submitted responses that specified corrective action plans of their own. For instance, DMHC stated that it would develop and implement formal policies and procedures and develop a monitoring tool to meet its responsibilities with regard to tracking financial audits and corrective action plans. Planned completion is this month (October 2012). DHCS acknowledged that annual medical audits were not being conducted and stated that they would resume them in 2012 and would work in conjunction with DMHC, to the extent feasible. DMHC stated that it will undertake responsibility to the extent that resources are not available at DHCS.

DMHC also assesses the adequacy of financial reserves and the administrative capacity of the Risk Bearing Organizations (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 certified public accountant-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 which the DMHC reviews to ensure the RBO's proposed corrective action plan actions and financial assumptions are viable and will correct the RBO's financial problems. After the DMHC approves the corrective action plan, DMHC continues to monitor and review any updates to ensure that the RBO is progressing toward compliance. 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% or more Medi-Cal (including HFP) enrollees. These 64 RBOs had approximately 2.6 million enrollees. DMHC's oversight activities have identified the following:

- 1) Five (5) out of the 64 RBOs (8%) were on a corrective actions plan for failure to meet the financial solvency requirements;
- 2) Three (3) RBOs are on corrective actions plans for noncompliance with Tangible Net Equity, Working Capital, cash to claims ratio, and claims timeliness standards;
- 3) Two (2) RBOs are on corrective actions plans for failing to meet claims timeliness standards;

- 4) Twenty-three (23) RBOs are being monitored closely for reasons such as rapid increase in Medi-Cal enrollment, low reserves, and consecutive net losses; and,
- 5) Thirty-six (36) RBOs were meeting the DMHC's grading criteria and presented no concerns.

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, DMHC conducted 10 audits on RBOs with more than 50% enrollment in Medi-Cal and/or HFP. In addition, during 2011-12, DMHC collected over \$3 million in penalties against health plans that have significant Medi-Cal, HFP, and Medicare populations. Many of these deficiencies included issues related to access to qualified providers, timely access to care, continuity of care, and other quality and access standards.

Measuring and Comparing Quality and Access. Regulatory and licensing requirements such as the Knox-Keene Act have limitations with regard to measuring access and generally do not measure utilization levels and quality of care. They also do not provide a way to compare plans with regard to access or quality of care. This gap has led to a variety of additional tools such as report cards, dashboards and consumer surveys.

NCQA. The NCQA is a private, not-for-profit organization that has come into being to partially fill this gap. Its mission is dedicated to improving health care quality. NCQA develops quality standards and performance measures for a broad range of health care entities. According to NCQA, these measures and standards are tools that organizations and individuals can use to identify opportunities for improvement. In order to be an NCQA accredited health plan, the plan must meet a set of 60 standards and report their performance in more than 40 areas. The primary tool for measuring health quality is the Healthcare Effectiveness Data and Information Set (HEDIS[®]). HEDIS consists of 75 measures across eight domains of care. A HEDIS audit analyzes the quality of health care and the service provided, evaluates the information and reporting systems, and reviews the methodologies for calculating performance measures. According to NCQA, developing a measure is a multi-step process. It involves identifying the clinical area to evaluate; conducting an extensive literature review; developing the measure with the appropriate medical and technical panels; vetting it with various stakeholders; and, performing a field-test that looks at feasibility, reliability and validity. Some of the areas covered are: use of asthma medications; controlling high blood pressure and diabetes; childhood wellness visits; immunizations status; and, breast cancer screening. By using a standardized national measure of quality of care that is independently audited, plans can be compared

Medi-Cal Managed Care Quality Measures. Federal law requires states that contract with managed care organizations to develop a written quality strategy. Over the next year, DHCS will

develop a comprehensive, DHCS Quality Strategy that is based upon the National Quality Strategy. This DHCS Quality Strategy will define priority areas, baselines, targets, and specific interventions. According to the Baseline Quality Report in April 2012, because of the nature of quality improvement, the DHCS Quality Strategy will be a living document that is updated on a regular basis to reflect ongoing learning, scientific developments, and stakeholder input. CMS and DHCS also require annual HEDIS reporting.

Plans must meet or exceed the DHCS-established Minimum Performance Level (MPL) for each required HEDIS measure. DHCS adjusts the MPL each year to reflect the national Medicaid averages reported in the most current version of NCQA Audit Means, Percentiles, and Ratios. Currently, the MPL is the 25th percentile of the national Medicaid rates. For each measure that a plan does not meet the established MPL or is reported as “Not Reportable” due to a material bias, a plan must submit a HEDIS Improvement Plan to DHCS within the specified timeframe that describes steps to be taken for improvement during the subsequent year. Additionally, plans that historically have multiple HEDIS measures that fall below the MPL or a measure that falls below the MPL without improvement after two consecutive years are required to submit corrective action plans and quarterly status reports. DHCS also establishes a High Performance Level for each required measure, which is currently at the 90th percentile of the national Medicaid average. DHCS publically reports audited HEDIS® results for each contracted health plan as well as the program average for MCMC and national Medicaid and commercial plan averages for each measure.

CMS also requires states to establish an external system to measure and the report on the performance of their contracted managed care plans to assess quality and appropriateness of care and services provided to members. In accordance with this federal law, DHCS is required to ensure that contracted plans conduct Quality Improvement Plans (QIPs). DHCS contracts with a health services contractor as the external quality review organization (EQRO) that validates QIP proposals and annual submissions using CMS produced protocols. Plans must always maintain two active QIPS. One is a statewide collaborative effort and the other is selected by the plan. Examples are improving rate of cervical cancer screening, improving the percentage of controlled blood pressure, and improving the rate of postpartum care.

Recognizing that growing inappropriate emergency room utilization is a considerable concern for increasing costs and that whenever possible, members should be treated by their primary care provider for non-emergency conditions in order to promote consistent quality care. Therefore, reducing avoidable emergency room visits was selected as a statewide QIP. The EQRO submits quarterly QIP status reports. However there is no aggregation or comparison across plans. The reports are predominantly an evaluation of the validity and reliability of the study results, but also include an element on appropriate improvement strategies and whether the plan actually showed improvement. According to the QIP Status Report January 1 through March 31, 2012,

as a whole, the statewide collaborative QIP did not yield the intended result of sustained improvement across all of the participating plans.

The EQRO is also responsible for administrating the Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) survey biennially. The CAHPS surveys a sample of MCMC members in English and Spanish and covers services provided to adults and children. According to DHCS, it is used by them and the health plans to evaluate member satisfaction with the care they received from their providers and plans to determine the need for further evaluation and to highlight areas where specific quality improvement interventions by DHCS and/or health plans are needed. The CAHPS survey was most recently administered in 2010. The report includes information about the survey methodology, the demographics of respondents, and results by plan and by MCMC delivery model (i.e., GMC, Two-Plan, and COHS). DHCS management reviewed and assessed the 2010 survey results; however DHCS reports that due to competing priorities and resource challenges, DHCS is still following-up on the survey findings, including reviewing aggregate results with contracted plans as a group, convening individual meetings with plans with particularly poor results, and determining the best process for improving the performance of any plans determined not to be meeting minimum access standards in accordance with contract requirements. The next CAHPS survey is scheduled for 2013, and will also focus on capturing the managed care experiences of the SPD population.

The DHCS documents, reports, and surveys, including plan specific performance evaluations can be found at: <http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDQualPerfMsRpts.aspx>

In 2005, DHCS also began using HEDIS performance measures as one factor in the algorithm that is used to assign a MCMC enrollee who does not select a plan. Previously, it was based solely on use of safety net providers. It is currently based on a mix of five HEDIS measures and a factor based on use of safety net providers. Points are assigned based on a comparison of the plans in the county and for improvement or exceptionally strong performance.

Dashboards. Modeled after the dashboard in an automobile, the concept is that all of the most important information can be found in one central location. This tool has been adopted by the health care industry and by the federal and state governments. A clinical dashboard is a toolset developed to provide clinicians with the relevant and timely information they need to inform daily decisions that improve quality of patient care. It provides these tools in a visual and user friendly format. In terms of quality improvement, dashboards have been developed as a way for clinicians to monitor patient care. Dashboards offer an excellent way to pull internal reports and analyze the day-to-day quality of care. A key benefit of a clinical quality dashboard is that they are an easy clinical decision aide tool.