



## *Department of Health Care Services*

It Has Not Ensured That Medi-Cal Beneficiaries  
in Some Rural Counties Have Reasonable  
Access to Care

*August 2019*

**REPORT 2018-122**





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August 6, 2019  
2018-122

The Governor of California  
President pro Tempore of the Senate  
Speaker of the Assembly  
State Capitol  
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As directed by the Joint Legislative Audit Committee, the California State Auditor performed an audit of the oversight by the Department of Health Care Services (DHCS) of the *Regional Model*, a form of administering managed care to beneficiaries of the California Medical Assistance Program (Medi-Cal) in 18 counties.

This report concludes that DHCS has not ensured that some Medi-Cal beneficiaries in the Regional Model received an acceptable level of care, which we define as adequate access to care combined with adequate quality of care. Specifically, DHCS did not enforce state requirements that limit the distances health plans may direct their Medi-Cal beneficiaries to travel to receive health care. By approving health plans' requests for exceptions to the requirements without validating the reasonableness of those requests, DHCS allowed the health plans to require some of the Regional Model beneficiaries to travel excessive distances to receive care. DHCS' actions also reduced the health plans' incentives to expand their provider networks to include providers within reasonable distances of their beneficiaries. The Regional Model beneficiaries also generally received a lower quality of care than beneficiaries in other areas of the State, although that quality has recently improved as a result of DHCS' enforcement of the health plans' quality-of-care requirements.

When transitioning the Regional Model counties in 2013 from a fee-for-service delivery system to managed care, DHCS did not adequately assist the counties in identifying the options available to them, despite some counties expressing interest in joining a county organized health system (COHS). The COHS Model, used in 22 other counties in the State, may provide beneficiaries in the Regional Model counties with better access to care than they receive through their current health plans. Establishing a COHS would likely provide the beneficiaries with access to a greater proportion of the Medi-Cal providers in their geographic areas, thereby reducing the distances that the beneficiaries would need to travel to receive care. Because DHCS plans to establish new managed care contracts with the health plans currently serving the Regional Model counties after its current contracts expire in 2023, it is an ideal time for DHCS to evaluate whether the COHS Model would be better suited to provide reasonable access to care and to assist counties with making such a transition if they desire to do so.

Respectfully submitted,

A handwritten signature in black ink that reads 'Elaine M. Howle'. The signature is written in a cursive, flowing style.

ELAINE M. HOWLE, CPA  
California State Auditor

## Selected Abbreviations Used in This Report

CAP	corrective action plan
CMS	Centers for Medicare & Medicaid Services
COHS	county organized health system
DHCS	Department of Health Care Services
HEDIS	Healthcare Effectiveness Data and Information Set
Managed Health Care	Department of Managed Health Care
Regional Model	New managed care model into which DHCS grouped 18 rural expansion counties in 2012
rural expansion counties	The 28 counties that state law required DHCS to transition to managed care in 2012

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## Summary

### Results in Brief

In 2012 state law required the Department of Health Care Services (DHCS) to transition the recipients of California Medical Assistance Program (Medi-Cal) services (beneficiaries) in 28 fee-for-service counties in rural areas (rural expansion counties) to managed care. In contrast to the fee-for-service delivery system in which a beneficiary seeks medical care from a Medi-Cal provider and that provider then bills the Medi-Cal program for the individual service, in the managed care delivery system, DHCS contracts with and pays monthly rates to health plans to coordinate and administer services to beneficiaries enrolled in these plans. Eight of the 28 counties chose to join a nonprofit health plan called Partnership Health Plan of California (Partnership) that operated under county oversight, while DHCS worked with two other counties to establish their own unique models for providing health care. DHCS grouped the remaining 18 counties into a new managed care model that it called the *Regional Model*. DHCS then contracted with two commercial health plans—Anthem Blue Cross Partnership Plan (Anthem) and California Health & Wellness (Health & Wellness)—to deliver managed care services to the beneficiaries covered under the Regional Model. The Joint Legislative Audit Committee requested that we determine whether the Regional Model beneficiaries have received an acceptable level of care and to evaluate how that care compares to the care beneficiaries in other models have received. *Acceptable level of care* is not a standard term DHCS uses, so for the purposes of this audit, we have defined the term to mean adequate access to care combined with adequate quality of care. Under this definition, beneficiaries in the Regional Model have not received an acceptable level of care.

Most significantly, even though Partnership operates in comparable rural counties, the two Regional Model health plans have provided beneficiaries with worse access to care than Partnership has provided its beneficiaries. In fact, our analysis showed that the Regional Model health plans have required some beneficiaries to travel hundreds of miles to reach certain health care providers, including obstetricians, oncologists, neurologists, and pulmonologists. In many instances, these distances far exceeded the distances that Partnership required its beneficiaries to travel for similar care. For example, according to DHCS' January 2019 provider location data, Partnership required rural beneficiaries to travel up to 60 miles for an appointment with a cardiologist compared to 239 miles for Anthem and 115 miles for Health & Wellness.

### Audit Highlights . . .

*Our audit of DHCS' oversight of managed care in the Regional Model counties revealed the following:*

» *The Regional Model health plans have not provided all Medi-Cal beneficiaries with adequate access to care.*

- *DHCS did not enforce state requirements that limit the distances health plans may direct their Medi-Cal beneficiaries to travel to receive health care—some beneficiaries were required to travel hundreds of miles to receive care.*

- *DHCS failed to hold Regional Model Health plans accountable for improving beneficiaries' access to care.*

» *Regional Model beneficiaries have generally received a lower quality of care than beneficiaries in other areas of the State.*

» *DHCS did not adequately educate the Regional Model counties about the options available to them regarding their transition to managed care.*

- *It did not assist Regional Model counties that wanted to create or join a COHS, which may have provided its beneficiaries with better access to care.*

Regional Model beneficiaries had to travel such long distances in part because most of the providers that contracted with the Regional Model health plans contracted with only one of the two health plans. Consequently, a beneficiary of one plan might have to travel significantly farther for care than a beneficiary of the other plan from the same location who was seeking the same care. For example, according to DHCS' January 2019 provider location data, a resident of Olancho in Inyo County who was seeking oncologist care would need to travel 60 miles to Ridgecrest if he were an Anthem beneficiary; however, if he were a Health & Wellness beneficiary, he would need to travel more than 150 miles to Burbank for the same care because Health & Wellness did not have a contract with the closer provider. When health plans require beneficiaries to travel this far to receive care, those beneficiaries may be unable or unwilling to do so.

In many cases, the distances that the Regional Model health plans required far exceeded the limits state law imposes, which range from 10 to 60 miles depending on the type of service. Nonetheless, DHCS did not effectively intervene when health plans did not meet these access requirements as it did when it found that health plans were not meeting quality standards. Instead, after the current distance and travel time requirements first became effective in 2018, DHCS ultimately approved all the requested exceptions to the access requirements even though it had not evaluated whether the health plans had exhausted all other reasonable options to identify providers that would meet those requirements. As a result, all the health plans—including those in the Regional Model counties—remained in compliance with state law because of those approvals even though the distances that the plans required beneficiaries to travel did not comply. If DHCS had placed health plans on corrective action plans (CAPs) pertaining to access to care instead of approving their exception requests, it might have motivated them to improve their provider networks. By establishing CAPs, DHCS could also have required the health plans to pay for out-of-network care for beneficiaries that did not have adequate access to care. However, by approving the health plans' requests for exceptions to travel-distance requirements, DHCS reduced their incentives to improve their networks and undermined the intent of the law, which is to provide beneficiaries access to care within prescribed distance limits.

In addition, the Regional Model health plans have consistently provided a lower quality of care than many other plans in the State. Specifically, from 2015 through 2018, DHCS determined that the health plans in all 28 rural expansion counties performed below a number of national minimum performance levels. Further, when the Department of Managed Health Care—which state law authorized to perform audits on behalf of DHCS—audited the



rural expansion counties' health plans from 2014 through 2016, it identified more serious deficiencies in the 18 Regional Model plans than in the health plans of the other 10 rural expansion counties. However, because DHCS has taken steps to address these types of issues, such as imposing CAPs, the quality of care in the Regional Model counties has steadily improved in recent years.

DHCS provided the counties with only limited guidance and information to assist them in their transition to managed care. As the agency responsible for overseeing the effective delivery of health care to Medi-Cal beneficiaries throughout the State, DHCS should have proactively educated the rural expansion counties on the available managed care model options before they transitioned to managed care and thus better ensured that the counties would select models that would best serve their beneficiaries' needs. According to DHCS, the limited-guidance approach had worked well when it transitioned other counties to managed care before 2012. However, this approach was not as effective for the rural expansion counties because many of them lacked the knowledge and resources to determine the model that would best serve their beneficiaries.

We believe that DHCS could improve the future access to managed care services of the Regional Model beneficiaries by assisting counties in transitioning from the Regional Model to a county organized health system (COHS). Partnership—the health plan that currently serves eight of the 28 rural expansion counties and has generally provided adequate access within those counties—is a COHS that non-rural expansion counties established before the rural expansion. In contrast to the Regional Model, a COHS uses a single health plan to deliver services to all of its beneficiaries. Consequently, these beneficiaries can receive care from the same network of providers unlike in the Regional Model in which the two health plans frequently contract with different providers. Further, a COHS operates under the direct influence of county officials who make up a portion of its board of commissioners. The counties are therefore better able to direct the COHS to use its resources to address the specific needs of their beneficiaries. Although many variables affect health plans' abilities to establish provider networks that deliver acceptable access to care, a COHS might enable better access to care in the Regional Model counties.

Transitioning the Regional Model counties to a COHS will be possible after DHCS' contract with Anthem expires in 2023. However, transitioning from the Regional Model to a multicounty COHS would require the counties to complete a number of necessary start-up activities, including establishing a special commission, hiring administrative staff, and gaining federal approval. Because the Regional Model counties tend to have

fewer resources than other counties, they will likely need DHCS' assistance in performing these activities. If Regional Model counties wish to be in a COHS, DHCS would need to immediately begin efforts to allow for a smooth transition for these counties' beneficiaries. By providing the counties with assistance in creating a COHS, DHCS could ensure that Regional Model beneficiaries are better able to receive the health care services that they need.

### Summary of Recommendations

To obtain assurance that health plans throughout the State have exhausted all of their reasonable options to meet the access requirements before seeking exceptions, DHCS should immediately begin doing the following:

- Develop written guidance that specifies the conditions under which staff should approve, deny, or contact health plans for clarification regarding their requests for exceptions.
- Determine a specific minimum number of providers that health plans must attempt to contract with before requesting an exception.
- Require health plans to report on their attempts to contract with providers when submitting their requests, including providing evidence of their efforts, such as the contact information for each provider with which they have attempted to contract.
- Establish a process for periodically verifying the health plans' efforts, such as contacting a sample of the listed providers and determining whether the plans attempted to contract with them.
- Require health plans to authorize out-of-network care if they do not demonstrate they have exhausted all of their reasonable options to meet the access requirements.

To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020:

- Determine the specific causes of Anthem's and Health & Wellness's inability to provide reasonable access to care in the Regional Model counties.
- Evaluate whether the structural characteristics of a COHS Model would be better suited to providing reasonable access to care in these counties and notify the counties of its conclusions. If some

or all of the counties desire to transition to a COHS, DHCS should assist them in making that change after their current contracts expire.

- Evaluate whether it has the financial resources to provide assistance to counties interested in establishing a COHS or other managed care model after the current Regional Model contracts expire. If DHCS does not have the required financial resources, it should seek an appropriate amount of funding from the Legislature.
- Provide counties with reasonable opportunities to decide whether to change their managed care models after the expiration of their current contracts. DHCS should provide counties that choose to do so sufficient time to establish their new models before the expiration of their current agreements to ensure continuity of service.

#### **Agency Comments**

Although DHCS agreed with most of our recommendations, it disagreed with several recommendations, stating that it will not implement them.

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# Introduction

## Background

Under the oversight of the Centers for Medicare & Medicaid Services (CMS), the federal Medicaid program authorizes grants to states for medical assistance to low-income individuals and families who meet federal and state eligibility requirements. In 1966 California began participating in the federal Medicaid program through its California Medical Assistance Program (Medi-Cal). The Department of Health Care Services (DHCS) is the designated state agency responsible for administering Medi-Cal. In December 2013, before the implementation of the Affordable Care Act in 2014, the Medi-Cal program had 8.6 million enrolled beneficiaries. As of November 2018, the Medi-Cal program provided services to 13 million enrolled beneficiaries—nearly one-third of California’s residents. During fiscal year 2018–19, the Governor’s budget funded DHCS with more than \$102 billion, of which more than \$21 billion came from the State’s General Fund.

Since the 1970s, the State has gradually transitioned Medi-Cal beneficiaries by county from fee-for-service delivery systems to managed care systems. When the State first established the Medi-Cal program, it relied solely on the fee-for-service system, under which beneficiaries choose the health care professionals from whom they receive care, and those professionals then bill DHCS directly for the approved services that they provide to the beneficiaries. Before 2012 DHCS transitioned 30 counties to managed care systems because of its belief that members enrolled in managed care can receive care coordination and case management services that are not available through the fee-for-service system. In 2012 state law required DHCS to transition the remaining 28 fee-for-service Medi-Cal counties, which DHCS refers to as the *rural expansion counties* because many are largely rural, to managed care.<sup>1</sup> Other states have also provided services to beneficiaries through managed care in a similar manner. Specifically, the four states that we reviewed—Arizona, Florida, Washington, and Oregon—all have enrolled the majority of their Medicaid beneficiaries in managed care and have continuously worked on expanding managed care over the last decade.

<sup>1</sup> The timeline for implementing the 2013 transition of the rural expansion counties to managed care was prompted in part by the State’s decision to end its Healthy Families program, a program that provided and promoted access to affordable health care services for families. The State wanted to continue providing managed care services to the individuals who had participated in that program.

Under managed care, DHCS contracts with managed care health plans and pays monthly capitation payments—a specified amount per person covered—to each plan to administer beneficiaries’ services and pay health care professionals. In turn, the health plans establish provider networks by contracting with medical professionals and groups, known as *providers*, who supply health care to the beneficiaries. Establishing such a network allows health plans to monitor the quality of the providers that serve their beneficiaries, such as through conducting site reviews and monitoring providers’ data. The health plans’ provider networks include providers located within the counties where the plans’ beneficiaries live; in nearby counties; and—at times—in adjacent states, such as Oregon and Nevada. As we discuss in more detail below, some of the State’s managed care health plans are privately owned while counties oversee the others.

### **DHCS Established the Regional Model in 2013**

As part of the State’s transition process from fee-for-service to managed care, DHCS has approved six models of managed care that it uses to contract with health plans to deliver services. Table 1 summarizes the models and the types of health plans that operate within each model, and Figure 1 identifies each county’s model. When transitioning counties to managed care, DHCS has allowed them to pursue various options, including establishing their own health plans, joining existing health plans that other counties had established, or contracting with a commercial health plan. The county-operated health plan options include a county organized health system (COHS), which provides health care through a single nonprofit health plan under county oversight, and a local initiative, which is a health plan with county oversight that provides services to beneficiaries in Two-Plan Model counties. For counties that did not join or create county-overseen health plans—either because they chose not to or were unsuccessful in doing so—DHCS contracted with commercial health plans. According to DHCS, this approach has worked well because it ensured that DHCS could establish managed care regardless of a county’s willingness to create or join a COHS or local initiative but also allowed counties to do so if they had the ability and desire. The four other states we previously mentioned also contract with both commercial and nonprofit health plans to provide services to beneficiaries.

DHCS transitioned the rural expansion counties from fee-for-service to managed care in 2013. Figure 1 shows that of the 28 rural expansion counties, eight joined a COHS administered by Partnership Health Plan of California (Partnership), and DHCS worked with two to form their own unique models. Because none of the remaining 18 counties joined or created county-overseen

health plans, DHCS grouped them to create the Regional Model, which is the focus of this audit. In 2013 DHCS contracted with two commercial health plans, Anthem Blue Cross Partnership Plan (Anthem) and California Health & Wellness (Health & Wellness), to serve the Regional Model counties. When selecting health plans, DHCS intended to contract with additional health plans that met its selection criteria, but Anthem and Health & Wellness were the only plans that qualified. DHCS initially contracted with these health plans for five years, from 2013 to 2018, but it has since extended both contracts. We discuss DHCS’ contracts with the two plans in more detail in Chapter 2.

**Table 1**  
**DHCS Has Six Models of Managed Care That Involve Different Types of Health Plans**

MANAGED CARE MODEL	DESCRIPTION	NUMBER OF COUNTIES
Regional	Beneficiaries may select one of two commercial health plans.	18
COHS	Beneficiaries receive services from a single, nonprofit health plan with county oversight.	22
San Benito	Beneficiaries select either to receive managed care delivered by a commercial health plan or to receive fee-for-service through Medi-Cal.	1
Imperial	Beneficiaries may select one of two commercial health plans; one of the health plans has county oversight.	1
Two-Plan	Beneficiaries may select between one commercial health plan and one local initiative, which is a health plan with county oversight.	14
Geographic Managed Care	Beneficiaries may select from three or more commercial health plans.	2

Source: Analysis of data from DHCS’ Medi-Cal managed care website, a DHCS presentation on Medi-Cal managed care, DHCS reports, Calviva Health’s website, and an Imperial County Board of Supervisors resolution.

**Two Agencies Share Responsibility for Overseeing Health Plans That Participate in Medi-Cal**

DHCS and the Department of Managed Health Care (Managed Health Care) are responsible for overseeing most health plans that contract with providers to deliver Medi-Cal care to beneficiaries. As part of its role to administer Medi-Cal, DHCS manages the health plans’ contracts and oversees their compliance with the terms of those contracts. In its role in protecting health care rights of consumers, Managed Health Care licenses health plans that are subject to the Knox-Keene Act—a state law that regulates most commercial health plans—and monitors their service delivery. Both departments evaluate whether the health plans are performing adequately by auditing their service delivery processes in areas such as access to care and quality of care.

**Figure 1**  
All 58 of California’s Counties Now Receive Medi-Cal Through Managed Care Models



Source: Analysis of data from DHCS’ Medi-Cal managed care website, a DHCS presentation on Medi-Cal managed care, and DHCS’ reports.



DHCS and Managed Health Care determine whether the health plans have provided adequate access to care and quality of care by assessing whether the plans meet the requirements established by law and the health plans' contracts. For access to care, these requirements address providers' availability to schedule appointments for beneficiaries within specific numbers of days, the distance beneficiaries must travel to obtain specified care, and the travel time needed for beneficiaries to arrive at the providers' locations. For quality of care, the requirements include providers' delivery of specific services, such as preventive services and some post-appointment follow-up services; the outcomes of some providers' service delivery; and the health plans' performance of certain administrative activities, such as authorizing service requests and addressing grievance claims. For the purposes of this audit, we focused our evaluation of the Regional Model health plans' performance on the specific indicators that the text box lists.

**This Audit's Criteria for Evaluating Health Plan Performance**

- **Access to Care:** Whether the health plans have met travel distance requirements.
- **Quality of Care:** How frequently the health plans' performances on national performance quality measures fell below acceptable levels.
- **Quality of Care:** Whether DHCS or Managed Health Care determined through their audits that the health plans were not meeting contractual quality-of-service delivery requirements.

Source: Analysis of state law and health plans' contracts.

**State Law Establishes Limits on the Distances Health Plans Can Require Beneficiaries to Travel to Receive Care**

Effective January 2018, state law established access requirements, which are predefined limitations on the times and distances Medi-Cal plans may require their beneficiaries to travel to obtain care. The Legislature passed the law in response to regulations that CMS issued in 2016 requiring states contracting with managed care plans to develop and enforce by 2018 time and distance standards for primary, specialty, hospital, and pharmacy services.<sup>2</sup> As the State's administrator of Medi-Cal, DHCS assumed responsibility for developing these requirements, which it did in 2016 and 2017, also establishing an evaluation process to ensure that those standards were reasonable. As part of that process, DHCS considered industry standards and solicited feedback from health plans and other stakeholders. Additionally, it analyzed data on the quantity of providers, the location of providers, and beneficiaries' use of services to identify the extent of beneficiaries' needs and the availability of providers to administer care.

When developing the access requirements, DHCS also considered the unique challenges of providing access in rural areas, such as the geographic dispersion of providers and beneficiaries; as

<sup>2</sup> State law requires health plans to evaluate whether they can meet travel distance standards for 36 different types of providers as well as pharmacies, hospitals, and mental health outpatient services for each area they serve.

a result, it established more lenient access standards for health plans operating in those locations. For primary care services, such as cancer screenings and vaccinations, DHCS established a universal requirement for all counties that aligns with a preexisting requirement in its contracts with managed care plans: within 10 miles or 30 minutes travel time from a beneficiary's residence to the provider's location. For specialty care, such as psychiatry and dermatology, DHCS created requirements based on four defined categories of counties' population densities: dense, medium, small, or rural. In dense counties like Sacramento and San Francisco, health plans must ensure beneficiaries can access specialty care within 15 miles or 30 minutes. In rural counties, such as Alpine or Inyo, health plans must ensure that their beneficiaries are able to access care within 60 miles or 90 minutes.

DHCS uses an annual network certification process to determine whether health plans are complying with the access requirements, as state law requires. It verifies the health plans' compliance in each zip code they serve by requiring them to indicate the locations of all of their providers. Using these data, DHCS calculates the time and distance required to travel to the plans' nearest providers from each zip code. In principle, for a health plan to pass the annual network certification, it would need to contract with a sufficient number of providers to ensure that beneficiaries in every zip code it serves can access care without having to travel farther than the distances specified by the access requirements.

State law also authorizes DHCS to exempt health plans from meeting the access requirements and to establish alternative requirements for them. Specifically, DHCS may allow alternative access standards upon the request of a health plan if the plan has exhausted all other reasonable options to secure local providers that meet the applicable requirement. When DHCS allows alternative access standards, it establishes the health plan's alternative standard as the distance between the location in question and the health plan's closest available provider.

### **DHCS Requires Health Plans to Meet Specific Performance Levels**

Federal regulations also require the State to annually measure and report the quality of care that Medi-Cal managed care health plans provide using a set of standardized performance measures. To comply with this requirement, DHCS uses a selection of performance measures primarily from the Healthcare Effectiveness Data and Information Set (HEDIS), which the National Committee for Quality Assurance developed. HEDIS is a nationally accepted set of measures for assessing health plans' performance, and DHCS uses HEDIS to evaluate health plans' delivery of preventive

services, provision of care for chronic conditions, and appropriate treatment and utilization of services. For example, DHCS evaluates plans against HEDIS measures such as the percentage of eligible beneficiaries who receive breast cancer screenings and the percentage of beneficiaries with persistent asthma who are prescribed appropriate medication.

DHCS' contracts with health plans require the plans to score at or above minimum performance levels for a selection of HEDIS measures. DHCS establishes these minimum performance levels based on the national performance of the Medicaid program. Specifically, DHCS expects plans to perform in the top 75 percent of Medicaid plans nationally.<sup>3</sup> Health plans report their performance for each of their reporting units, which correspond to counties or groups of counties that the plans serve. For example, the Regional Model has two reporting units, which together represent the model's 18 counties. The number of measures for which DHCS holds plans accountable may vary from year to year because it periodically adds or removes HEDIS measures to align with its areas of focus, such as maternal and child health, for quality improvement. When DHCS requires health plans to report on newly added measures, it does not require the health plans to meet the minimum performance levels until the second year in which those measures are in place.

### **Counties Are Important Stakeholders in the Medi-Cal System**

County health agencies are key to Medi-Cal because they may participate as advocates for beneficiaries, as providers who serve beneficiaries, and as administrators of health plans. In addition, state law requires county health agencies to initially determine which applicants are eligible for Medi-Cal and to assist the applicants in the application process as needed. As advocates, county health agencies may assist beneficiaries who have questions or are experiencing difficulty receiving services. For example, some counties help beneficiaries schedule appointments with providers and arrange transportation for them to attend appointments. Additionally, counties serve as primary providers for some beneficiaries in rural areas of the State through county-operated clinics. Finally, several counties are involved in administering health plans through a COHS or through a local initiative in Two-Plan Model counties.

<sup>3</sup> DHCS plans to modify its performance measurement process in 2020. DHCS will expect health plans to perform in the top 50 percent of Medicaid plans nationally to meet minimum performance levels, and it will select performance measures from lists published by CMS.

As a result of the many functions county health agencies perform in the Medi-Cal system, they often have specific expertise about the local conditions within their communities and may have experience working with local providers. Consequently, they are well-positioned to negotiate and collaborate with health plans and with DHCS to improve the level of care beneficiaries receive.

## Chapter 1

### **DHCS HAS ALLOWED HEALTH PLANS TO REQUIRE SOME OF THEIR MEDI-CAL BENEFICIARIES TO TRAVEL HUNDREDS OF MILES TO RECEIVE CARE**

#### **Chapter Summary**

The Regional Model health plans have not provided all beneficiaries with adequate access to care. As a result, some beneficiaries in Regional Model counties may have had to travel hundreds of miles to receive medical care from in-network providers of one health plan, even though the same care was available from closer providers who contracted with the other health plan. During the period we reviewed, DHCS failed to hold health plans accountable when they did not provide beneficiaries with access to care that met state requirements. Instead, it reduced the plans' incentives to improve their provider networks by excusing them from meeting these requirements, even though it had not ensured that they had exhausted all of their reasonable options to secure local providers as state law requires. Our analysis indicates that some beneficiaries' access to care would improve dramatically if DHCS were to require health plans to allow beneficiaries to obtain care from out-of-network providers that are closer to them when the plans are unable to provide adequate access themselves.

Additionally, the HEDIS scores for health plans in the rural expansion counties indicate that beneficiaries in these counties have generally received a lower quality of care than beneficiaries in other areas of the State. According to the HEDIS scores, the quality of care that Anthem and Health & Wellness provided in the Regional Model counties was comparable to the care that Partnership—a COHS that serves eight rural expansion counties—provided in its counties. However, Managed Health Care's audits of the rural expansion counties suggest that Anthem and Health & Wellness experienced greater difficulty meeting contractual requirements pertaining to quality of care than Partnership did. In addition, DHCS has limited the counties' abilities to respond to those problems and assist their beneficiaries in receiving adequate services because it has not taken adequate steps to share with the counties the deficiencies it and Managed Health Care have identified.

#### **Some Beneficiaries in Regional Model Counties Have Had Poor Access to Care**

The Regional Model health plans have required some beneficiaries to travel excessive distances to obtain medical care from providers. In most cases, managed care beneficiaries may receive medical care

only from the contracted providers within their plan's network. In this way, health plans choose the providers that beneficiaries may visit to obtain medical care. Within the Regional Model counties, the distances that beneficiaries have had to travel to access the closest contracted providers have varied widely, from less than 10 miles to 365 miles. Table 2 identifies the distances some beneficiaries within these counties have had to travel to receive specific health care.

**Table 2**  
The Regional Model Health Plans Have Required Some Beneficiaries to Travel Unreasonable Distances to Access Care

PROVIDER TYPE	MAXIMUM DISTANCE REQUIRED TO ACCESS CARE (IN MILES)		
	REGIONAL MODEL		COHS
	ANTHEM	HEALTH & WELLNESS	PARTNERSHIP
<b>Specialty Care</b>			
Cardiology/Interventional Cardiology	239	115	60
Dermatology	272	365	60
Endocrinology	313	225	60
ENT/Otolaryngology	343	200	60
Gastroenterology	83	150	60
General Surgery	123	115	60
Hematology	99	200	165
HIV/AIDS Specialists/Infectious Diseases	324	140	60
Mental Health (Nonpsychiatry) Outpatient Services*	83	60	60
Nephrology	124	230	60
Neurology	300	215	60
OB/GYN Specialty Care*	164	60	60
Oncology	299	170	120
Ophthalmology	81	60	120
Orthopedic Surgery	164	150	60
Physical Medicine and Rehabilitation	327	220	120
Psychiatry	327	170	60
Pulmonology	327	180	60
<b>Primary Care</b>			
OB/GYN Primary Care	NA†	230	10
Primary Care Physician	10	85	45
<b>Other Provider Types</b>			
Hospital	81	120	45
Pharmacy	45	90	10

Source: Analysis of the most recent alternative access standards that DHCS had approved as of January 2019.

NA = Not applicable.

\* We include OB/GYN Specialty Care and Mental Health (Nonpsychiatry) Outpatient Services with other specialists because they have the same time and distance standards.

† Anthem was exempt from this requirement because it does not designate its OB/GYN providers as primary care physicians.

Although it may be difficult for health plans to provide beneficiaries with close access to care when those beneficiaries reside in remote regions of the State, we would expect this difficulty to equally affect all the health plans that serve rural counties. However, as Table 2 also shows, Partnership provided its beneficiaries in rural counties with access to most care within 60 miles. Moreover, the longest distances beneficiaries had to travel to receive care in Partnership's counties were generally much shorter than those that Regional Model beneficiaries were required to travel for the same care. For example, Table 2 shows that Partnership required rural beneficiaries to travel up to 60 miles for an appointment with a cardiologist compared to 239 miles for Anthem and 115 miles for Health & Wellness. The additional distances that Anthem and Health & Wellness have required their beneficiaries to travel may have deterred some beneficiaries from seeking care.

We also identified inconsistencies between the distances that Anthem and Health & Wellness required their beneficiaries from the same locations to travel for the same care. When we reviewed provider location data that the two health plans submitted to DHCS, we identified more than 100 instances in which either of the plans required its beneficiaries to travel at least 100 miles farther than the other plan for the same care. In the five most extreme cases, the difference between the two plans ranged from 255 to 305 miles. For example, DHCS' data indicate that a beneficiary of Health & Wellness residing in June Lake, in Mono County, who needed to take her child to a pediatric dermatologist would have been required to travel up to 365 miles while if the same beneficiary were with Anthem, she would only have been required to travel up to 60 miles.

On some occasions, Anthem and Health & Wellness each required its beneficiaries to travel significantly farther than the other plan required of its beneficiaries. As Figure 2 shows, a beneficiary of Health & Wellness residing in Olancho, in Inyo County, who needed to see an oncologist would have to travel more than 150 miles to Burbank to receive cancer treatment. However, if this same beneficiary were with Anthem, he would have to travel only 60 miles for the same care. Similarly, a beneficiary of Anthem residing in Tecopa, also in Inyo County, who needed to see a pulmonologist, would have had to travel 327 miles, which is more than 175 miles farther to receive asthma treatment than if she were with Health & Wellness.

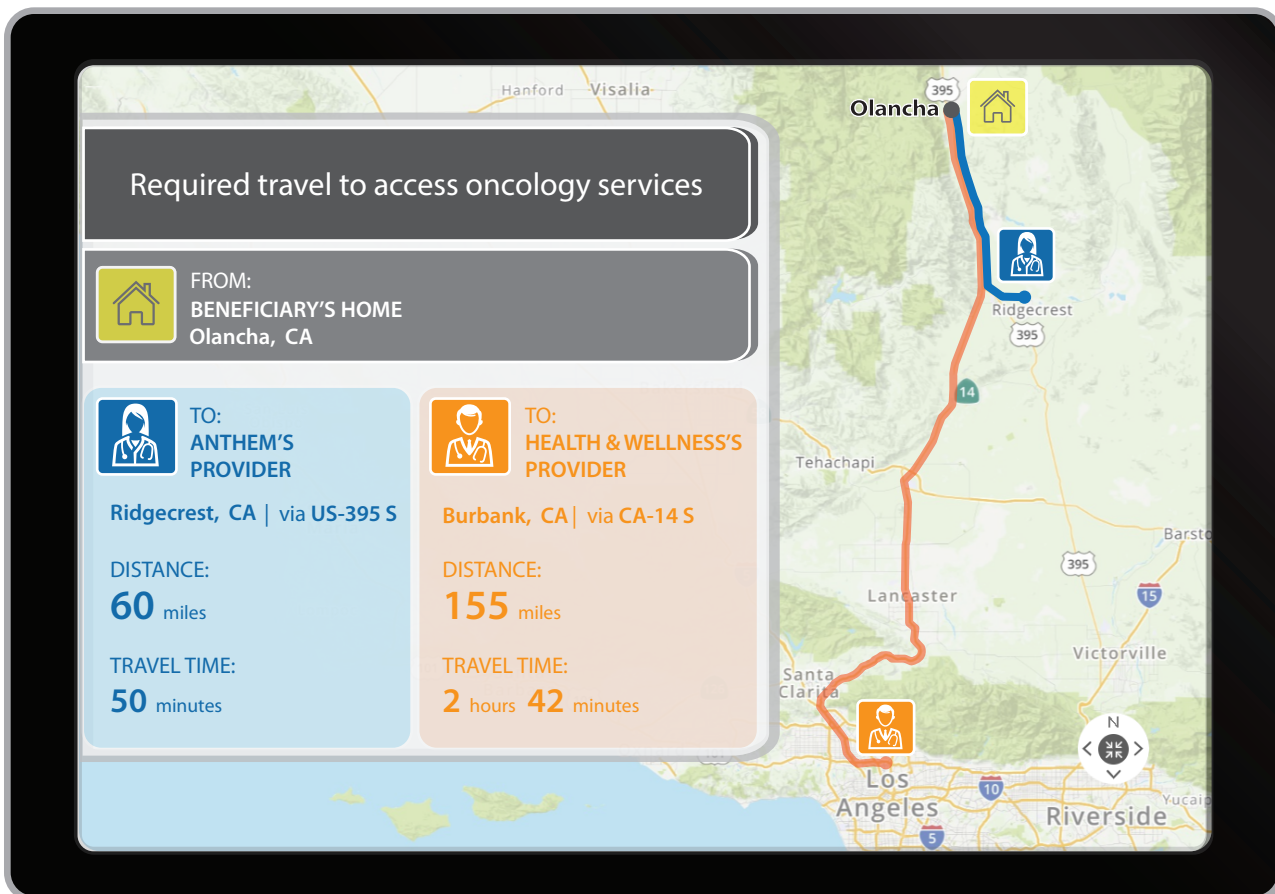
The differences in the distance requirements between the two health plans are also noticeable in more densely populated areas of the Regional Model counties. For example, according to the January 2019 data, a beneficiary of Health & Wellness who needed to take his child to visit a pediatric cardiologist and who resided in the Lake Tahoe community of Kings Beach in Placer County—

*We identified inconsistencies between the distances that Anthem and Health & Wellness required their beneficiaries from the same locations to travel for the same care.*

which is more densely populated than many other rural expansion counties—would have to travel up to 70 miles farther than an Anthem beneficiary from the same location who sought that same service. As we discuss in more detail below, these instances suggest that the difference in distances is not always the result of a general lack of providers but rather a lack of providers who have contracted with a specific Regional Model health plan. In other words, some beneficiaries may live reasonably close to providers who offer the needed care; however, those providers are not in-network for their plans. Although beneficiaries have the right to switch health plans, doing so may disrupt the continuity of the care they receive because they may not be able to continue seeing their primary care physicians and other providers from whom they have already received care.

**Figure 2**

The Two Regional Model Health Plans May Require Beneficiaries in the Same Location to Travel Significantly Different Distances to Receive the Same Services



Source: Analysis of the alternative access standards that DHCS had approved as of January 2019, Anthem's Medi-Cal provider directory, and Google Maps.



Traveling significant distances to reach providers may limit beneficiaries' ability to receive care. A beneficiary who has to travel hundreds of miles to receive medical care might be forced to miss an entire day of work and lose wages—a loss that might be critical considering that beneficiaries who qualify for Medi-Cal while employed have limited incomes. Further, some beneficiaries might be unable to tolerate the physical hardship of traveling such substantial distances for health care. When health issues require multiple visits, it likely will exacerbate such concerns: for example, the U.S. Department of Health and Human Services suggests weekly appointments for pregnant women nearing their delivery dates.<sup>4</sup> If beneficiaries are unwilling or unable to seek care because of the distances required to do so, it undermines the fundamental purpose of the Medi-Cal program, which is to improve the overall health and well-being of all residents by providing access to affordable, integrated, and high-quality health care.

*If beneficiaries are unwilling or unable to seek care because of the distances required to do so, it undermines the fundamental purpose of the Medi-Cal program.*

#### **DHCS Has Failed to Hold Regional Model Health Plans Accountable for Improving Beneficiaries' Access to Care**

As we discuss in the Introduction, DHCS uses a network certification process to assess whether health plans are complying with state access requirements. DHCS published the initial results of its first annual network certification in June 2018 and finalized the results in January 2019. These results, which remain in effect until July 2019, indicate that DHCS granted alternative access standards to the State's health plans in nearly 10,000 instances in which they requested them. More than 1,000 of these 10,000 instances involved the Regional Model health plans. On our website, we present an interactive map of the extended distances DHCS approved through alternative access standards by county and provider type. Given that DHCS made a considerable effort in 2016 and 2017 to ensure that the access requirements that state law established were reasonable and that this effort included analyzing the availability of providers who could meet those requirements, we question why it has chosen not to enforce them. By approving alternative access standards, DHCS is not holding health plans accountable to meet the access requirements prescribed in state law. Instead, alternative access standards allow health plans to deviate from the prescribed requirements by extending the time and distance that they may require beneficiaries to travel for care.

<sup>4</sup> Although state law requires health plans to provide transportation services to their beneficiaries in some instances, the beneficiaries would still incur significant travel time for extensive distances.

We are particularly concerned with DHCS' decision not to enforce these state requirements given the weaknesses we identified in its process for evaluating requests for alternative access standards. In particular, although DHCS denies requests for alternative access standards if they are incomplete or inaccurate, it has not adequately evaluated whether health plans have, in fact, exhausted all other reasonable options to identify providers that would meet the access requirements before approving their requests for alternative access standards, as state law requires. DHCS stated that it must approve requests for alternative access standards, no matter what the potential hardship those alternative standards may present to beneficiaries, as long as the health plans meet legal requirements, specifically that the plan exhausts all other reasonable options to contract with providers that would meet the access requirements. DHCS requires health plans to provide written explanations of their contracting efforts that it uses to evaluate whether they have complied with this requirement. However, DHCS does not analyze the validity of these explanations; thus, its approach does not meet the apparent intent of the law.

Even though DHCS has required health plans to provide written explanations, it has not required them to provide supporting documentation to corroborate those explanations. Moreover, DHCS has not verified with any providers mentioned in those explanations whether the plans attempted to add them to their networks. Additionally, DHCS has not established a minimum number of providers that the health plans should attempt to contract with in a designated location before it considers an exemption request. We question how DHCS could conclude that a health plan had exhausted all reasonable efforts to seek providers that met an access requirement without establishing such a minimum threshold and substantiating at least some of the health plan's efforts.

***DHCS has not consistently enforced its requirements for the explanations health plans must include when requesting alternative access standards.***

Moreover, DHCS has not consistently enforced its requirements for the explanations health plans must include when requesting alternative access standards. DHCS' instructions for making such requests state that health plans must detail their efforts to meet the access requirements in order for it to consider their requests. However, when we reviewed a selection of 30 approved requests for alternative access standards, we found six requests in which health plans prepared their explanations using the same boilerplate text for multiple requests. For example, Health & Wellness stated all of the following as its justification in each request for a pediatric specialist we reviewed: "There are no pediatric subspecialists located to meet the standard, the available pediatric specialists do not accept Medi-Cal patients, or the available pediatric specialists have declined to contract with the Plan primarily due to capacity constraints." In none of these cases did the plan identify the specific condition that applied to the request. Similarly, Anthem

stated in some requests that no providers were in the area, yet we identified providers in the area that met the prescribed requirements. We determined that DHCS did follow up in some instances by requesting additional documentation when the health plan provided vague or inaccurate explanations, such as when it submitted a request with inaccurate provider information. DHCS acknowledged that its staff did not consistently identify when further clarification was necessary. This inconsistency can likely be attributed to DHCS' lack of formal guidance specifying the conditions under which a request should be approved or denied.

By approving alternative access standards without proper justification, DHCS has reduced incentives for health plans to improve their beneficiaries' access to care. When a health plan fails to comply with the access requirements specified in state law, DHCS has the authority to require that it complete a corrective action plan (CAP) to improve its provider network, which DHCS calls a *network certification CAP*. Network certification CAPs require health plans to make the necessary improvements to comply with the access requirements, such as contracting with providers that meet the travel distance requirements. DHCS initially placed health plans on network certification CAPs in 2018 but closed them after approving alternative access standard requests for those health plans that were still unable to meet access requirements. However, it approved those requests even when the health plans did not demonstrate that they had exhausted all reasonable options to obtain closer providers. As a result, DHCS' approval of such alternative access standards involving excessive distances was unreasonable. By enforcing network certification CAPs rather than approving unsupported requests for alternative access standards, DHCS could have ensured that health plans remained obligated to improve their networks.

Further, DHCS could have used network certification CAPs to provide some beneficiaries access to closer providers. Through such CAPs, DHCS may require health plans to temporarily allow beneficiaries to obtain medical care from out-of-network providers, provided that those out-of-network providers do not have a history of quality issues and are willing to accept reasonable rates as determined by the health plans. Although there is no assurance that out-of-network providers will agree to offer such care, a network certification CAP requiring plans to authorize out-of-network care to meet time and distance requirements would provide beneficiaries with greater opportunities to access care. As we previously describe, we identified multiple instances under the Regional Model in which either health plan's nearest in-network provider was significantly farther than the other health plan's provider. In such cases, the ability to seek care from out-of-network providers could significantly improve some beneficiaries' access to care.

*By approving alternative access standards without proper justification, DHCS has reduced incentives for health plans to improve their beneficiaries' access to care.*

***Although DHCS requests that the health plans provide rate information when requesting alternative access standards, it has not required them to do so.***

DHCS expressed concern to us that providers might demand unreasonably high rates from health plans if they were aware that DHCS would not approve certain requests, which could burden the health plans financially and could result in increased rates that DHCS would have to pay the health plans. However, we disagree with this reasoning. DHCS could enforce the state requirements on the distances health plans may require beneficiaries to travel but allow exceptions if there are no closer providers or if health plans can demonstrate that the rates providers have requested are unreasonably high. Although DHCS requests that the health plans provide rate information when requesting alternative access standards, in practice it has not required them to do so. None of the health plans provided this information for the 30 requests that we reviewed. When health plans are unable to demonstrate that nearby, available providers are demanding unreasonably high rates, neither they nor DHCS can justify the reasonableness of their requests for alternative access standards that require beneficiaries to travel excessive distances.

When we asked DHCS for its perspective regarding the weaknesses we identified in its process for evaluating and approving requests for alternative access standards during its 2018 network certification, DHCS indicated that it intends to continually adjust its procedures for evaluating health plans' requests based on the lessons it learns through each annual certification. However, DHCS did not inform us of the specific outcomes it desires to achieve through its adjustments. Instead, it informed us that as part of the 2019 network certification that it expects to complete in January 2020, it has already made changes to its process and anticipates implementing additional changes as part of its next network certification in 2020.

Although DHCS' recent efforts may address some elements of its process, these efforts do not resolve certain concerns we identified pertaining to access to care. For instance, DHCS informed us that it plans to reject health plans' requests that do not include supporting documentation to demonstrate that they attempted to contract with closer providers. However, we believe that this approach is insufficient because, according to DHCS, it would only be requiring health plans to demonstrate attempts to contract with a single provider. Consequently, that effort would not fulfill the intent of state law—requiring health plans to *exhaust all reasonable options* to obtain providers that meet access requirements—because health plans would likely have multiple providers available to them that they could attempt to contract with. Additionally, DHCS indicated that it plans to deny requests that it deems unreasonable, yet it has not developed formal guidance for its staff to use in making that determination. Without establishing such guidance for its staff and ensuring that health plans attempt to contract with multiple providers, DHCS will likely continue to approve requests that

unjustifiably excuse health plans from their obligation to meet access requirements and allow them to require beneficiaries to travel unreasonable distances to obtain care.

### **The Structure DHCS Selected for the Regional Model May Have Contributed to Some Beneficiaries' Inadequate Access to Care**

DHCS was unable to offer a definitive explanation as to why Anthem and Health & Wellness could not provide their beneficiaries with better access to care. Managers at DHCS responsible for overseeing the approval of health plans' alternative access standard requests identified three potential causes of the excessive distances some beneficiaries may be required to travel: a lack of available providers, providers that contract with only one health plan rather than multiple plans, and providers that are unwilling to accept the payment rates that the health plans offered. Our analysis showed that a significant number of providers in the Regional Model have not contracted with either Anthem or Health & Wellness. However, we could not determine whether doing so would have improved beneficiaries' access to care because the data we evaluated did not identify the noncontracting providers' potential Medi-Cal specialties or all of the locations where they provide care. Nevertheless, our findings support the explanation that many providers contracting with only one of the two Regional Model health plans likely contributed to poor access. Additional analysis is necessary to determine whether a lack of providers in specific geographic areas of the Regional Model or their unwillingness to accept offered payment rates has contributed to the access issues.

When we analyzed licensing data from the Medical Board of California and the Osteopathic Medical Board of California—two entities responsible for licensing doctors in the State who participate in Medi-Cal—and provider network data from the health plans, we found that Anthem and Health & Wellness contracted with more than 3,900 providers located in the Regional Model counties. However, more than 1,900 additional providers in the Regional Model counties had not contracted with either health plan to provide services within these counties. It is unclear whether the two health plans contracting with these providers would improve beneficiaries' access to care. For example, some of these 1,900 providers may be located near beneficiaries who do not experience challenges with limited access.

We believe that DHCS would benefit from knowing the locations within the Regional Model counties that require additional providers and the types of providers required in those areas. If it had such knowledge, DHCS could determine the extent to which a lack of providers is causing some beneficiaries' poor access to care, and it could also develop the appropriate strategies to

*DHCS would benefit from knowing the locations within the Regional Model counties that require additional providers and the types of providers required in those areas.*

***Some beneficiaries in the Regional Model would have significantly better access to care if they were able to seek it from the provider networks of both health plans.***

alleviate those provider shortages. DHCS indicated that it would be willing to assist in an analysis of this nature, but that other state departments—such as the Office of Statewide Health Planning and Development—would be better suited to address workforce shortages among providers. Nonetheless, given DHCS’ critical role in overseeing the State’s provision of Medi-Cal services, we believe that it is well positioned to oversee such an analysis.

Our findings related to providers who contract with only one of the two plans are more straightforward. According to the data that the two health plans reported to DHCS in December 2018, fewer than 29 percent of the providers that contracted with either Anthem or Health & Wellness contracted with both health plans concurrently. Our analysis shows that some beneficiaries in the Regional Model would have significantly better access to care if they were able to seek it from the provider networks of both health plans. To evaluate how beneficiaries’ access to care would change if they had access to both networks, we reviewed DHCS’ data related to the health plans’ adherence to the time and distance requirements specified in state law. During its first annual network certification, DHCS identified more than 700 instances in which one or both Regional Model plans failed to meet these access requirements.<sup>5</sup> However, if the Regional Model’s beneficiaries had access to both health plans’ provider networks, we estimate that this number would decrease to about 125, the number of instances in which both plans failed to meet the same access requirements in the same locations.

This difference reinforces our conclusion that DHCS could improve beneficiaries’ access to care if it required plans to authorize out-of-network care when they do not demonstrate that they have exhausted all of their reasonable options to contract with providers that meet the state requirements and when DHCS determines that significantly closer providers of the needed care are available. The difference also underscores the supposition that the providers’ tendency to contract with only one of the two Regional Model health plans has contributed to some beneficiaries’ poor access to care. The geographic distribution of providers in rural areas already makes it difficult for health plans to provide adequate access to care; when providers do not contract with multiple plans, it can further compound this difficulty.

<sup>5</sup> We excluded OB/GYN primary care from this analysis because DHCS informed us that it exempted Anthem from the access requirement for OB/GYN primary care. As a result, DHCS does not have sufficient data for us to conclude how often both Regional Model plans are meeting the access requirement for OB/GYN primary care.

Given that Partnership operates in comparably remote areas of the State, its ability to provide significantly better access to care than the Regional Model plans suggests that beneficiaries in rural counties may receive better access to care when those counties operate under a single health plan rather than multiple plans. As part of DHCS' annual network certification, Partnership requested alternative access standards for 11 of the 39 types of providers that DHCS measures. In comparison, Health & Wellness and Anthem requested alternative access standards for 35 and 37 of the 39 provider types, respectively. Unlike the Regional Model, the structure of a COHS—such as Partnership—allows only one health plan in each county, meaning beneficiaries in COHS Model counties all have access to the same providers. We believe that this feature of the COHS Model may have contributed to Partnership's ability to provide better access to care in some rural areas of the State. We discuss the benefits of the COHS Model in greater detail in Chapter 2.

Increasing beneficiaries' access to providers currently outside of their networks could require some beneficiaries to schedule appointments farther in advance. However, the reduction in the distances the beneficiaries would have to travel might well outweigh this additional effort. As we mention in the Introduction, state law requires most health plans to ensure that their providers offer appointments within a specific number of days of the request for services. According to DHCS, if more Medi-Cal providers were to provide care to beneficiaries in both health plans, it might strain some providers' capacities and reduce their ability to meet this requirement. However, state law permits providers to extend the waiting time for appointments if they determine that waiting longer would not negatively affect the health of the beneficiaries involved. This exception could permit beneficiaries to make individual choices that are both safe and potentially more convenient. We believe that in certain circumstances beneficiaries might be willing to schedule appointments farther in advance if doing so would shorten how far they would have to travel. For example, the parent of a child with a heart condition requiring routine cardiology appointments might be willing to schedule those appointments farther in advance to avoid having to drive an additional 70 miles each direction.

Given Partnership's ability to provide its beneficiaries with better access to care and the apparent tendency of providers to contract with either but not both of the Regional Model health plans, we question whether having two separate health plans best serves the Regional Model counties. Conducting an assessment to identify the locations within the Regional Model that need additional providers and the types of providers necessary could offer DHCS

*Increasing beneficiaries' access to providers currently outside of their networks could require some beneficiaries to schedule appointments farther in advance.*

*In 2016 DHCS commissioned an access assessment that may assist it in identifying and resolving shortages of providers in the Regional Model.*

valuable perspective on whether access issues in the Regional Model are the result of provider shortages, the structure of the model, or both.

In 2016 DHCS commissioned an access assessment that may assist it in identifying and resolving shortages of providers in the Regional Model. DHCS commissioned the assessment in response to federal requirements issued in 2015. According to documentation provided by DHCS, the completed assessment will include maps comparing the number of providers for each specialty and each health plan with the number of beneficiaries. The assessment will also identify the percentage of available providers for each specialty that each health plan is contracting with, the average distance between beneficiaries and each health plan's closest primary care physicians and hospitals, and recommendations for addressing systemic deficiencies it identifies. DHCS plans to finalize the assessment in October 2019. This assessment should enhance DHCS' knowledge of the locations throughout the State, including those in the Regional Model counties, that are lacking certain types of providers.

### **Regional Model Health Plans Have Not Provided an Acceptable Quality of Care to Beneficiaries**

Although most health plans in the State have not met some of their contractual requirements related to quality of care, the health plans that serve the 28 rural expansion counties have consistently delivered a lower quality of care to beneficiaries than the health plans delivering services to beneficiaries in other areas of the State. Further, Managed Health Care's audits of the rural expansion counties suggest that the Regional Model health plans have had more difficulty than Partnership in meeting their contractual requirements related to quality of care.

Our review of HEDIS data from 2015 through 2018 found that the Regional Model health plans failed to meet a significant number of minimum performance levels. As the Introduction explains, DHCS requires health plans to meet minimum performance levels for key HEDIS measures related to the quality of care that they provide to beneficiaries. However, both Anthem and Health & Wellness scored below minimum performance levels for at least 24 percent of these HEDIS measures for each of the four years for which the data were available. For instance, neither of the two plans conducted an adequate number of breast cancer screenings in 2018. As Table 3 shows, the two Regional Model plans scored extremely poorly in 2016: Anthem and Health & Wellness failed to meet an average of 12 and 14, respectively, of the 22 minimum performance levels. To supplement these figures on the number of HEDIS measures below the minimum performance level, we present an interactive



map on our website that shows by county, plan, and measure the percent of HEDIS scores below the minimum performance levels during the past four years.

**Table 3**  
The Regional Model Health Plans and Partnership Have Provided a Similar Quality of Care in the Rural Expansion Counties

YEAR	NUMBER OF MEASURES*	AVERAGE NUMBER OF HEDIS MEASURES BELOW MINIMUM PERFORMANCE LEVEL		
		REGIONAL MODEL†		COHS
		ANTHEM	HEALTH & WELLNESS	PARTNERSHIP‡
2015	22	9.5	10.5	10.5
2016	22	12	14	11
2017	18	6.5	7.5	8
2018	21	5	6	6

Source: Analysis of HEDIS data.

Note: Anthem, Health & Wellness, and Partnership report on their performance using reporting units made up of groups of counties. We averaged their scores in each of their rural expansion county reporting units to determine their overall performance in the rural expansion counties.

\* Excludes measures for which DHCS has not specified a minimum performance level.

† Excludes Kaiser Permanente, which operates in a limited manner in three of the 18 Regional Model counties.

‡ Excludes Lake County, which is part of the rural expansion. Partnership reports Lake County's data as part of a group of counties that includes three counties that were not in the rural expansion.

The HEDIS data indicate that although the quality of care the Regional Model health plans provided was comparable to the quality of care in the other rural expansion counties, it was lower than the quality of care in the rest of the State. As Table 3 shows, the performance of Anthem and Health & Wellness within the 18 Regional Model counties was similar to Partnership's performance in its rural expansion counties. However, Table 4 shows that the rural expansion health plans' average performance was well below the average performance of the plans serving the counties in the rest of the State. Improvements in the HEDIS scores of the Regional Model plans since 2016 have reduced the gap between the Regional Model counties and other areas of the State. According to the quality and monitoring chief, the improvements in these health plans' HEDIS scores indicate that their quality of care has improved as a result of a CAP—which it refers to as a *quality CAP*—that it imposed when they fell below standards.

**Table 4**  
**Beneficiaries in the Rural Expansion Counties Have Received a Lower Quality of Care Than Other Beneficiaries in the State**

YEAR	NUMBER OF MEASURES*	AVERAGE NUMBER OF HEDIS MEASURES BELOW MINIMUM PERFORMANCE LEVEL	
		RURAL EXPANSION†	REMAINDER OF THE STATE‡
2015	22	10.2	4.1
2016	22	12.3	6.7
2017	18	7.3	4.7
2018	21	5.7	2.3

Source: Analysis of HEDIS data.

\* Excludes measures for which DHCS has not specified a minimum performance level.

† Excludes Kaiser Permanente, which operates in a limited manner in three of the 18 Regional Model counties. Also excludes Imperial and San Benito counties, which Anthem and Health & Wellness serve outside the Regional Model.

‡ Includes Lake County, which is part of the rural expansion. Partnership reports Lake County's data as part of a group of counties that includes three counties that were not in the rural expansion.

Other measures suggest that the Regional Model plans have struggled more than Partnership in meeting their contractual requirements for quality of care. As we discuss in the Introduction, both DHCS and Managed Health Care perform routine audits to verify whether health plans are complying with legal and contractual requirements that affect quality of care. However, these audits generally cover each plan's performance throughout the State, without indicating the particular model or county with which the departments have identified deficiencies. Consequently, the audits do not address conditions that are specific to the Regional Model plans. Nonetheless, under the terms of an interagency agreement between DHCS and Managed Health Care for 2014 through 2016, Managed Health Care conducted an audit of each of the three health plans—Anthem, Health & Wellness, and Partnership—that focused on their legal and contractual compliance within the 28 rural expansion counties. These audits suggest that the Regional Model health plans had greater difficulty meeting their contractual requirements than Partnership did.

Managed Health Care identified contractual and legal violations that all three health plans committed in the rural expansion counties, but it identified potentially more serious deficiencies in its reviews of Anthem and Health & Wellness than of Partnership. For example, Managed Health Care determined that both Anthem and Health & Wellness failed to properly document and address potentially significant grievances and other quality issues pertaining to inadequate care, including a cardiac arrest caused by a medication error and a provider's failure to detect a serious infection. The health plans' failure to properly address these

reported quality issues may have exposed beneficiaries to harm. In contrast, Managed Health Care's findings related to Partnership did not indicate significant risks to beneficiaries' health. For example, Managed Health Care found that Partnership resolved grievances promptly but did not always list the dates it received the grievances when responding to beneficiaries.

DHCS has taken steps to ensure that the health plans have resolved the deficiencies that Managed Health Care's audits identified. As part of its interagency agreement, DHCS used quality CAPs to address these violations. In our April 2019 audit report, *Department of Health Care Services: Although Its Oversight of Managed Care Health Plans Is Generally Sufficient, It Needs to Ensure That Their Administrative Expenses Are Reasonable and Necessary*, Report 2018-115, we determined that DHCS' process to oversee health plans' quality of care—including quality CAPs—was generally sufficient.

#### **DHCS Has Not Effectively Communicated to Counties When It Identified Quality of Care Deficiencies**

Although DHCS has generally complied with state and federal reporting requirements, it could do more to inform county officials when it identifies significant quality of care issues with the Regional Model health plans. Federal and state laws require DHCS to publicly report different elements of its monitoring efforts, and DHCS complies with these requirements by publishing its HEDIS results and medical audit reports on its website. However, it has not adequately educated counties about all the types of monitoring that it performs, such as the medical audits we previously discuss and the corresponding CAPs, which DHCS calls *medical audit CAPs*. Through its medical audits, DHCS evaluates health plans' performance and compliance with contractual requirements in six categories: utilization management, case management and coordination of care, access and availability of care, member rights, quality management, and administrative and organizational capacity. If stakeholders are not aware of DHCS' monitoring efforts, they are unlikely to seek out the results of those efforts. Moreover, when it completes its audit reports, DHCS does not notify counties or distribute the reports to them, thereby placing the responsibility on the counties to review its website regularly to become aware of new medical audit findings.

Further, DHCS does not promptly update its website with its medical audit reports, which delays stakeholders' ability to review those results. For example, DHCS issued its most recent audit of Anthem in August 2018; however, it still had not made the results publicly available as of July 2019. DHCS explained that it waits

*DHCS has not adequately educated counties about all the types of monitoring that it performs, such as its medical audits.*

***By providing counties with information about the significant quality of care issues that it identifies, DHCS could better enable them to help beneficiaries receive the care to which they are entitled.***

until the health plans complete the medical audit CAPs pertaining to their audits before it publishes the audit results on its website. Although state law allows this delay, counties could better assist their beneficiaries if DHCS informed them of performance issues more promptly. We believe that DHCS should publish medical audit results as they become available and then post the completed medical audit CAPs later. DHCS said it would consider making this change.

By providing counties with information about the significant quality of care issues that it identifies, DHCS could better enable them to help beneficiaries receive the care to which they are entitled. County representatives indicated that they were aware of beneficiaries' difficulties with receiving appropriate care, and that in some cases, beneficiaries have reached out to them directly to report issues. Information about problems that DHCS has identified with health plans' performance would likely assist counties in their efforts to help these beneficiaries, particularly when DHCS has identified violations of beneficiaries' rights. For example, DHCS concluded in a 2017 audit that Health & Wellness had wrongfully denied a beneficiary an evaluation to determine whether he was eligible for an organ transplant, even though a physician recommended an evaluation and the health plan's contract with DHCS entitled its beneficiaries to such evaluations. If DHCS consistently informed counties of such problems, the counties would be better positioned to assist other beneficiaries who are facing similar issues.

To obtain the counties' perspectives on DHCS' outreach efforts, we spoke with representatives of county health agencies in a number of rural expansion counties. Representatives of seven of these counties were unfamiliar with the full scope of DHCS' monitoring efforts, and representatives of five stated that they did not even know that DHCS conducted medical audits. In general, most of these individuals who we spoke with stated that they would like DHCS to be more proactive in notifying them when it identifies serious deficiencies in their county's health plans.

The representatives' comments suggest that counties would benefit if DHCS issued a periodic form of communication, such as a newsletter. In fact, one county representative described DHCS' website as overwhelming, and another said that it is difficult to find the reports about health plans' performance levels on that website. Another county official explained that her staff lack the time to review the website regularly to determine whether DHCS has published new reports. When we asked DHCS for perspective, it explained that counties and other stakeholders can request to be added to an email distribution list (mailing list) it uses to update stakeholders on managed care topics. It also stated that it has

two advisory groups in which counties may participate, and each of these groups has an email address to which stakeholders can submit questions or concerns. However, DHCS acknowledged that it does not discuss its medical audits and other monitoring efforts in these groups unless a member requests that it do so, nor does it send such information to stakeholders on its mailing list. By improving its process for publishing its monitoring results, which it is willing to do, DHCS could better ensure that county stakeholders have the knowledge necessary to assist beneficiaries in receiving the care that they need.

### **Recommendations**

To ensure that beneficiaries in Regional Model counties have adequate access to care, DHCS should identify by August 2020 the locations requiring additional providers and the types of providers required. It should also develop strategies for recruiting and retaining providers in those locations. If it requires additional funding to complete this assessment or to implement actions to address its findings, DHCS should determine the amounts it needs and request that funding from the Legislature.

To obtain assurance that health plans throughout the State exhaust all of their reasonable options to meet the access requirements before requesting alternative access standards, DHCS should immediately begin doing the following:

- Develop written guidance that specifies the conditions under which staff should approve, deny, or contact health plans for clarification regarding their alternative access standard requests.
- Determine a specific minimum number of providers that health plans must attempt to contract with before requesting an alternative access standard.
- Require health plans to report on their attempts to contract with providers when submitting their alternative access standard requests, including providing evidence of their efforts, such as the contact information for each provider with which they have attempted to contract.
- Establish a process for periodically verifying the health plans' efforts, such as contacting a sample of the listed providers and determining whether the plans attempted to contract with them.
- Require health plans to authorize out-of-network care if they do not demonstrate they have exhausted all of their reasonable options to meet the access requirements, unless the health

plans can demonstrate that closer providers are demanding unreasonably high rates or have documented deficiencies in quality of care.

To ensure that it promptly and sufficiently notifies counties and other stakeholders about health plans' quality of care deficiencies, DHCS should immediately do the following:

- Post its medical audit reports to its website within one month after it issues the reports to the health plans.
- Include information about its recently published medical audit reports and other monitoring efforts in its communication with counties and other stakeholders on its mailing list.
- Ensure that relevant county officials are included on its mailing list.

## Chapter 2

### **DHCS HAS NOT ENSURED THAT ALL MEDI-CAL BENEFICIARIES IN RURAL EXPANSION COUNTIES RECEIVE SERVICES THROUGH A MODEL THAT BEST MEETS THEIR NEEDS**

#### **Chapter Summary**

Over the course of the past seven years, DHCS has not adequately engaged with the Regional Model counties regarding their managed care model and contracted health plans. Specifically, before the 2013 transition, DHCS did not actively educate the rural expansion counties about the options available to them. Further, even when these counties sought to create or join a COHS, it did not assist them. DHCS' lack of engagement with the counties continued well after the transition occurred. For example, it did not seek feedback from the Regional Model counties regarding their satisfaction with Health & Wellness's performance before it extended its contract with the health plan.

However, DHCS could now take steps to begin acting on counties' preferences and feedback. Since the completion of the rural expansion in 2013, a number of counties have expressed the desire to leave the Regional Model and instead create or join a COHS. DHCS' current agreements with the Regional Model health plans make such a change difficult until 2023, but at that time, transitioning Regional Model counties to a COHS will be a viable option. Because creating a COHS would require the counties and DHCS to complete several time-consuming activities, such as establishing a provider network, starting the process now would better enable the counties and DHCS to complete these activities before the current health plan contracts expire and ensure continuity of care for the counties' beneficiaries. By assisting the counties in making such a change, DHCS could better ensure that beneficiaries receive adequate access to care.

#### **DHCS Did Not Adequately Educate and Assist Rural Expansion Counties During Their Transition to Managed Care**

As the agency responsible for overseeing the effective delivery of health care to Medi-Cal beneficiaries throughout the State, DHCS should have ensured that before the rural expansion counties transitioned to managed care, it proactively educated them on the available managed care options so that they could select a model that would best serve their needs. Instead, the counties selected their own models without receiving sufficient guidance

from DHCS. Several county representatives we interviewed stated that they were unclear about their managed care options at the time of the rural expansion transition. In addition, even when counties determined that they wanted to join or create a COHS, DHCS did not assist them in exploring that option.

### ***DHCS Did Not Adequately Inform and Educate Rural Expansion Counties on Their Managed Care Options***

DHCS did not actively collaborate with the rural expansion counties before their transition to managed care to inform them of their options, to identify any potential concerns they should consider, or to confirm that they understood the transition process. According to the special projects manager of the DHCS director's office (special projects manager), who formerly served as the managed care chief, DHCS representatives had several conversations with county representatives and providers, such as hospitals, that approached it with questions about managed care. For example, some counties asked DHCS about joining Partnership, and DHCS informed them of the steps they would need to take, including seeking federal approval. Nevertheless, because DHCS relied on the counties to select their own models, we expected it to have provided them with adequate information to ensure that they made informed decisions. That type of involvement likely would have helped ensure the overall success of the transition.

State law required DHCS to solicit feedback from relevant managed care stakeholders such as beneficiaries, providers, and health plans regarding their perspectives on the models that would be most suitable for the 28 rural expansion counties. During the rural expansion, DHCS held open meetings to solicit feedback from stakeholders, but it did not conduct outreach that specifically targeted the counties. Because counties are able to create COHS Models and local initiatives in a Two-Plan Model, we expected DHCS to have considered them relevant stakeholders and to have sought their feedback. However, DHCS' meetings did not address topics of specific relevance to counties, such as the steps a county would need to take to create a COHS Model. According to the special projects manager, DHCS believes it addressed its responsibility to inform stakeholders, including counties, about the rural expansion transition by facilitating these meetings and by being willing to address concerns stakeholders brought to its attention.

However, we question the effectiveness of this approach given that many counties told us they were unclear about their managed care options at the time of the transition. Representatives from several Regional Model counties stated that their counties had

***Because counties are able to create COHS Models and local initiatives in a Two-Plan Model, we expected DHCS to have considered them relevant stakeholders and to have sought their feedback.***



not fully understood the options that were available to them, the type of assistance DHCS was willing to provide them, or the steps they needed to take to establish or join a managed care model. Consequently, those counties did not take specific action to join or create another model and instead deferred to DHCS, which placed them in the Regional Model.

Neither DHCS' chief deputy director—who was not involved in communications with the counties during the time of the rural expansion—nor its special projects manager could recall whether DHCS actively approached and educated the rural expansion counties beyond the transition meetings that it held for interested stakeholders. However, the special projects manager acknowledged that DHCS did not prepare informational material for stakeholders to explain the available managed care options, the steps the counties would need to take to act on those options, or the resources DHCS could offer to assist with the transition. Further, neither the chief deputy director nor the special projects manager recalled whether DHCS advised the counties on how to evaluate their demographics to determine whether particular models might be more effective in serving their beneficiaries. They also could not recall whether DHCS allocated staff resources, such as an assigned group of staff members, to monitor the progress of the counties during the transition and to serve as a resource for them. We expected DHCS to have taken some or all of these actions to ensure that the counties were well informed to select their own managed care models.

#### ***DHCS Did Not Assist Rural Expansion Counties That Wanted to Create or Join a COHS***

Despite the questionable effectiveness of DHCS' approach to inform counties of their managed care model options, many of the rural expansion counties attempted to create or join a COHS or local initiative, as we discuss in the Introduction. However, four of the Regional Model counties were unsuccessful in their attempts. Three of these four counties informed us that they attempted to join Partnership by discussing with Partnership representatives the viability of having that health plan serve their Medi-Cal beneficiaries. One county indicated that it also passed a county board resolution affirming its support of Partnership's expansion into the county. Representatives of the three counties explained that Partnership ultimately rejected the counties' proposals because it had reached its capacity of additional counties it could accept. The other county attempted to join another COHS, the Central California Alliance for Health (Central Alliance). According to a

***Several counties had not fully understood the options that were available to them, the type of assistance DHCS was willing to provide them, or the steps they needed to take to establish or join a managed care model.***

*Most of the eight rural expansion counties that successfully joined Partnership in 2013 received assistance from an external resource, which better prepared them to join a COHS.*

county representative, Central Alliance indicated that it would not be able to accept the county because it would have been financially prohibitive for it to do so.

Most of the eight rural expansion counties that successfully joined Partnership in 2013 received assistance from an external resource, which better prepared them to join a COHS. Several of these counties participated in stakeholder meetings facilitated by Health Alliance of Northern California (Health Alliance), a network of nonprofit community health clinics and health centers. The meetings informed these counties about their managed care model options, including the locations of the current COHS they could seek to join. Health Alliance recruited Partnership to attend the meetings. A Health Alliance representative informed us that Health Alliance also coordinated with the counties to obtain declarations from their boards of supervisors that demonstrated their desire to receive Medi-Cal services through Partnership. At least two counties then contacted their respective state legislators, who encouraged DHCS to allow the counties to join Partnership. DHCS subsequently approved these counties' requests to join Partnership.

DHCS did not provide the type of assistance that Health Alliance provided because it did not believe that doing so was part of its role. According to the chief deputy director, DHCS expected counties that were interested in joining a COHS to reach out directly to that COHS to determine whether it was interested in providing services in the county. Further, the special projects manager explained that the COHS would have needed to consider whether it was able to establish or expand its provider network into the counties. In other words, because DHCS believed that the counties and health plans should have taken the initiative to work together, it did not attempt to facilitate or encourage any communication among them. However, we expected DHCS—like Health Alliance—to have provided assistance to the counties to ensure that they were well positioned to work with the health plans to provide the best service to their beneficiaries.

In addition, if DHCS had made information about the transition available to counties sooner, more counties might have been able to select the health plans they determined would best serve their beneficiaries. A representative from one of the Regional Model counties told us that her county became interested in joining Partnership too late in the managed care transition process, after Partnership already reached its capacity. By that time, the county was not able to create its own COHS or establish a multicounty COHS with other counties. According to DHCS' records, it held its first stakeholder meeting to inform Regional Model counties of the transition to managed care in July 2012—only seven months before it awarded the contracts to Anthem and

Health & Wellness in February 2013. We question the sufficiency of this seven-month period to allow counties to explore the option of joining a health plan or creating an alternate managed care model, especially without informational assistance from DHCS.

Because DHCS is the entity responsible for administering the Medi-Cal program, we believe that it was in the best position to provide assistance to counties that wanted to create a COHS. We expected DHCS to have informed the counties about the specific actions required to create a COHS and to provide assistance to those counties that did not have the resources to perform such actions. For example, two Regional Model counties told us they did not explore the option of creating a COHS at the time of the transition because they believed they did not have the necessary financial resources or knowledge. Had DHCS been proactive in offering assistance, the counties might now have managed care models that are more effective at providing services to their beneficiaries.

The chief deputy director explained that providing such assistance to counties would not have been possible in 2013 because DHCS did not have sufficient financial resources at that time. She also stated that if DHCS were to take on the responsibility of providing financial assistance to counties that want to be in a different managed care model, it would need additional funding from the State. We discuss this possibility in more detail below.

### **DHCS Extended Its Contracts With the Regional Model Health Plans Without Seeking Input From the Counties**

State law allows DHCS to enter into contracts with one or more health plans to provide managed health care services to Medi-Cal beneficiaries in the rural expansion counties. In addition, DHCS has the exclusive authority to establish rates, terms, and conditions of managed care plan contracts and subsequent amendments, although these elements are subject to federal approval. Although state law required DHCS to request stakeholder feedback as part of the rural expansion counties' transition to managed care in 2013, it does not require DHCS to request feedback from stakeholders, including counties, before extending its contracts with the Regional Model health plans. However, we believe that before taking such an action, DHCS should request the counties' feedback. Otherwise, it may miss opportunities to gain important insight from the counties on whether the health plans have been effectively serving beneficiaries.

In 2013 DHCS established five-year contracts with Anthem and Health & Wellness to provide services in the Regional Model counties through October 2018. In November 2018, DHCS

*DHCS has the exclusive authority to establish rates, terms, and conditions of managed care plan contracts and subsequent amendments, although these elements are subject to federal approval.*

***Although DHCS does not have a formal internal review process for determining whether to extend a contract, it stated that it considers health plans' performance when deciding whether to extend their contracts and would not do so if it identified significant issues.***

extended its contract with Health & Wellness through a provision that allowed it the option to extend the terms in one-year increments up to four additional years. DHCS initially exercised the option to extend the contract through June 2019 and extended it again through June 2020 without seeking feedback from counties about their satisfaction with the health plan's performance. According to the managed care chief, DHCS extended the contract because of this provision and because it did not identify any concerns with Health & Wellness that warranted terminating that contract.

Although DHCS does not have a formal internal review process for determining whether to extend a contract, it stated that it considers health plans' performance when deciding whether to extend their contracts and would not do so if it identified significant issues. DHCS asserted that it continually monitors health plans' performance through various methods, including but not limited to its medical audits and its review of HEDIS measures. DHCS also stated that it did not request stakeholder feedback before extending the contract, citing the absence of such a requirement and the fact that DHCS had received feedback from stakeholders when it first solicited proposals for the rural expansion counties in 2012. However, we question the timeliness and relevance of that feedback, given that it occurred before DHCS had even entered into a contract with Health & Wellness. We expected that each time DHCS extended Health & Wellness' contract, it would request feedback from stakeholders, including counties, to gain insight regarding the health plan's performance and the counties' desire to continue in the Regional Model.

DHCS also extended Anthem's contract without seeking feedback from stakeholders although it did so under other unique circumstances for which feedback would not have been relevant. In 2014 just one year after executing the original contract, DHCS agreed to a settlement with Anthem that extended its contracts for five additional years in all of the counties in which Anthem provided Medi-Cal services, including the Regional Model counties. According to DHCS, the settlement was the result of several lawsuits Anthem filed against DHCS regarding rates that DHCS paid it to provide Medi-Cal services. Because of the settlement, the Regional Model counties are obligated to remain in that model and have Anthem serve as one of their health plans through October 2023.

Nevertheless, it appears that DHCS did not inform counties of this extension until long after it was executed. DHCS' current management were unclear about the extent of any discussions that their predecessors had with counties before extending the contract. However, according to representatives of several Regional Model

counties, DHCS did not inform them of the extension at the time it occurred. Some of these representatives informed us that they had multiple meetings with DHCS' executive staff in 2017 and early 2018 to discuss the managed care model options that were available to them after DHCS' contracts with Anthem and Health & Wellness expired. According to some of these counties, DHCS informed them during those meetings that it had extended Anthem's contract through 2023 and that it would not be able to remove them from that contract because it would incur significant financial penalties.

DHCS announced on its website that it will initiate a new request for proposals (RFP) that it anticipates releasing in 2020 for commercial managed care health plans throughout the State that include the Regional Model counties. It plans to place all of its commercial managed care health plan contracts up for bid in 2020, including Anthem's and Health & Wellness's Regional Model contracts. According to the chief deputy director, if the Regional Model counties want to join or create a COHS, they will need to begin working on the transition while DHCS' contracts with Anthem and Health & Wellness are still in place, and they will need to inform DHCS before it issues the RFP. DHCS also identified January 2024 as the potential implementation date for the Regional Model contracts. However, that implementation date is subject to change, based on the health plans' ability to provide services. According to DHCS, the four-year period for implementation is based on the amount of time needed for it to evaluate and score proposals and to ensure that the selected health plans complete all required plan readiness activities. Although DHCS indicated it is not requesting feedback from stakeholders on this RFP because the stakeholders in those affected counties already have experience with managed care, it is willing to accept any public comments it receives after it issues the request.

### **The COHS Model Is a Viable Option for the Regional Model Counties That Could Ensure That Its Beneficiaries Receive Better Access to Care**

As we discuss in Chapter 1, the majority of the providers that contract with the Regional Model health plans contract with only one of the health plans but not both. Because the COHS Model consists of a single health plan that a county directly oversees, its structure might facilitate better access to care for Regional Model beneficiaries because they could access all of its contracted providers. With the assistance of DHCS, many Regional Model counties could establish a multicounty COHS that likely would more effectively serve their beneficiaries. However, any formal change could likely not occur until the contracts with the two existing Regional Model health plans expire.

*DHCS announced on its website that it will initiate a new RFP that it anticipates releasing in 2020 for commercial managed care health plans throughout the State that include the Regional Model counties.*

### ***The COHS Model May Provide Better Access to Care for the Beneficiaries in the Regional Model Counties***

As we discuss in Chapter 1, the Regional Model's use of two health plans that must each establish adequate provider networks has negatively affected beneficiaries' access to care. The majority of providers in the Regional Model contract with either of the Regional Model health plans but not both, meaning that some beneficiaries may have to travel hundreds of miles to receive care from in-network providers. In contrast, one of the defining characteristics of the COHS Model is that it consists of a single health plan that provides services to its beneficiaries. By implementing a COHS in the Regional Model counties, all of the beneficiaries in those counties would have access to all of the providers in that model. DHCS indicated that it is not aware of any evaluation that has concluded that a particular managed care model is more effective at providing access to care than another model. However, the poor access conditions we identified in the Regional Model counties led us to conclude that DHCS could benefit from performing such an evaluation to determine whether a COHS would improve access to care for those beneficiaries.

***A COHS can dedicate a greater portion of its financial resources to recruiting Medi-Cal providers to rural locations in which it operates that do not currently have such providers.***

A COHS also can dedicate a greater portion of its financial resources to recruiting Medi-Cal providers to rural locations in which it operates that do not currently have enough such providers. A COHS is a nonprofit organization with a governing board that is largely composed of officials of the counties they serve. Because of its nonprofit status, a COHS does not dedicate a portion of the capitation payments it receives to corporate shareholders in the same way that Anthem and Health & Wellness do. Consequently, a COHS could have more flexibility than a commercial health plan to commit its resources to improving provider availability.

Additionally, because a COHS's board is composed largely of officials of the counties that it serves, these county officials have influence in directing the organization to dedicate its resources to their counties' greatest needs, including recruiting providers. According to Partnership, its board directed the organization to prioritize recruiting for providers to fill service gaps in its counties. Partnership asserts it has since committed significant resources to recruiting new providers for those counties and retaining existing providers.

### ***Establishing a COHS Is a Viable Option for the Regional Model Counties***

Since the completion of the rural expansion transition in 2013, at least seven counties have expressed to DHCS their interest in either switching to a COHS Model or in learning more about doing so.

We spoke with representatives of these and other counties in the Regional Model about their experiences with the rural expansion transition, their current service delivery, and their perspectives on their future involvement with managed care. Several counties identified potential benefits of the COHS Model that they do not have in the Regional Model. For example, representatives from some counties believe that the direct county oversight of a COHS can lead to the health plan's implementation of programs that address the counties' specific needs. When we spoke to Partnership, it explained that it has implemented programs to assist with the opioid epidemic in response to concerns from its counties.

DHCS' settlement with Anthem and its contract with Health & Wellness would likely preclude the counties from considering other models until those contracts expire in 2023 and 2020, respectively. Thereafter, the Regional Model counties could consider creating or joining a COHS. Federal regulations generally require that states mandating that Medicaid beneficiaries must enroll in a managed care health plan must give those beneficiaries a choice of at least two plans. However, federal regulations allow an exception for COHS Models if the COHS offers its beneficiaries a choice of at least two primary care providers.

To create a COHS that would serve multiple counties in the Regional Model, those counties would need to establish the COHS's administrative structure and provider network. For example, the counties would need to create a special commission to negotiate the contract and arrange for the provision of health care services. The counties would also need to hire personnel, procure computer systems, and establish contracts with providers, which all have associated costs. Because DHCS cannot issue health plan capitation payments until a COHS begins serving Medi-Cal beneficiaries, the COHS would not have those resources available to fund its start-up costs. Given that some of the Regional Model counties may not have sufficient staff or financial resources to fund the start-up costs of a COHS, it would seem reasonable for DHCS to provide assistance to the counties to help create the entity and hire core personnel. Further, for this same reason, it may be more cost-effective for the Regional Model counties to create a multicounty COHS for the region rather than one or more of them creating a county-specific COHS.

Although DHCS has yet to provide any such assistance to counties that currently desire to create a COHS, the chief deputy director stated that DHCS would need additional funding before it could provide assistance to counties. Similarly, DHCS indicated it does not provide financial resources to new health plans for start-up costs and would need to seek funding from the Legislature to do so.

*To create a COHS that would serve multiple counties in the Regional Model, those counties would need to establish the COHS's administrative structure and provider network.*

However, without DHCS' assistance, small and rural counties may not be able to develop the infrastructure required to change their managed care models.

Because DHCS' current staff do not have experience with establishing a COHS, we interviewed a representative of the State's most recently established COHS, Gold Coast Health Plan (Gold Coast), about the process Ventura County used to establish it in 2011. According to the representative, the formation of Gold Coast required Ventura County to hire staff to administer the health plan. Gold Coast then contracted with external vendors to perform some of its administrative functions, such as operating its claims and encounter data computer systems. Gold Coast obtained a portion of its start-up funding from one of its vendors. Gold Coast estimated that creating and staffing the COHS cost about \$15 million.

In addition, before the Regional Model counties could begin operating a new COHS, both federal regulations and state law require DHCS to evaluate whether the COHS is adequately prepared to provide services to beneficiaries. That evaluation would entail reviewing the health plan's provider network and its procedures to monitor and improve quality of care.

### ***The Cost to Deliver Managed Care Depends on the Specific Needs of the Beneficiary Population Being Served***

To evaluate whether the costs of delivering Medi-Cal services using a COHS in the Regional Model counties would differ from the current costs of delivering those services, we reviewed DHCS' capitation payments and other associated costs for Partnership counties and for the Regional Model counties. DHCS pays monthly capitation payments to health plans to cover services that DHCS has contractually required the health plans to provide to beneficiaries. DHCS groups eligible beneficiaries into 10 aid categories, each of which consists of individuals who have similar health risk traits. It then pays different capitation payments depending on the aid category. For example, DHCS would pay a different capitation payment for a beneficiary in the *breast and cervical cancer* aid category than for a beneficiary in the *family and adult* aid category. DHCS provides certain services to beneficiaries even though it does not require some health plans to include these services in their contracts. DHCS pays providers directly for these services, which we refer to as *noncapitated services*.

As Table 5 shows, DHCS spent more per beneficiary per month from fiscal years 2013–14 through 2016–17 to deliver services to Partnership's beneficiaries than to the Regional Model beneficiaries.

***DHCS pays monthly capitation payments to health plans to cover services that DHCS has contractually required the health plans to provide to beneficiaries.***



However, DHCS indicated that the overall average per-member per-month cost of providing services to Partnership beneficiaries is not a reasonable representation of how much it would cost DHCS to provide services to beneficiaries in the Regional Model counties through a COHS. The research and analytic studies chief (research chief) explained that the differences in the overall average per-member per-month cost for capitation payments between the Regional Model and Partnership was primarily driven by the variation in enrollment patterns between the model types during this period. The research chief stated that Partnership’s higher overall average per-member per-month cost is attributable to its counties having enrolled a greater proportion of beneficiaries in high aid categories than the Regional Model counties enrolled. For example, DHCS determined that in fiscal year 2013–14, about 13 percent of Partnership’s capitation payments were for beneficiaries in one of its disabled aid categories, while only 1 percent of the Regional Model counties’ payments were for such beneficiaries.

**Table 5**  
**DHCS Spent More per Member per Month for Partnership’s Beneficiaries Than for the Regional Model’s Beneficiaries**

FISCAL YEAR	PAYMENT TYPE	MANAGED CARE MODEL TYPE	
		COHS (PARTNERSHIP)	REGIONAL MODEL
2013–14	Capitated	\$409	\$266
	Noncapitated*	231	88
	<b>Totals</b>	<b>\$640</b>	<b>\$354</b>
2014–15	Capitated	\$428	\$364
	Noncapitated*	195	113
	<b>Totals</b>	<b>\$623</b>	<b>\$477</b>
2015–16	Capitated	\$365	\$315
	Noncapitated*	201	129
	<b>Totals</b>	<b>\$566</b>	<b>\$444</b>
2016–17	Capitated	\$318	\$308
	Noncapitated*	210	141
	<b>Totals</b>	<b>\$528</b>	<b>\$449</b>

Source: Analysis of DHCS’ Medi-Cal expenditures from fiscal years 2013–14 through 2016–17.

Note: According to DHCS, neither capitation payments nor noncapitated services costs include certain supplemental payments, Medicare premiums, pharmacy rebates, or settlements.

\* Noncapitated services are those that DHCS does not require health plans to provide to beneficiaries in their benefits packages. Instead, DHCS pays providers directly for the services when billed by the providers.

According to the research chief, another factor contributing to the difference between Partnership's costs and Regional Model health plans' costs is their beneficiaries' utilization of noncapitated services. For example, DHCS paid about \$27 more per member per month in fiscal year 2016–17 for Partnership's beneficiaries to receive in-home supportive services, which are noncapitated, than it did for the Regional Model beneficiaries. The research chief informed us that like capitation payments, costs relating to noncapitated services depend on the number of beneficiaries in a health plan who qualify to receive the services and the degree of assistance that each beneficiary needs. If a health plan has more beneficiaries that require noncapitated services, DHCS will pay a higher overall average per-member per-month cost for those beneficiaries. Consequently, the costs that DHCS incurs for health plans to deliver care to their beneficiaries is based on the specific needs of those beneficiaries whom the health plans serve.

### Recommendations

To ensure that all counties are aware of the managed care model options available to them and of the steps necessary to implement those models, DHCS should provide by December 2019 information to all counties that clearly defines each managed care model and the steps and legal requirements needed to establish each model.

To ensure that it makes informed decisions regarding the extension or renewal of its contracts with managed care health plans, DHCS should immediately begin the practice of requesting annual feedback from the counties that the health plans serve and of using that feedback in its decision-making process.

To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020:

- Determine the specific causes of Anthem's and Health & Wellness's inabilities to provide reasonable access to care in the Regional Model counties.
- Evaluate whether the structural characteristics of a COHS Model would be better suited to providing reasonable access to care in the Regional Model counties and notify the counties whether a COHS would improve beneficiaries' access to care. If some or all of these counties desire to transition to a COHS, DHCS should assist them in making that change after their current contracts expire.

- Evaluate whether it has the financial resources to provide assistance to counties interested in establishing a COHS or other managed care model after the current Regional Model contracts expire. If DHCS does not have the required financial resources, it should seek an appropriate amount of funding from the Legislature.
- Provide these counties with reasonable opportunities to decide whether to change their managed care models after the expiration of the Regional Model health plan contracts. DHCS should provide counties that choose to do so sufficient time to establish their new models. DHCS should also include language in its 2020 RFP to allow Regional Model counties that can demonstrate their ability to implement a COHS Model in their county by 2023 to opt out of the RFP process.

We conducted this audit under the authority vested in the California State Auditor by Government Code 8543 et seq. and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the Scope and Methodology section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA  
California State Auditor

Date: August 6, 2019

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# Appendix

## SCOPE AND METHODOLOGY

The Joint Legislative Audit Committee (Audit Committee) directed the California State Auditor to examine DHCS’ oversight of the rural expansion and of managed care in the Regional Model counties. Specifically, the Audit Committee directed us to identify the process DHCS used to create the Regional Model, determine whether the level of care health plans have provided the Regional Model’s beneficiaries has been acceptable, and identify factors that may prevent the Regional Model counties from establishing a COHS. The table below lists the objectives that the Audit Committee approved and the methods we used to address them.

### Audit Objectives and the Methods Used to Address Them

AUDIT OBJECTIVE	METHOD
<p>1 Review and evaluate the laws, rules, and regulations significant to the audit objectives.</p>	<p>Reviewed relevant federal and state laws, rules, and regulations related to DHCS’ oversight of managed care, health plans’ acceptable delivery of managed care, and the establishment of a COHS.</p>
<p>2 Identify the process by which DHCS identified and grouped the 18 counties in question into the Regional Model and evaluate the reasonableness of the process.</p>	<ul style="list-style-type: none"> <li>• Interviewed DHCS staff to identify the process it used to transition the 28 rural expansion counties, including the 18 Regional Model counties, to managed care.</li> <li>• Interviewed representatives of the rural expansion counties, including the Regional Model counties, to determine how their counties learned they would be transitioning from fee-for-service to managed care, what types of interactions they had with DHCS, and whether DHCS addressed any concerns or health plan preferences they had.</li> <li>• Evaluated any efforts DHCS made to communicate with counties regarding the managed care transition process.</li> <li>• Reviewed and evaluated the process DHCS used to group the 18 counties into the Regional Model and whether that process was reasonable.</li> </ul>
<p>3 For the past three years, assess the rates of claims being paid by the Regional Model commercial plans and how they compare to Medi-Cal managed care plans offered through the COHS Model.</p>	<ul style="list-style-type: none"> <li>• Evaluated available fiscal years 2015–16 through 2017–18 financial records for Anthem, Health &amp; Wellness, and Partnership to determine the amounts they spent to provide services to their beneficiaries.</li> <li>• Interviewed DHCS staff to determine how it sets capitation rates.</li> <li>• Evaluated the differences between the benefit packages for the Regional Model and the COHS Model and the effect that the benefit packages had on the amounts DHCS paid those models’ health plans per beneficiary.</li> <li>• Evaluated Medi-Cal cost data from fiscal years 2013–14 through 2016–17 for all 18 Regional Model counties and eight Partnership counties to determine how much DHCS spent to deliver services to the beneficiaries of those counties.</li> </ul>
<p>4 Determine how DHCS selected the Regional Model commercial plans, review the terms of any relevant agreements, and assess the degree to which DHCS considered stakeholder input or other relevant factors.</p>	<ul style="list-style-type: none"> <li>• Interviewed DHCS staff to determine the process it used to select the Regional Model health plans.</li> <li>• Evaluated whether DHCS followed the applicable laws when it selected the Regional Model health plans. We determined that DHCS followed relevant laws when it selected Anthem and Health &amp; Wellness to provide services in the Regional Model counties.</li> <li>• Evaluated DHCS’ method for requesting feedback from stakeholders before it selected the health plans, as well as the extent to which DHCS addressed that feedback during its selection process.</li> </ul>

*continued on next page...*

AUDIT OBJECTIVE	METHOD
<p>5 For the counties served under the Regional Model, determine the following:</p> <p>a. Whether the level of care in those counties is disproportionately low as compared to other parts of California. To the extent possible, determine whether and how the level of care has changed since the implementation of the Regional Model.</p> <p>b. Whether the level of care received is acceptable as it relates to industry standards and state and federal requirements.</p> <p>c. Whether DHCS has taken steps to ensure that the plans adhere to the provisions of their contracts and whether DHCS has provided that information to the counties.</p> <p>d. Whether opportunities exist to improve the current level of care Medi-Cal beneficiaries receive under the Regional Model.</p>	<ul style="list-style-type: none"> <li>• Analyzed DHCS' statewide alternative access standard data to determine whether Anthem and Health &amp; Wellness provided beneficiaries in the Regional Model with access to care that was comparable to other parts of the State.</li> <li>• Analyzed statewide HEDIS data from 2015, the earliest year data was available, through 2018 to determine how the quality of care Anthem and Health &amp; Wellness provided beneficiaries in the Regional Model changed since its implementation and whether that care was comparable to other parts of the State.</li> <li>• Reviewed DHCS' and Managed Health Care's audit reports to determine whether the care that Anthem and Health &amp; Wellness provided was similar to the care provided by other plans operating in rural expansion counties.</li> <li>• Analyzed DHCS' provider directory data to calculate the number of providers with which Anthem, Health &amp; Wellness, and Partnership contracted.</li> </ul> <p>Interviewed staff at DHCS and Managed Health Care to identify criteria defining an acceptable level of care.</p> <ul style="list-style-type: none"> <li>• Reviewed DHCS' and Managed Health Care's audit reports of Anthem and Health &amp; Wellness to determine whether the health plans met state, federal, and contractual requirements.</li> <li>• Analyzed HEDIS data from 2015 through 2018 to determine whether Anthem and Health &amp; Wellness met the minimum performance levels that DHCS required.</li> <li>• Analyzed DHCS' alternative access standard data to determine whether Anthem and Health &amp; Wellness provided beneficiaries in the Regional Model with access to care that met state requirements. We were unable to identify the number of beneficiaries whose access to care exceeded the state requirements because DHCS could not provide us with records that identified the number of beneficiaries assigned to each health plan by zip code.</li> </ul> <ul style="list-style-type: none"> <li>• Reviewed DHCS' policies and procedures related to medical audits and corrective action plans.</li> <li>• Determined the extent to which DHCS made its monitoring results available to counties and potential stakeholders.</li> <li>• Evaluated DHCS' efforts to notify counties and potential stakeholders of its monitoring and of the results of that monitoring.</li> <li>• Interviewed a selection of Regional Model and Partnership county representatives to obtain their perspectives on DHCS' efforts to notify them of its monitoring results.</li> </ul> <ul style="list-style-type: none"> <li>• Interviewed DHCS staff to determine whether DHCS has identified opportunities to improve the Regional Model's level of care.</li> <li>• Evaluated DHCS' policies and procedures related to alternative access standards and network certification CAPs to identify opportunities to reduce access barriers.</li> <li>• Evaluated the extent of DHCS' authority to require health plans to take corrective actions.</li> <li>• Compared provider data from the Medical Board of California and the Osteopathic Medical Board of California to DHCS' provider directory data to determine whether Anthem and Health &amp; Wellness have contracted with all of the available providers located in the Regional Model counties.</li> <li>• Evaluated the characteristics of DHCS' managed care models to determine whether any were better suited than others to serve the Regional Model counties.</li> </ul>
<p>6 Determine whether DHCS, when negotiating and extending its contract with the Regional Model commercial plans, made efforts to consider and mitigate any concerns communicated to DHCS by affected counties. Assess whether the process was sufficiently transparent.</p>	<p>Interviewed DHCS staff and a selection of Regional Model county staff to determine whether DHCS requested feedback from the counties before it extended Anthem's and Health &amp; Wellness's contracts.</p>

AUDIT OBJECTIVE	METHOD
<p>7 Evaluate what compels the Regional Model counties to remain in the existing commercial plan model as opposed to creating or joining a COHS.</p>	<ul style="list-style-type: none"> <li>• Evaluated DHCS’ contracts with Anthem and Health &amp; Wellness to determine whether they require the counties to remain in the Regional Model.</li> <li>• Interviewed DHCS staff and other personnel at selected Regional Model and Partnership counties, Partnership, and Gold Coast to identify the processes for joining or establishing a COHS, the cost of establishing a COHS, and the entities responsible for funding the establishment of a COHS.</li> <li>• Evaluated federal and state laws to determine whether they impose any limitations on DHCS’ contracting with an additional COHS.</li> </ul>
<p>8 Review and assess any other issues that are significant to the audit.</p>	<ul style="list-style-type: none"> <li>• Interviewed DHCS staff to determine its process for approving or denying alternative access standards.</li> <li>• Evaluated DHCS’ policies and procedures for reviewing alternative access standard requests.</li> <li>• Evaluated a selection of 30 alternative access standard requests to determine whether DHCS adhered to its policies and procedures when it approved them.</li> </ul>

Source: Analysis of the Audit Committee’s audit request number 2018-122, state law, and information and documentation identified in the column titled Method.

### Assessment of Data Reliability

The U.S. Government Accountability Office, whose standards we are statutorily required to follow, requires us to assess the sufficiency and appropriateness of the computer-processed information that we use to support our findings, conclusions, and recommendations. In performing this audit, we relied on DHCS’ provider directory, alternative access standard data, and HEDIS performance data to evaluate the access to care and quality of care that the Medi-Cal managed care health plans provided to their beneficiaries. Additionally, we relied on license and eligibility data from the Medical Board of California and the Osteopathic Medical Board of California in order to identify licensed medical providers who are eligible to contract with Medi-Cal. To evaluate these data, we performed electronic testing of the data, reviewed existing information about the data, interviewed agency officials knowledgeable about the data, and performed data set verification procedures. We found that the DHCS provider directory, alternative access standards, and HEDIS performance data were sufficiently reliable for the purposes of our audit.

However, during our review, we identified limitations with the Medical Board of California and Osteopathic Medical Board of California license data. Specifically, we found that the license data limited the number of practice locations for each provider and that not all providers submitted this information. As a result, we found the license data were of undetermined reliability for identifying the practice location of all providers. Although this determination may

affect the precision of some of the numbers we present, there is sufficient evidence in total to support our findings, conclusions, and recommendations.



August 2019

JENNIFER KENT  
DIRECTORState of California—Health and Human Services Agency  
Department of Health Care ServicesGAVIN NEWSOM  
GOVERNOR

Ms. Elaine M. Howle\*  
California State Auditor  
621 Capitol Mall, Suite 1200  
Sacramento, CA 95814

Dear Ms. Howle:

The California Department of Health Care Services (DHCS) hereby provides response to the draft findings of the California State Auditor's (CSA) report entitled, *Department of Health Care Services: It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care*. The CSA conducted this audit and issued 13 recommendations.

DHCS agrees with nine of the recommendations, disagrees with three of the recommendations, and believes it is already in compliance with the remaining recommendation. DHCS has prepared corrective action plans to implement the nine recommendations it agrees with. DHCS appreciates the work performed by the CSA and the opportunity to respond to the findings. If you have any questions, please contact Ms. Nicole Jacot, External Audit Coordination Manager, at (916) 713-8812.

Sincerely,

A handwritten signature in black ink, appearing to read "Jennifer Kent". The signature is written in a cursive style with a large initial "J" and "K".

Jennifer Kent  
Director

Enclosure

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\* California State Auditor's comments begin on page 59.

**Department of Health Care Services' Response to the California State Auditor's  
Draft Report, *Department of Health Care Services: It Has Not Ensured That Medi-Cal Beneficiaries in Some Rural Counties Have Reasonable Access to Care*  
Report Number: 2018-122 (19-06)**

**Finding 1: The Department of Health Care Services (DHCS) has allowed health plans to require their Medi-Cal beneficiaries to travel hundreds of miles to receive care.**

**Recommendation 1**

To ensure that beneficiaries in Regional Model counties have adequate access to care, DHCS should identify by August 2020 the locations requiring additional providers and the types of providers required. It should also develop strategies for recruiting and retaining providers in those locations. If it requires additional funding to complete this assessment or to implement actions to address its findings, DHCS should determine the amounts it needs and request that funding from the Legislature.

**Current Status:** Will Not Implement

**Estimated Implementation Date:** N/A

**Implementation Plan:**

As previously stated in the responses to the audit conducted by the California State Auditor titled: "Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services," DHCS does agree increasing the number of physicians who practice in California is beneficial for all health care delivery systems; however, such statewide assessment is not something that DHCS is the subject matter expert in given that Medi-Cal is responsible for about 30% of the health care coverage. DHCS suggests that this would be better suited for the Office of Statewide Health Planning and Development (OSHPD) and the California Workforce Investment Board and DHCS would support OSHPD in addressing this important matter. However, we do note that within DHCS' purview, DHCS has been actively involved in implementing a physician and dental provider loan repayment program using Proposition 56 funds as authorized and approved in the Budget Act of 2018. These loan repayments were targeted specifically at newly-practicing providers that agree to see a specific percentage of Medi-Cal patients in their practice (at least 30 percent) and maintain that commitment for at least five years. The loans were open to both pediatric and adult providers and additional criteria will include providers that are practicing in high-need specialty areas such as child psychiatry or practicing in a medically underserved area. On July 2, 2019, DHCS announced that it paid \$58.6 million in student loans for 247 physicians through the loan repayment program. These efforts are specifically targeted at increasing participation in Medi-Cal within the state's existing workforce.

**Recommendation 2**

To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Develop written guidance that specifies the conditions under which staff should approve, deny, or contact health plans for clarification regarding their alternative access requests.

**Current Status:** Not Fully Implemented

**Estimated Implementation Date:** July 2020

**Implementation Plan:**

DHCS currently has written guidance that is used to process alternative access requests. DHCS ensures that the alternative access requests are being process correctly through a secondary review process that includes multiple levels of management. DHCS will continue to expand on the existing guidance, including information on process changes that will be put into place for the July 1, 2020, annual network certification process. ②

**Recommendation 3**

To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Determine a specific minimum number of providers that health plans must attempt to contract with prior to requesting an alternative access standard.

**Current Status:** Not Fully Implemented

**Estimated Implementation Date:** July 2020

**Implementation Plan:**

DHCS is in the process of modifying the alternative access request process for the July 1, 2020, annual network certification. The health plans will be required to search the same databases that DHCS uses when reviewing alternative access requests. If a provider is identified that is in closer proximity to what has been requested, the health plan will be required to submit contracting efforts to DHCS. DHCS would note that the amended process will be more stringent than what the CSA is suggesting. Previously, DHCS had a process that required the health plans to attempt to contract with a minimum number of providers and report that information to DHCS. DHCS was unable to process the requests in a timely fashion due to health plan errors. The enhancements that DHCS has made to date and is in the process of operationalizing for the July 1, 2020, annual network certification are both stricter and more efficient that what has been done in the past. ③

**Recommendation 4**

To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Require health plans to report on their attempts to contract with providers when submitting their alternative access standard requests, including providing evidence of their efforts, such as the contact information for each provider with which they have attempted to contract.

**Current Status:** Not Fully Implemented

**Estimated Implementation Date:** July 2020

**Implementation Plan:**

DHCS is in the process of modifying the alternative access request process for the July 1, 2020, annual network certification. The health plans will be required to search the same databases that DHCS uses when reviewing alternative access requests. If a provider is identified that is in closer proximity to what has been requested, the health plan will be required to submit contracting efforts to DHCS that would demonstrate why a health plan was unable to enter into such contracts.

**Recommendation 5**

To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Establish a process for periodically verifying the health plans' efforts, such as contacting a sample of the listed providers and determining whether the plans attempted to contract with them.

**Current Status:** Not Fully Implemented

**Estimated Implementation Date:** September 2019

**Implementation Plan:**

DHCS has already established a process to select a random sample of alternative access approvals and verify health plan contacting efforts. This process is currently underway for the approvals issued for the annual network certification process that was completed on July 1, 2019. DHCS aims to complete the sampling and analysis by September 2019.

**Recommendation 6**

To obtain assurance that health plans throughout the state exhaust all of their reasonable options to meet the access requirements, DHCS should immediately begin doing the following: Require health plans to authorize out-of-network care if they do not demonstrate they have exhausted all of their reasonable options to meet the access requirements, unless the health plans can demonstrate that closer providers are demanding unreasonably high rates or have documented deficiencies in quality of care.

④ **Current Status:** Will Not Implement/Already In Compliance

**Estimated Implementation Date:** N/A

**Implementation Plan:**

This is a current requirement in the health plan contract. The health plan contract requires that health plans allow beneficiaries to obtain medically necessary covered services from out-of-network providers if the services cannot be provided in-network. A

link to the current health plan boilerplate contract is listed below, but this requirement can be found in Exhibit A, Attachment 9 - Out of Network Providers. If DHCS denies an alternative access request, the health plan will be held to the contractual requirements prescribed in their contract and state and federal law. DHCS will deny alternative access requests when the department determines that there are potentially willing providers and a health plan has not sufficiently demonstrated that it made efforts to contract and providers were not willing to contract for reasonable rates.

④

<https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx>

### **Recommendation 7**

To ensure that it promptly and sufficiently notifies counties and other stakeholders about health plans' quality of care deficiencies, DHCS should immediately do the following: (a) Post its medical audit reports to its website within one month after it issues the audit to the health plan. (b) Include information about its recently published medical audit reports and other monitoring efforts in its communication with counties and other stakeholders on its mailing list. (c) Ensure that relevant county officials are included on its mailing lists.

**Current Status:** Not Fully Implemented

**Estimated Implementation Date:** September 2019

### **Implementation Plan:**

DHCS is currently in compliance with its state law requirements to post annual medical audits and their corrective action plans to its website once they have both been completed. DHCS does post its audit reports to its website once they have been completed and meet various requirements for public posting, such as accessibility. DHCS will include additional information on its monitoring efforts in its communications with stakeholders through its mailing lists.

⑤

**Finding 2: DHCS has not ensured that all Medi-Cal beneficiaries in the rural expansion counties receive services through a model that best meets their needs.**

### **Recommendation 8**

To ensure that all counties are aware of the managed care model options available to them and of the steps necessary to implement those models, DHCS should provide by December 2019 information to all counties that clearly defines each managed care model and the steps and legal requirements needed to establish each model.

**Current Status:** Not Fully Implemented

**Estimated Implementation Date:** December 2019

**Implementation Plan:**

- ⑥ DHCS already provides via the DHCS website, the various Plan Model types and a description of each model. However, DHCS agrees to post additional information on the DHCS website for counties to access, that provides information on the steps and legal requirements to establish each model. In addition, DHCS has been willing to meet with counties when requested to discuss issues about managed care and answer questions regarding the models.

Link to current DHCS website for Plan Model Type Information:

<https://www.dhcs.ca.gov/services/Documents/MMCD/MMCDModelFactSheet.pdf>

**Recommendation 9**

To ensure that it makes informed decisions regarding the extension or renewal of its contracts with managed care health plans, DHCS should immediately begin the practice of requesting annual feedback from the counties that the health plans serve and of using that feedback in its decision-making process.

**Current Status:** Not Fully Implemented

**Estimated Implementation Date:** July 2020

**Implementation Plan:**

DHCS agrees to implement a practice of requesting annual feedback from the counties that the health plans serve and use that feedback in its decision-making process when extending or re-procuring health plan contracts.

**Recommendation 10**

To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020: Determine the specific causes of Anthem's and Health and Wellness's inability to provide reasonable access to care in the Regional Model counties.

**Current Status:** Not Fully Implemented

**Estimated Implementation Date:** June 2020

**Implementation Plan:**

DHCS will conduct an analysis of access in the Regional Model using available data, existing workforce shortages information, alternative access standard requests, the independent Access Assessment required under the Special Terms and Conditions of the 1115 Waiver that is being conducted by the DHCS External Quality Review Organization, and other relevant information pertinent to the analysis as its being designed.

**Recommendation 11**

To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020: Evaluate whether the structural characteristics of a County Organized Health System (COHS) model would be better suited to providing reasonable access to care in the Regional Model counties and notify the counties whether a COHS would improve beneficiaries' access to care. If some or all of these counties desire to transition to a COHS, DHCS should assist them in making that change after their current contracts expire.

**Current Status:** Not Fully Implemented

**Estimated Implementation Date:** Unknown

**Implementation Plan:**

Will implement as needed. As noted in recommendation ten, DHCS will conduct an analysis of access in the Regional Model. Once this analysis has been completed, DHCS will use the results to determine next steps. Additionally, DHCS has and will remain open to meeting with counties and plans to discuss what is necessary to transition to a different model.

⑦

**Recommendation 12**

To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020: Evaluate whether it has the financial resources to provide assistance to counties interested in establishing COHSs or other managed care models after the current Regional Model contracts expire. If DHCS does not have the required financial resources, it should seek an appropriate amount of funding from the Legislature.

**Current Status:** Will Not Implement

**Estimated Implementation Date:** N/A

**Implementation Plan:**

DHCS will not implement as DHCS does not have the financial resources to provide direct financial assistance to counties to establish a Health Care Plan. The county interested in establishing a COHS would be responsible for seeking the necessary funding (from any source, whether county, state, or other) and overall county support to establish the COHS plan.

⑧

**Recommendation 13**

To ensure that beneficiaries in the Regional Model counties have reasonable access to care, DHCS should do the following by June 2020: Provide counties with reasonable opportunities to decide whether to change their managed care models after the expiration of the Regional Model health plan contracts. DHCS should provide counties who choose to do so sufficient time to establish their new models. DHCS should also include language in the 2020 request for proposals (RFP) to allow Regional Model

counties that can demonstrate their ability to implement a COHS model in their county by 2023 to opt out of the RFP process.

⑨ **Current Status:** Will Not Implement

**Estimated Implementation Date:** N/A

**Implementation Plan:**

⑨ The RFP release and the dates of implementation will not preclude counties from seeking a COHS model in those counties that are a part of the RFP. We would expect counties and plans interested in switching to a COHS model in any of the RFP counties to make DHCS aware during the RFP process, which should provide them a reasonable amount of time to choose to opt out of the RFP process and take the necessary steps to implement a COHS model.



## COMMENTS

### CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE DEPARTMENT OF HEALTH CARE SERVICES

To provide clarity and perspective, we are commenting on DHCS' response to our audit. The numbers below correspond to the numbers we have placed in the margin of DHCS' response.

We stand by our recommendation. As we state on page 24, given DHCS' critical role in overseeing the State's provision of Medi-Cal services, we believe that it is well positioned to perform the assessment of locations requiring additional providers and strategies for recruiting those providers we describe. If DHCS believes that it would benefit from collaborating with other state agencies, we would encourage it to do so while still maintaining overall responsibility for performing this assessment.

①

Contrary to its assertion, the written guidance DHCS currently uses to process alternative access requests, which we evaluated during the audit, is inadequate. As we state on page 21, DHCS lacks formal guidance specifying the conditions under which its staff should approve or deny a request. Consequently, DHCS cannot ensure that its staff approve only those requests in which health plans have demonstrated that they exhausted all reasonable options to obtain closer providers so that beneficiaries are not required to travel excessive distances to receive care.

②

DHCS' statement is incorrect. As we state on page 20, DHCS has not established a minimum number of providers that health plans should attempt to contract with in a designated location before it considers an alternative access standard request. By not requiring health plans to demonstrate that they have attempted to contract with a minimum number of providers before approving their alternative access standard requests, DHCS cannot ensure that the health plans have exhausted all reasonable efforts to seek providers that are closer to beneficiaries.

③

We disagree with DHCS' statement that it is already in compliance with our recommendation. We acknowledge that the current contracts for Anthem and Health & Wellness contain a requirement that the health plans must allow beneficiaries to obtain medically necessary covered services from out-of-network providers if they cannot provide the services in-network. However, we did not observe DHCS sufficiently enforcing this requirement during our audit. As we report on page 21, DHCS initially placed health plans

④

on network certification CAPs in 2018 to enforce the requirement but closed those CAPs after approving alternative access standard requests for those health plans that were still unable to meet access requirements. However, DHCS approved those requests even when health plans did not demonstrate that they had exhausted all reasonable options to obtain closer providers. We look forward to reviewing DHCS' 60-day response to the audit recommendations to learn about the steps that it will implement to enforce this contract requirement when it determines that health plans have not made sufficient efforts to contract with providers.

- ⑤ DHCS misses the point of our recommendation, which is to ensure that it promptly and sufficiently notifies counties and other stakeholders about health plans' quality of care deficiencies. Although state law allows DHCS to delay the publication of health plan audits until the health plans complete the medical audit CAPs, which we acknowledge on page 30, we believe counties could better assist their beneficiaries if DHCS informed them of performance issues more promptly. Therefore, to provide this important information in a more timely manner to counties, we recommended DHCS post its medical audit reports to its website within one month after it issues the audit to the health plan, which state law allows.
- ⑥ We look forward to reviewing DHCS' 60-day response to learn about the progress it has made to post additional information regarding the steps and legal requirements to create each model. However, DHCS also needs to send this information directly to counties—especially rural counties that lack resources and ability to seek such information—to ensure that they are informed of their managed care options. Simply posting or updating information on DHCS' website does not necessarily ensure that counties become aware of such information; we cite examples on page 30 of counties that find DHCS' website overwhelming or that experience difficulties finding information on DHCS' website about health plans.
- ⑦ DHCS' approach to implement this recommendation does not sufficiently address the issues we identified with access to care. As we state starting on page 39 of the report, there are structural aspects of the COHS Model that may provide better access to care for beneficiaries in the Regional Model counties than those beneficiaries currently receive. However, the analysis that DHCS refers to, which is described in its implementation plan for recommendation 10, does not include an evaluation of whether the COHS Model would be better suited to provide reasonable access to care in the Regional Model counties. Until DHCS performs the evaluation we recommend and proactively assists counties

that desire to transition to a COHS, those counties with limited resources may not be able to establish the health care systems that could best serve their beneficiaries.

We disagree with DHCS' perspective. Because the Regional Model includes many counties that may desire to transition to a single multicounty COHS, we believe that it would be more effective for DHCS to submit a consolidated funding request to the Legislature rather than for each county to submit its own individual request. As we state on page 7, DHCS is the state agency responsible for administering Medi-Cal. By submitting a single request, DHCS would help expedite authorization of such funding and would also help ensure that all of the counties are treated equitably, despite differences in their size and resources. As we characterize on page 42, small and rural counties may not be able to develop the infrastructure required to change their managed care models without DHCS' assistance.

⑧

We disagree with DHCS' determination that it does not need to implement our recommendation. Although DHCS acknowledges that the release of the RFP and the dates of implementation will not preclude affected counties from seeking a COHS Model, it did not specify that it would include that provision in the RFP. By implementing our recommendation to include language in the 2020 RFP to allow counties to opt out of the Regional Model if they can demonstrate their ability to implement a COHS Model, DHCS would demonstrate its commitment to helping small and rural counties improve the access to care for their beneficiaries.

⑨