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March 4, 2015

Access to Care in Medi-Cal: Focusing Oversight on Managed Care

LEGISLATIVE ANALYST'S OFFICE

Presented to:
Assembly Committee on Health
Hon. Rob Bonta, Chair
Senate Committee on Health
Hon. Ed Hernandez, Chair

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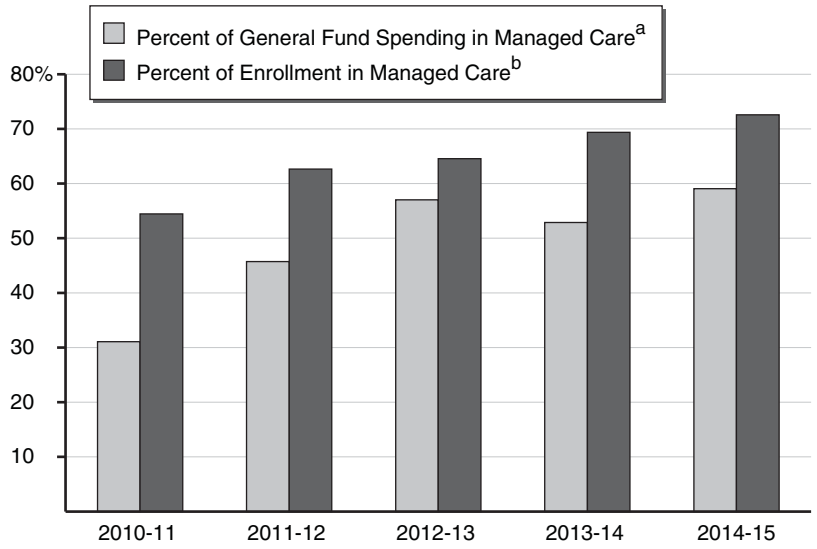
Introduction

Recap of 2014-15 Budget Analysis. In our February 2014 report, *The 2014-15 Budget: Analysis of the Health Budget*, we laid out an agenda intended to maximize the returns from the Legislature's oversight of access-to-care issues in Medi-Cal.

☑ ***Focus Majority of Oversight on Managed Care Access...*** As shown by the figure below, managed care has overtaken and surpassed fee-for-service as the primary Medi-Cal delivery system. Accordingly, we recommend the Legislature refocus its oversight priorities generally on monitoring the Medi-Cal managed care system.

Majority of Medi-Cal Spending and Enrollment Now in Managed Care



[a] As appropriated in annual budget act.

[b] Actual for 2010-11 through 2012-13, estimated for 2013-14 and 2014-15.

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Introduction *(Continued)*

☑ ***...And Existing Access Standards.*** We advise the Legislature to narrow its focus to working on the most immediate and tractable problems within Medi-Cal managed care: (1) the meaningfulness of existing access standards and (2) the administration's performance in monitoring health plans' compliance with those standards.

Today's Presentation. Our presentation for this hearing is organized as follows.

☑ ***Overview of Existing Standards and Monitoring.*** First, we outline the main state requirements that govern access to care in Medi-Cal managed care. We also summarize the state's current activities to monitor these requirements.

☑ ***Issues for Legislative Consideration.*** Next, we highlight three areas within managed care oversight that the Legislature should explore and potentially address in the near term.

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Overview of Existing Standards and Monitoring

State Law Lays Foundation for Managed Care Access Requirements. Health plans are required to meet various state standards to ensure that services are available and accessible to their enrollees. A major source of these standards is the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). The Knox-Keene Act establishes three main categories of managed care access requirements, as well as default standards within each category.

- ***Numbers and Types of Providers.*** Plans must demonstrate that their provider networks contain minimum numbers of providers in relation to the number of enrollees. Default standards include the following ratios: (1) one full-time equivalent (FTE) physician of any type for every 1,200 enrollees, and (2)one FTE primary care physician for every 2,000 enrollees.

- ***Geographic Access.*** Plans must limit the distance or amount of time their enrollees have to travel to see a provider. Default standards require plans to make primary care and hospital services available within 30 minutes or 15 miles of every enrollee's residence or workplace.

- ***Timely Access.*** Plans must ensure that providers offer appointments to their enrollees within specified time frames. For example, one default standard is a maximum allowable waiting time of ten business days for a primary care appointment.

For plans that operate in service areas with known provider shortages, the state may approve alternative standards for demonstrating reasonable access within each category.

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Overview of Existing Standards and Monitoring *(Continued)*

Two Departments Oversee Medi-Cal Managed Care.

☑ ***Department of Managed Health Care (DMHC) Oversees Statutory Compliance. . .*** The DMHC licenses health plans for most lines of business (known as "Knox-Keene licensure"), and is responsible for ensuring that licensees comply with the Knox-Keene Act. Most plans are required to obtain Knox-Keene licensure for their Medi-Cal line of business, making these Medi-Cal products subject to DMHC regulation.

☑ ***. . .Except for Medi-Cal Managed Care Products Exempt From Licensure.*** As discussed later, current law exempts certain plans from having to obtain Knox-Keene licensure for their Medi-Cal line of business. Unless these plans are voluntarily licensed, DMHC does not possess formal regulatory authority over their Medi-Cal products.

☑ ***Department of Health Care Services (DHCS) Oversees Contractual Compliance.*** The DHCS contracts with health plans to provide services to enrollees in Medi-Cal managed care, and is responsible for ensuring that plans satisfy the terms and conditions of their contracts. All contracts include Knox-Keene access standards, even for Medi-Cal products exempt from Knox-Keene licensure. Contracts also contain additional access requirements based on federal and state Medicaid law and regulations.

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Overview of Existing Standards and Monitoring *(Continued)*

☑ ***How Departments Monitor Compliance.*** Both DMHC and DHCS conduct various periodic activities—summarized in part by the figure below—to monitor plans' compliance with statutory and contractual access requirements. Some activities take place under interagency agreements (IAs) between the two departments. These IAs call for DMHC to assist DHCS in monitoring ongoing or recent transitions of enrollees into Medi-Cal managed care.

Selected State Monitoring Activities for Medi-Cal Managed Care

Activity	Department	Description	Frequency
Medical Survey	DMHC	Onsite review of plan compliance with Knox-Keene access standards	Triennial[a]
Medical Audit	DHCS	Onsite review of plan compliance with Medi-Cal contract access standards	Annual[a]
Network Adequacy Assessment	DMHC	Evaluate Medi-Cal provider networks under interagency agreements with DHCS	Quarterly
Provider Directory	DHCS	Telephone survey to verify accuracy of contact information for listed providers	Biannual
Timely Access Assessment	DMHC	Review self-reported plan compliance with Knox-Keene timely access standards	Annual

[a] Departments can also initiate non-routine surveys and audits outside of the normal schedule for any reason.
DMHC = Department of Managed Health Care and DHCS = Department of Health Care Services.

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Issue 1: Verifying Accuracy of Reporting on Provider Networks

Accurate Reporting on Provider Networks Are Essential for Meaningful Monitoring and Enrollee Choice. Both DMHC and DHCS rely on data submitted by health plans—including lists and maps of the plans' provider networks—to monitor access in Medi-Cal managed care. In other words, existing standards and monitoring are useful only to the extent that plans' self-reported data are accurate. State law requires that prior to enrolling Medi-Cal beneficiaries, "managed care health plans…maintain an updated, accurate, and accessible listing of a provider's ability to accept new patients and…make it available to enrollees, at a minimum, by phone, written material, and Internet Web site."

☑ ***Concerns About Accuracy of Network Reporting…*** There have been recent concerns about the accuracy of provider directories made available to Medi-Cal managed care enrollees. Some directories may contain significant numbers of providers who have stopped practicing, no longer contract with plans, and/or do not accept new Medi-Cal patients.

☑ ***…Have Prompted Legislative Audit.*** The Legislature has requested the State Auditor to examine (1) the accuracy of provider directories in Medi-Cal managed care and (2) the methods used by DHCS, DMHC, and plans to verify Medi-Cal provider networks. The audit findings are due later this year. Should the audit uncover serious departmental and/or plan deficiencies in verifying networks, the Legislature will face the challenge of overseeing an effective response.

☑ ***Quality Versus Quantity of Network Reporting.*** Provider networks can quickly go out of date for various reasons. However, more frequent plan reporting by itself may not translate into more accurate reporting on provider networks. For instance, while DHCS requires Medi-Cal managed care plans to submit network data on a monthly basis, it is unclear whether or how DHCS verifies the accuracy of these submissions.

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Issue 1: Verifying Accuracy of Reporting on Provider Networks *(Continued)*

☑ ***Options to Verify Providers' Participation in Networks…*** Two methods for verifying the number of FTE providers actively participating in plans' networks are provider surveys and "secret shopper" calls. Under existing regulations for timely access, Knox-Keene plans are required to conduct annual surveys of providers' appointment availability. However, these surveys do not directly test the accuracy of network reporting. Currently, there are no state requirements to conduct secret shopper calls in managed care.

☑ ***…Should Focus on Cost-Effectiveness.*** Provider surveys and secret shopper calls have certain limitations and may be costly and time-consuming to administer. Still, depending on the audit's findings, the Legislature may decide whether to require the targeted use of one or both of these methods. For example, surveys might focus on the most likely sources of network inaccuracy, such as listed providers who have not submitted any recent Medi-Cal claims.

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Issue 2: Lifting the Hood on DHCS's Contractual Monitoring

Contracts Impose Access Standards Beyond Knox-Keene. Some Knox-Keene standards may not sufficiently address access in Medi-Cal managed care. For example, provider-to-enrollee ratios are not specific to the pediatricians, obstetricians, and high-demand specialists that may be important for the Medi-Cal population. Medi-Cal managed care contracts are the main vehicle for imposing additional access requirements. The Legislature should determine whether the content and monitoring of these contracts can be improved.

☑ ***Lack of Clarity of Contract Standards Impedes Accountability.*** Many contract provisions related to Medi-Cal managed care access—as well as the state law and regulations referenced by these provisions—lack clear metrics or benchmarks for holding plans accountable. For example, contracts require plans to "maintain adequate numbers and types of specialists within their network to accommodate the need for specialty care," without defining what "adequate" means.

☑ ***Ongoing DHCS Monitoring Should Be Evaluated.*** The main tool for monitoring plans' compliance with Medi-Cal contracts is DHCS's annual medical audit. Medical audits typically emphasize whether plans' stated policies and procedures conform to contractual requirements. Audits also include "verification studies" of small samples of Medi-Cal claims submitted to the plans. The Legislature should evaluate whether medical audits and other forms of ongoing monitoring performed by DHCS—such as tracking grievances and calls to the Medi-Cal Ombudsman—provide a useful picture of access in the managed care system.

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Issue 2: Lifting the Hood on DHCS's Contractual Monitoring *(Continued)*

☑ ***Reliance on IAs With DMHC Raises Issues.*** The DHCS depends heavily on DMHC's network adequacy assessments under various IAs. These include DMHC's reviews of specialist capacity and requests and approvals for out-of-network care. The reviews rely on self-reported data from plans, and the degree of reporting to the Legislature differs across IAs. Because the IAs are generally limited to several years, the Legislature should examine DHCS's plans and capacity to pursue this level of ongoing monitoring once the IAs expire.

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Issue 3: Revisiting Exemptions From Knox-Keene Licensure

County Organized Health Systems (COHS). Six COHS plans operate Medi-Cal managed care in 22 counties, covering 2 million—or over one-fifth—of the state's Medi-Cal managed care enrollees. In each of these counties, the COHS operates the sole managed care plan available to Medi-Cal enrollees. Eight of the COHS counties are new to Medi-Cal managed care via the recent rural expansion.

☑ ***Statutory Exemption From Knox-Keene Licensure for COHS. . .*** The COHS are the only type of health plan exempt from Knox-Keene licensure for their Medi-Cal business. These exemptions have been in effect since the initial creation of the COHS in the early 1980s. Currently, only the Health Plan of San Mateo has voluntarily obtained Knox-Keene licensure. The figure on the next page shows the 21 counties covered by the remaining five unlicensed COHS.

☑ ***. . .Raises Issues About Consistency of State Oversight.*** While all COHS contracts contain Knox-Keene requirements, a lack of Knox-Keene licensure means DHCS is primarily responsible for monitoring these standards. Timely access—an important and complex category of standards—may be especially challenging for DHCS to effectively oversee. This raises the issue of whether the oversight of COHS that have not obtained Knox-Keene licensure is less effective overall than the oversight of those plans also subject to DMHC oversight. The Legislature should weigh the continuing justification for exempting COHS from Knox-Keene licensure against the benefits of direct DMHC oversight.

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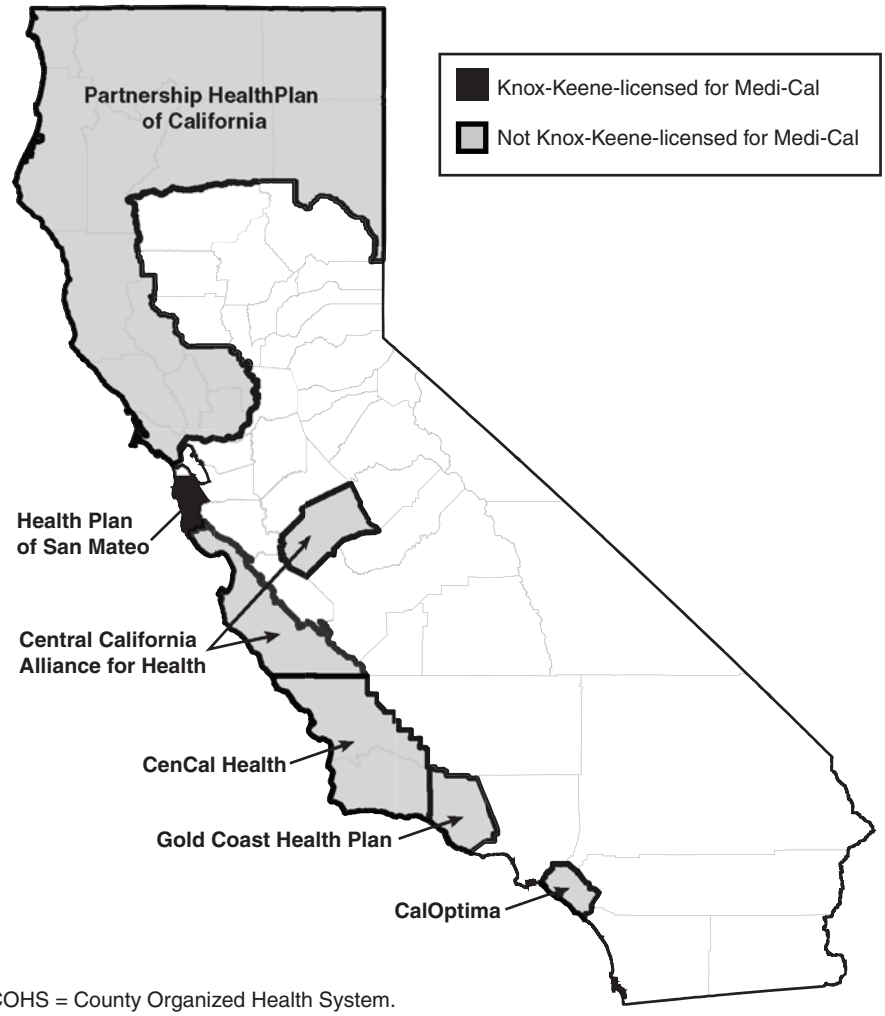
Issue 3: Revisiting Exemptions From Knox-Keene Licensure *(Continued)*

Five of Six COHS Plans Are Not Knox-Keene-Licensed for Medi-Cal



COHS = County Organized Health System.